Shared wisdom for supporting mental health in the community

Stories and resources for using evidence in practice

FALL 2019

Community Mental Health Action Plan

CONTACT INFORMATION:
info@mentalhealthactionplan.ca
www.mentalhealthactionplan.ca

"Wisdom is the reward of experience and should be shared."

[Unknown]

"There is no power for change greater than a community discovering what it cares about."

[Margaret J. Wheatley]

"Inside each of us, and among all of us, are the necessary elements to make our systems better."

[Institute for Healthcare Improvement]

Acknowledgments

Like all resources created by the Community Mental Health Action Plan, *Shared Wisdom for Supporting Mental Health in the Community* is a labour of love. Many hearts, hands and minds have shaped this work. With deep gratitude, we acknowledge the wisdom and practical advice so generously shared by people whose passion for a better system and a better world is dynamite. How powerful we can be when we work together for change!

We especially thank those who have shared their stories of supporting mental health in the community. You are living proof that with passion, courage and a spirit of learning and improving the "way we do things", we *can* move mountains!

Thank you!

In harmony with the premise of ongoing learning and improving, Shared *Wisdom for Supporting Mental Health in the Community* is a living resource. It will evolve over time as we apply findings and insights from evaluations, reflective practice and other forms of feedback.

How to cite this document:

Community Mental Health Action Plan. (2019). *Shared wisdom for supporting mental health in the community. Stories and resources for using evidence in practice*. Author.

"What if, instead of spending our lives doing, doing, doing, performing, performing, performing, we spent more time exploring, asking, listening, experimenting, striving and becoming? What if we each always had something we were working on to improve?...

And, what if we got clear within ourselves and with our teammates about when we seek to learn and when we seek to perform, so that our efforts can become more consequential, our improvement never-ending and our best even better?"[1]

TABLE OF CONTENTS

Background

Shared Wisdom for Supporting Mental Health in the Community ("Shared Wisdom" in short) is a product of the Community Mental Health Action Plan, a vital partnership consisting of diverse stakeholders and experts from community and government who are passionately invested in creating positive changes within the mental health system that we all share. A brief history of the Action Plan is outlined in the box below.

The history of the Community Mental Health Action Plan in seven sentences…

- In our community, there were many mental health supports and services; however, people and families were struggling alone, as were the professionals who were supporting them.
- Frequently, we complained in silos that services and supports were not coordinated and integrated and we were frustrated with the focus being on wait lists, budgets and not on people.
- Until we realized that just talking about the problem was not moving us forward. We began to talk together about collaborative solutions.
- Because numerous diverse and caring stakeholders came together with a purpose, we began building trusting relationships.
- Because of that, the Community Mental Health Action Plan was born, and committees and teams began to work together toward systems change and service delivery based on evidence.
- Until finally, the change we wanted to see from others came from within us, as together, we are the mental health system.
- And now, we have some new tools, resources and new ways of working together as a result of trusted colleagues collaborating to serve people.

The priorities of the Community Mental Health Action Plan are promoting positive mental health; ensuring Albertans can access supports during a crisis; and, preventing a crisis from happening in the first place. These goals are organized under three focus areas:

- System integration – working collaboratively across sectors to share resources and increase access to the full continuum of mental health and wellness services.
- Service delivery – building capacity of on the ground professionals, community members, individuals and families in navigating the mental health system.
- Evidence foundation – encouraging the use of evidence as the foundation for actions and practices.

Shared Wisdom for Supporting Mental Health in the Community was created under the Evidence Foundation focus area but encompasses all three. It is a vehicle for sharing evidence-informed practices (EIPs) and innovations for supporting mental health in the community, and for inspiring and supporting those who wish to optimize the care and supports they provide to others.

Purposes and audiences for *Shared Wisdom*

Wisdom has been shared in all shapes and forms throughout history. We respect and honour the practices and traditions of past and present cultures who have valued storytelling as a method for sharing wisdom to teach, connect, and grow the future. We have used a similar approach of sharing experiences, insights and knowledge with one another through a heart-based approach. This approach recognizes the value of not only evidence from research and evaluation, but also practice-based learning and the wisdom and experiences of people living with mental health challenges. We believe this relational method of sharing multiple forms of wisdom and evidence can enrich, enliven and optimize the care and supports we provide to the people and communities we serve.

Purposes

For our work to be rewarding, we need to know we're doing a good job and making a difference for the people we serve. But it can be frustrating when we don't get the results we're hoping for, or when we're not sure what the most promising approach might be.

There has been a strong push in recent years for health and human services practitioners and organizations to become "evidence-informed", but what does that really mean? And how is that done? How, exactly does one become "evidence-informed", especially given the time and resource constraints most of us face? How do we find and make sense of "evidence"? What does that "evidence" look like when it's put into action in our communities, with real people? How do we know it's making a difference?

We developed *Shared Wisdom for Supporting Mental Health in the Community* to help practitioners answer these questions. Specifically, *Shared Wisdom* was developed with four purposes in mind. These are to:

Share what's working "on the ground"; that is, to share locally developed innovations and evidence-informed[i] practices (EIPs) that can result in better mental health outcomes. We all, as individuals or agencies, have things that we excel at, and *Shared Wisdom* is a forum for sharing these assets. And, we know that people often learn best by hearing stories about what others have done.

Acknowledge, support, and celebrate what people are doing in Alberta to improve community-based mental health and addiction services and supports and to achieve positive outcomes for individuals, families, groups and communities. *Shared Wisdom* is a venue to make visible and celebrate the excellent work already underway in the province.

Inspire and support implementation of innovations and evidence informed practices, including continuous learning and adaptation to dynamic and evolving contexts - by providing information, ideas and resources to help along the way. These are not prescriptions or recipes, but rather, an array of possible approaches that can be used to implement new ideas and practices on the ground.

Build a learning community around the sharing of wisdom and experience to better support mental health in the community. The spirit is one of "mutual aid" – working and learning together to optimize mental health outcomes for individuals, families and communities.

[i] We define **"evidence-informed practice" (EIP)** as an ongoing decision-making process informed by many kinds and sources of evidence, weighed in light of the context in which one is working, in order to determine the most promising way(s) to address a particular issue or opportunity. An **"innovation"** is any product, action, service, relationship or policy that is novel and useful to a practitioner or organization and that has the potential to enhance mental health and wellbeing. EIPs and innovation are both integral to optimizing the care and services we offer.

"This work is heart work. It's hard work, but it's heart work. We are here because we are driven to connect with other people. This is at the root of all of it."

[Jerilyn Dressler, CEO, Distress Centre, Calgary]

Audiences

Shared Wisdom is intended for people and organizations with a spirit of inquiry and a commitment to serving others with excellence – people who strive every day to better support people, families and communities in their journey to mental wellbeing, resilience and recovery. This includes government and non-government organizations, whether large or small in size and in urban, rural and remote settings. It also includes any other individuals, groups or organizations in a position to support mental health in the community.

The major focus is on evidence-informed practices and innovations in organizations. Some information will be particularly relevant to managers charged with overseeing these activities; other information will be relevant to individual practitioners doing the work "on the ground". In essence, ***there is something for anyone who is interested in optimizing supports for mental wellbeing in the community.***

SELF-QUIZ

QUESTION	YES	NO
Have you ever struggled to achieve the outcomes you're hoping for when working with a service user or program?		
Have you tried to find new ways to solve problems in your practice?		
Do you wonder how other practitioners or organizations have solved a problem that's frustrating you?		
Have you ever wondered how you could take an approach used by another organization and apply it in your own organization?		
Do you have an idea for a new practice or approach and want to see if it works?		
Do you have an opportunity to try something new but wonder how to proceed?		
Do you ever wonder how effective your efforts really are?		
Is your funder requiring you to use "evidence-informed practices" but you're not sure where to start?		

If you answered "yes" to any of these questions, *Shared Wisdom for Supporting Mental Health in the Community* is for you!

Philosophy and principles of *Shared Wisdom*

Shared Wisdom is grounded in a specific philosophical orientation and set of principles. These are described below.

The term "mental health" is used to indicate a positive and holistic phenomenon. Mental wellbeing is holistic in that it is inseparable from other dimensions of wellbeing – physical, emotional, spiritual, social and intellectual. The focus of *Shared Wisdom* is on supporting people to be well and resilient even while living with a mental illness. This means being able to feel and think and act in ways that enhance our ability to enjoy life and deal with the challenges we face.

Emphasis on the spectrum of non-clinical, community-based mental health and addiction care and services that can be implemented by agencies and workers of all backgrounds (and lay people, too) to support people to be mentally well, resilient and to flourish, including, for example:

- Promotion of positive mental health and resilience.
- Prevention of mental health challenges and illnesses wherever possible.
- Early identification and intervention for mental health challenges and illnesses.
- Services and supports for people living with mental health challenges to meet their immediate and longer-term needs and interests, and to pursue meaningful and satisfying lives.
- Approaches that community-based organizations can take to improve service delivery such as, for example, improving access to, and integration of services.

Note that the focus is not on clinical interventions for mental illness (e.g., counseling or other forms of therapy) as it is assumed that mental health professionals learn about clinical practices in their training and ongoing professional development, and there are other forums for evidence informed clinical practice (e.g., clinical practice guidelines).

Person/family/community-centered care and services; that is, developing collaborative relationships between service providers and service users that are:

- Based on mutual trust and respect and,
- Characterized by "*working with*" rather than *"doing for"* - in essence, *"nothing for us without us*".

People, whether individuals, families or communities are the experts regarding their own health and wellbeing. That's why they are at the centre of all efforts.

From the heart: A spirit of care and compassion. Importantly, perhaps crucially, the foundation of this resource is a spirit of care and compassion and recognition that **"mental health is all of us",** meaning that:

- Mental wellbeing and mental health challenges alike are part of our shared humanity.
- Everyone is impacted in some way by mental health challenges.
- Everyone can make a difference.

We believe the fundamental technology of health and human services is caregiving – a process of caring for others in ways that help them to heal, learn and grow.[2] It is not a job to serve people in this way; it is a calling and it is an art, complemented by various forms of evidence. *Shared Wisdom* thus aims to honour and illuminate this caring and compassion-focused art of practice.

> "In my view, the best of humanity is in our exercise of empathy and compassion. It's when we challenge ourselves to walk in the shoes of someone whose pain or plight might seem so different than yours that it's almost incomprehensible."
>
> ***[Sarah McBride (American activist)]***

Within existing resources and structures. Like the Community Mental Health Action Plan, *Shared Wisdom* is premised on the notion of acting now, within existing resources and structures. It is about finding ways to work in a more integrated fashion in order to promote mental wellbeing, prevent addiction and mental health challenges wherever possible, and to intervene early rather than waiting until people require advanced and intensive supports. This requires innovative thinking and action – striving to see and do things differently: *What things can we do differently? What different things can we do?*

"Let's not start by saying we need more money and staff. While that sometimes may be the case, often it is not. It is an assumption. It is an easy go-to solution because it requires far less work than transforming the system."[3]

Recognition that supporting mental health in the community is complex work and occurs in complex environments where there are few "one-size-fits-all" solutions, given the diversity of individuals, families, communities and the issues they face. Tackling complex issues in complex environments requires not only understanding what has worked elsewhere and why, but also, flexibility, experimentation, and most importantly, ongoing learning and adaptation.

Guiding Principles

The guiding principles for this resource are those set out in the *Community Mental Health Action Plan*. These include:

Dignity: people will be recognized, valued and respected and treated in a manner consistent with their inherent human rights.

Compassion: individuals and families experiencing mental health needs and mental illness will be respected and treated with compassion.

Equality: equal opportunities to access effective prevention and treatment of mental illness should be available to all who would benefit from them.

Diversity: an appreciation of, and responsiveness to diverse populations and cultures will be the basis of engagement and intervention approaches.

Collaboration: partnership, collaboration, shared responsibility and accountability will be sought and maintained among all stakeholders – individual, family, community, business and government.

Empowerment: individuals and families will be engaged in their own journey to strive for positive mental health, resiliency and to maximize their potential to pursue fulfilling lives.

Quality: high quality, person-directed, timely, transparent, effective, efficient and accessible mental health care services are worthy of investment.

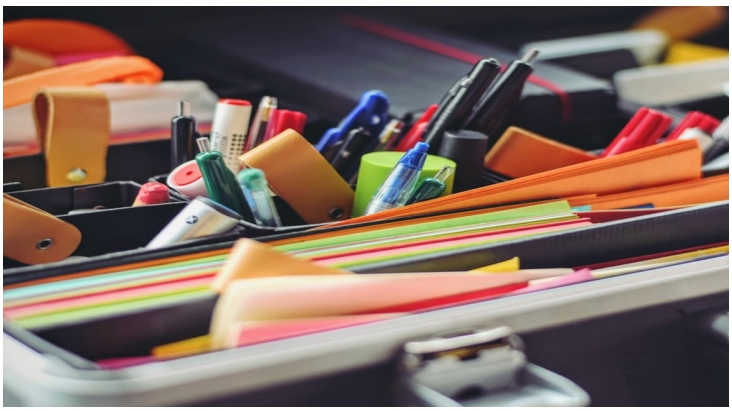
Evidence-informed: decisions are informed by many kinds and sources of evidence, weighed in light of the context in which one is working, in order to determine the most promising way(s) to address a particular issue or opportunity.

Comprehensive: all facets of an individual are considered – intellectual, emotional, physical, spiritual, familial and communal.

Two complementary components: Stories and resources

Shared Wisdom has two complementary components, each designed to inspire and inform efforts to improve practice based on evidence:

- **Stories about the experiences of people and organizations** who are traveling the path of improving supports for mental health and addictions in the community. If, like many people, you learn best from stories, these are for you!
- **Resources for implementing evidence-informed practices and innovations "on the ground".** This is not a prescriptive, "how to" manual or guide; but rather, a smorgasbord of ideas and resources that others have found to be helpful. Our hope is that you might also find these to be valuable in your own practice and/or organization.



By sharing these stories and resources, we hope people will see that change can indeed happen and make a difference – it *is* doable! And much can be achieved within existing resources. We hope you will be encouraged and inspired to use evidence from various sources or innovate as needed to support mental health and make a difference for the people you serve.

How to navigate Shared Wisdom

This is a big document! It might look daunting, but it's not. There is no need to read it all and there is no single way to navigate through the information. There's certainly no prescribed linear pathway. To help you navigate quickly to whatever content inspires you the most, major topics are listed below. Simply click on whatever seems most interesting or helpful and go from there!

Stories – click here for a brief description for each story.

Resources and information for implementing evidence informed practice and innovating "on the ground":

Endnotes

[1] Briceño, E.(2017). *How to get better at the things you care about*. TED Talk.

[2] Kahn, W. (2005). *Holding fast. The struggle to create resilient caregiving organizations.* New York: Brunner-Routledge.

[3] Leader, T. (2016). *It's not about us. The secret to transforming the mental health and addiction system in Canada*. Cathydia Press; pg. 114.

Shared wisdom for supporting mental health in the community: STORIES

How people and organizations in Alberta are using evidence and innovating to support mental health in the community.

Community Mental Health Action Plan

The power of stories for learning and change

For thousands of years, stories have been used to pass on wisdom, learning and knowledge. Our brains are hardwired for story; we think in narratives all day long. We identify closely with stories, imagining how we might have acted in similar circumstances. They light up the whole brain, evoking emotions, curiosity and imagination. They raise awareness, bring issues to light, humanize concepts, inform debates and discussion and inspire listeners/readers to know more. So, what better way to *share wisdom* for supporting mental health in the community than through stories? What's great about the stories in *Shared Wisdom* is that they are about people living and working in Alberta. You may even know some of them, or at least be able to reach out to them to understand more about their experiences and "lessons learned".

For the most part, *Shared Wisdom* stories are about the experiences of Albertans who are invested in improving the system and/or the supports provided for mental health in the community. This includes stories from people living with mental health challenges. Most of the stories are exemplars of how people and organizations have implemented evidence or innovated in ways that are making a positive impact on mental health. These stories typically describe *what* changes were made as well has *how* they were made, thus giving readers ideas for how they might implement something similar in their own sphere. Many stories come from mental health and addiction or other community service organizations, but there are also stories from "mental health allies" – businesses and schools, for example.

Using the stories

There are several ways you could use these stories:

- Simply as sources of information and ideas about how others have successfully implemented evidence or innovated to better support mental health in the community.

- As case studies for reflective practice and learning. These stories can be the launching pad for conversations in your team or organization about how you might be dealing with similar challenges, or how you might want to adopt a similar practice in your organization.

- Understand what theory looks like in practice, "on the ground" in different kinds of settings and for different groups of people; and access theory and research-based evidence through links provided in each story.

Links to Shared Wisdom stories

Here is a listing of current *Shared Wisdom* stories. You can access them by visiting the website under the topic area "evidence-informed practices" or by searching using the title of the story.
We are developing new stories all the time, so keep checking back!

www.mentalhealthactionplan.ca

From enforcement to coffee and compassion: Trauma informed care at Edmonton City Centre

Trauma-informed care in a shopping centre? You bet! At Edmonton City Centre, "security" means something entirely different today than it did a few short years ago. Arrests of "trespassers" are down. Inclusion, respect, a listening ear, kind words, linkages to services, and donations of coffee, food and clothing to those who could be considered "vulnerable" are up. What's happening at Edmonton City Centre has the potential to transform hundreds, if not thousands of lives, yet the "technology" is simple and something anyone can provide: respect, compassion and an understanding of how trauma can impact our lives.

"Trauma-informed care is our foundation": The Aventa Centre of Excellence for Women with Addictions

What does gender-responsive trauma-informed care (TIC) look like in a residential treatment centre for women with addictions? For the past 12 years, the Aventa Centre of Excellence for Women with Addictions has been basing its' work on the research of Stephanie Covington. In this story, we describe how TIC has become embedded into the very fibre of the organization, and share Aventa's advice for others wishing to do the same.

The power of love at the BRICK Learning Centre: Transforming students' lives through caring relationships

Many students at the BRICK Learning Centre in Ponoka have experienced or are experiencing significant trauma in their lives. But students here are thriving largely because of the fundamental philosophy of connection and caring for students: *"When relationships are the core foundation of what we do, we change kids and we change their futures."* The BRICK is an exemplar of the power of protective factors, especially caring adults and cultural safety, to mitigate trauma and help students to flourish.

Sustaining a culture of continuous learning at the Aventa Centre of Excellence for Women with Addictions

For decades, the Aventa Centre of Excellence for Women with Addictions has fostered and sustained a culture devoted to ongoing learning and quality improvement. In this story, we map out how this award-winning organization has managed to make it work.

Shared wisdom for supporting mental health in the community: RESOURCES

Resources for implementing evidence-informed practices and innovations "on the ground"

Community Mental Health Action Plan

Resources Part I. Introduction

What is “evidence”, and why should we care about it?

Where do we find it? What do we do with it? How do we use it in our day-to-day practice?

What are innovations? How do we innovate?

How do we know if our use of evidence or innovation makes a difference or not?

The intent of this Resources section of Shared Wisdom is to unpack the answers to these questions. Evidence comes in many shapes and forms, and from many sources including, but also beyond academic research. We all use evidence in our day-to-day lives - we are continually assessing how things are going for us and adjusting to make things better.

Innovating and using evidence in our practice and agencies is really about being open to new ideas, understanding the issues we face, examining what experience and research and service users tell us, and paying attention to how what we do makes a difference or not. It’s about learning and using what we learn to make things better. These processes put us on the path of enhancing the care we provide and achieving better results for the people we serve. And that is the heart of the matter – why using evidence wisely is so important – to optimize our efforts to support people in their journey toward wellbeing and/or recovery. Using evidence and innovating enables us to offer our very best and to truly make a difference. And that can make our work more rewarding and satisfying.

“There is no greater joy, nor greater reward than to make a fundamental difference in someone’s life.”

[Mary Rose McGeady]

The Resources section of *Shared Wisdom* contains ideas and resources implementing evidence-informed practice and innovating in community-based organizations and groups that are in a position to support mental health. True to evidence-informed practice, *Shared Wisdom* is grounded in numerous forms of evidence including:

- Theory and research about complexity and systems thinking, implementation science, knowledge translation, learning and change in organizations and more.
- The wisdom and practical experience of community-based practitioners who contributed to *Shared Wisdom.*
- Feedback provided by stakeholders on previous drafts of *Shared Wisdom.*

You will not find prescriptions or recipes and there are no "silver bullets" or magical solutions to making change; but rather, you will find a smorgasbord of theories, ideas and practices that have worked for others. This is our attempt to provide a helpful summary of key ideas and processes that are described "out there", alongside questions for reflection and links to helpful resources. We hope this content – this *shared wisdom* from the academic and practice worlds – will be helpful to anyone wishing to improve the care and supports they provide to others.

Overview of the Resources section of Shared Wisdom

Here is how we've organized this Resources section of *Shared Wisdom*:

- In **Part 2**, we present a brief discussion about complexity and what that means for improving practice.
- In **Part 3**, we present some key ideas about "leading for learning" in organizations.
- In **Part 4**, we define and describe the terms "innovation" and "evidence-informed practice (EIP)".
- In **Part 5A**, we outline a simple model and principles for implementing EIPs and innovations on the ground in complex environments.
    - The remainder of the Resources section is devoted to describing each process in the model:
        - **Part 5B:** Engaging and building relationships with service users and other stakeholders.
        - **Part 5C:** Understanding the issue and context.
        - **Part 5D:** Exploring the evidence and deciding where to begin.
        - **Part 5E:** Planning and preparing.
        - **Part 5F:** Implementing the EIP or innovation through cycles of acting, learning and adapting.

The intent is not to provide exhaustive content, but rather to introduce key ideas, then offer some questions to consider in your own practice. At the end of each section or in some cases, sub-section, you will find a table like the one below that provides links to additional information, helpful resources and tools and interesting new ideas or emerging practices.

Some resources that might be helpful…	
	Links to resources and tools
	Links to interesting ideas or short examples (wherever relevant)

Resources Part 2. Seeing our world and work through the lens of complexity

In this Part we offer a brief explanation as to **why we have grounded Shared Wisdom in complexity thinking**[ii] – and specifically, why, when working to support mental health in the community, it is crucial to:

- Understand and consider the context in which we're working.
- Expect the unexpected.
- Cultivate and sustain mutually respectful and trusting relationships.
- And, most importantly, continually learn and adapt efforts in order to serve with excellence.

The Evidence Foundation focus area of the *Community Mental Health Action Plan* is about encouraging the use of evidence as the foundation for actions and practices to support mental health in the community. But, how do we actually keep abreast of what might work best for a particular issue or opportunity, or for a particular service user or community given their unique life circumstances, and given the context in which we're working and the resources available to us?

Keeping updated on current research-based evidence is certainly an important way of doing this, and indeed, there is a strong push in our current environment to adopt this kind of evidence in our practice. Of course, this makes sense. But, as with most things in life, in reality, it's not that simple because the world in which we work and the issues experienced by the people and communities we serve are, in two words, messy and complex.

[ii] For a fuller description of complexity thinking, see Appendix A.

"Complexity thinking presents… a view of the world as organic, adapting, becoming and emerging. We argue that this worldview is more realistic than a mechanical worldview, of a world that is predictable, where change goes according to plan and in which the cogs in the machine, including people, are unchanging and controllable. We have concluded that a view of the world as complex, systemic, full of variety, and one that is able to evolve, is the more realistic.[4]"

More often than not, the problems we tackle are interconnected, tangled up with other issues. They wax and wane and morph over time and take on a life of their own. Think about, for example, some of the actions and goals outlined in the *Community Mental Health Action Plan*: integrating services more effectively, finding better ways of navigating the system, providing culturally appropriate care to Indigenous people and newcomers; or other issues, such as promoting the mental wellbeing of children and youth, preventing suicide, or tackling the current opioid crisis. There are few, if any, easy answers or simple solutions for these multi-faceted issues.

We can't blind ourselves to, nor wish away this messiness and complexity. Far better to embrace it and learn how to navigate it. Embracing a complexity perspective helps us to do this. In contrast to a mechanical mindset which views the world as predictable and controllable (think: clocks, machines), a complexity perspective views the world as organic and always evolving (think: clouds, communities).

In the table below, some of the differences between mechanical thinking and complexity thinking are outlined (see Appendix A for more detail).

Differences between mechanical thinking and complexity thinking[5]

	Mechanical thinking	Complexity thinking
How we can understand the world	The world can be understood by taking apart the pieces and understanding them separately.	The whole is more than the sum of the parts. The parts work synergistically and thus cannot be understood in isolation from each other. We need to understand the relationships amongst the parts.
Nature of the world	The world is predictable and controllable.	The world is continually changing, evolving and adapting. On the surface it might look as if things are stable for quite some time although small changes are occurring. Then a radical change can suddenly happen.
Causality	Linear cause and effect. Action A leads to effect B. The same stimulus or action evokes the same response each time it is applied.	Non-linear. The relationship between cause and effect is often obscure and understood only in retrospect. Different parts respond to their environment in different ways. The same stimulus doesn't always produce the same response. Small actions can sometimes result in large changes; and sometimes, large change efforts result in little change.
Importance of history	History and the past are not very relevant.	History and an understanding of how things unfolded matter – they are viewed as key to shaping the future. What has happened in the past will influence what we do in the present.
The importance of context	One size generally fits all. Context is not very relevant.	There are few if any one-size-fits all solutions; understanding and matching interventions to the local context is crucial for success.
How to ensure productivity	Closely monitor and tightly control to make things efficient (managerialism).	Support people in being effective. Hire knowledgeable, skilled people; set direction and support innovation and action toward goals.
Application of evidence to practice	Best practice – assumption that a practice implemented in one setting can be replicated, perhaps with some adaptation, in other settings. Emphasis on fidelity to the original approach.	Emergent practice – practice is informed by multiple sources of evidence and ongoing observation and monitoring. Practice is adapted to fit the local context.

What are the implications of applying a complexity lens to evidence-informed practice and innovation?

The worldview we adopt shapes how we make sense of and approach the world. Complexity thinking shifts how we think about implementing evidence-informed practices and innovations. While being clear on achieving intended goals remains important, **what changes with a complexity worldview is adding in a greater degree of flexibility in order to seize opportunities, respond to the unexpected, and adapt to changing circumstances**[6]. Flexibility is also needed to spot and respond to anticipated and unanticipated signs of change. And, **learning becomes paramount**. This is made possible by embedding learning processes, such as evaluation and reflection into the change project. [For more information about supporting learning in organizations, see the next section, *Leading for Learning in Organizations*.]

Four key implications of complexity for our practice

Our journey through the literature illuminated four key implications for implementing evidence-informed practices and innovations from a complexity perspective:

- **Context matters – a lot**. What happens is shaped by the contexts in which we are working (e.g., the community, culture, politics, the nature of our own organization). Context shapes not only the issue or opportunity we're addressing, but also what approaches and actions will or will not succeed, even if they have worked elsewhere. And finally, the context itself is dynamic, continually evolving over time, meaning that our efforts need to evolve over time, too.
- **"Stuff" will happen - expect the unexpected**. There will be curve balls; whatever you do might have unintended consequences; and, new factors or dynamics may emerge that were not expected or planned for. Thus, it can be futile to map out every little detail in advance. Instead, flexibility is required to allow adaptation and course corrections as needed.
- **Continuous learning and adaptation = the ability to improve care and services.** Given the dynamism of context and the inevitability of "the unexpected", continuous learning through reflection, observation, and evaluation of efforts is a "must". Interventions will need to be adapted and tested again as the system evolves and learning about any unanticipated effects occurs. The careful study of information from diverse perspectives informs any needed changes or adaptations that will support movement toward the ends we desire.
- **Mutually respectful and trusting relationships are the fuel and vehicle for effective action and change.** What we learn and what we do is mediated through our relationships and interactions with one another. Where there is authentic and mutual trust and respect, there is great potential for success. It is within such spaces that diverse perspectives and ideas can be safely exchanged and explored, where deep listening yields deeper understanding of self and others, and thus where creativity and innovation can flourish. These "generative spaces[7]" are a fertile ground for improving the services and supports we provide.

Some resources that might be helpful…

Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press.

Braithwaite, J. (2018). Changing how we think about healthcare improvement. *British Medical Journal*. 361. https://doi.org/10.1136/bmj.k2014

Braithwaite, J., Churruca, K., Ellis, L., Long, J., Clay-Williams, R…Ludlow, K. (2017). *Complexity science in healthcare – Aspirations, approaches, applications and accomplishments: A white paper.* Sydney, Australia: Macquarie University - Australian Institute of Health Innovation.

Canadian Centre on Substance Abuse. (2012). *Systems approach workbook: Systems thinking and complexity in substance use systems.* Author.

Dodd, S., & Savage, A. (2016). Evidence-informed social work practice. *Encyclopedia of Social Work.*

Kania, J., & Kramer, M. (2013). Embracing emergence: How collective impact addresses complexity. *Stanford Social Innovation Review*.

Livingood, W., Allegrante, J., Airhihenbuwa, C., Clark, N., Windsor, R…Green, L. (2011). Applied social and behavioral science to address complex health problems. *American Journal of Preventive Medicine*, 41(5), 525-531.

Plsek, P. (2003). Complexity and the adoption of innovation in health care. Paper presented to the conference: *Accelerating Quality Improvement in Health Care – Strategies to Speed the Diffusion of Evidence-Based Innovations*, Washington, CD, 27-28 January.

Preskill, H., Gopal, S., Mack, K., & Cook, J. n.d. *Evaluating complexity. Propositions for improving practice*. FSG.

Sterman, J. (2006). Learning from evidence in a complex world. *American Journal of Public Health*, 96(3), 505-514.

Westley, F., Zimmerman, B., & Patton, M. (2006). *Getting to maybe: How the world is changed.* Random House Canada.

Zimmerman, B., Lindberg, C., & Plsek, P. (2008) *Edgeware. Lessons from complexity science for health care leaders.* Authors.

New, advanced work from the UK about complexity and funding agencies

Lowe, T. (2019). *Radical models of commissioning.* YouTube video.

Davidson Knight, A., Lowe, T., Brossard, M., & Wilson, J. (2017). *A whole new world: Funding and commissioning in complexity.* Collaborate for social change.

Lowe, T., & Plimmer, D. (2019). *Exploring the new world: Practical insights for funding, commissioning and managing in complexity.* Collaborate for social change.

Lankelly Chase. N.d. System behaviours. [A list of core behaviours that help systems function better for people facing disadvantage.]

Endnotes

[4] Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press; pg. 106.

[5] Adapted from:
Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press; pg. 130.

Braithwaite, J., Churruca, K., Ellis, L., Long, J., Clay-Williams, R. Ludlow, K. (2017). *Complexity science in healthcare – Aspirations, approaches, applications and accomplishments: A white paper.* Sydney, Australia: Macquarie University - Australian Institute of Health Innovation.

Carlisle, Y. (2011). Complexity dynamics: Managerialism and undesirable emergence in healthcare organizations. *Journal of Medical Marketing,*11(4), 284-293.

Plsek, P. (2003). Complexity and the adoption of innovation in health care. Paper presented to the conference: *Accelerating Quality Improvement in Health Care – Strategies to Speed the Diffusion of Evidence-Based Innovations*, Washington, CD, 27-28 January.

[6] Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press; pg. 130.

[7] Reay, T., GermAnn, K., Casebeer, A., Golden-Biddle, K., & Hinings, C.R. (2016). Creating and sustaining the right kind of space for organizational learning in primary healthcare. In J. Swan, S. Newell, & D. Nicolini (Eds.) *Mobilizing knowledge in healthcare. Challenges for management and organization.* Oxford, UK: Oxford University Press.

Resources Part 3. Leading for learning in organizations

In this Part we give a high-level overview of ways to nurture creativity and learning in organizations and other collectives. This includes psychological safety for learning, cultures of innovation and learning, and the psychology of change.

Implementing EIPs and innovations means something is going to change in your practice or organization. Implementation researchers consistently identify ongoing leadership and facilitation of the change effort as key drivers of successful implementation of evidence-informed practices (EIPs). We would be remiss not to bring that up here! All of what follows in this *Resources* section is premised on the assumption that organizational leaders (formal and informal) are championing and facilitating the change effort.

Supportive leaders are strong champions for the changes that need to be made to implement EIPs, and for creating the conditions under which their organization and its people can learn and improve their efforts. Facilitators are those leaders intimately involved with implementing innovations and EIPs. They are the people who help navigate the process and all of the challenges encountered along the way. They have been described as the "active ingredient" for successful implementation[8].

Psychological safety for learning

Doing something new or different always entails taking some degree of risk, and this is why creativity and innovation can only flourish in an environment that welcomes experimentation, challenging of assumptions, risk taking, failure, and learning. Organizational researcher Amy Edmondson calls this "psychological safety[9]" – a shared belief that the work unit is safe for taking the risk of generating, exploring and trying out new ideas without a fear of censure, ridicule or sanctions[10]. This is a characteristic of a unit or team - not individuals - and it is a feature of work environments that leaders can build and sustain.

"In psychologically safe environments, people are willing to offer ideas, questions and concerns. They are even willing to fail, and when they do, they learn[11]."

Psychological safety has also been described as a culture that recognizes and contains the anxiety associated with innovation and change. Critical reflection and learning, when done well, can challenge existing assumptions and mental models about "how things should be done". This can create anxiety and disagreement, so the importance of skilled facilitation and creation of a "safe space" for such dialogue cannot be understated. Skilled facilitators can help create that safe space, dig beneath the surface, and push teams to think more deeply in order to arrive at deeper and more helpful insights.

Confronting fear means confronting our imperfections. This takes courage because, of course, it is unpleasant. But acknowledging our limits with good nature and a sense of humour allows us to get on with things, to be creative and innovative. Environments that discourage the reporting of problems, mistakes, and failures block this forward movement.[12]"

Key characteristics of psychologically safe environments for learning

Key characteristics of psychologically safe environments[13] include:

- Trusting relationships such that people feel they will be listened to, heard and supported if they put forward a new idea.
- Openness to new ideas and openness to the external world with a willingness to learn from what others are doing, whether they are peers, experts or academics – "*it's cheaper than having to invent it yourself.*"[14]
- Insistence on time and space for individuals and teams to reflect on what they are learning and how they need to adapt.
- Comfort with questioning or challenging assumptions and evidence.
- Diversity of backgrounds, perspectives, experiences and motivations – and the ability to constructively navigate the conflict and tension that comes with this diversity.
- Willingness to take risks, to experiment and to fail.
- Recognition for experimenting with new ideas, helping to solve problems and helping each other to learn.
- Being quick to take advantage of opportunities.
- The ability to learn by doing.

SHARED WISDOM STORY:

The Aventa Centre of Excellence for Women with Addictions has a well-established culture of continuous learning.

SEE THE STORY:

Sustaining a Culture of Continuous Learning at the Aventa Centre of Excellence for Women with Addictions.

Cultures of learning and innovation

Psychological safety is the ground for cultures of learning and innovation. Research about learning and innovation in organizations[15] has shown that innovative teams and organizations are those characterized by:

- Leaders who genuinely value and support creativity, innovation and learning.
- Leaders who admit when they don't know the answer to the question.
- Leaders who coach, mentor and facilitate employees' learning and who model the importance of learning.
- Psychological safety for learning (see above).
- Supports for social innovators – psychologically, socially and financially.
- Supports for reflective practice among social innovators – isolation of innovators can lead to doubt and despair; bringing them together to explore issues, reflect on what they have learned, and to identify patterns of action – is not navel gazing luxury! It is the hard work of standing still and reflecting together. Harvesting insights can build new knowledge. Some of these supports for reflective practice include:
    - Support learning as a meaningful outcome – and reporting on learning as a form of authentic accountability; adapt your approach in response to what is learned, whether that is something small or through major re-alignments where called for.
    - Nurture experimentation and learning especially in the case of failed policies and initiatives.
    - Support small 'safe-fail' initiatives to learn what works and doesn't work before implementing change more broadly.
    - Embrace meaningful and ongoing reality testing; make developmental evaluation part of the organizational culture.
    - Report, discuss and learn from failures as well as successes – and keep these balanced and in perspective.

- Avoid taking more personal responsibility for failure (or success) than is appropriate. Social innovations and transformation are the products of many forces. Overly harsh self-criticism and self-blame hinder rather than enhance learning and things often get worse before they get better.
- Don't let fear of failure hold you back. Be prepared for ups and downs and live the Stockdale Paradox: eyes on the stars, feet on the ground.

What a continuous learning mindset looks like…

Heitfetz and colleagues[16] describe what a continuous learning mind-set looks like in an organization. It includes:

- People who make mistakes or experiment with new ways of doing things are not marginalized. Rather, they are treated as founts of wisdom because they have experiences that the organization needs to capture.
- When strategic decisions need to be made, the perspectives of frontline people are considered. It is agreed that some of the most useful knowledge resides in those in the field and who deal with the organization's day-to-day realities.
- Retreats and off-sites are regularly scheduled and include people from all levels of the organization. These are two-way conversations, not one-way mandates delivered from "on high". A diverse group sets the agenda and space is left for issues not anticipated in advance.
- When something bad happens, the news is acknowledged and the event is debriefed to identify lessons learned, not treated as a cause for punishment.
- Senior people are encouraged to get away from the office, refresh themselves and gain new perspectives through sabbaticals and leaves of absence.
- Communication and interaction are nurtured across all formal and informal boundaries. The organization brings together units that don't regularly interact. People are put together face-to-face to generate learning opportunities. People may shadow one another to learn about other perspectives and to get another angle on the organization's work.
- Executives encourage pure reflection as well as more disciplined processing of complex, dynamic situations – for example, some meetings are scheduled with no agenda so people can test different interpretations of current, past and future realities.
- The organization supports coaching for those in top positions, knowing that having a sounding board outside the organization can prevent the insularity that undermines adaptation.
- People view the latest strategic plan as today's best guess rather than a sacred text; and, they expect to constantly refine it as new information comes in.

What does it look like in your organization?

For fun, you might want to have a look at the quizzes below. The first one, "*How Adaptive is Your Organization?"* was developed by Heifetz and colleagues, based on their research. The second one, "*Self-Quiz Two"* is not a tested tool; it's something we put together based on our review of the literature, but it does pose some helpful questions for reflection.

You might choose to review these quizzes just by yourself or if you have a "safe" space in your organization to speak frankly, talk them over with your colleagues or team.

Self-Quiz One: How adaptive is your organization?

QUIZ: How adaptive is your organization?[17]		
Adaptability Criteria	Description	Rating (1 = "very low" 10 means "very high")
Elephants in the room	How long does it take to get conversations from inside peoples' heads to the coffee machine and then to meeting rooms? How quickly are crises identified and bad news discussed? Are there structures, incentives and supports for speaking the unspeakable?	1 2 3 4 5 6 7 8 9 10
Shared responsibility	To what extent do people in your organization, especially those in senior management, act from the perspective of and for the betterment of the whole organization, as opposed to worrying about and protecting their individual groups and silos?	1 2 3 4 5 6 7 8 9 10
Independent judgment	To what extent are people in your organization valued for their own judgment rather than their capacity to divine the boss's preferences? And when someone takes a reasonable risk in service of the mission and it doesn't work out, to what extent is that seen as a learning opportunity rather than a personal failure?	1 2 3 4 5 6 7 8 9 10
Develop leadership capacity	To what extent do people know where they stand in their organization and their potential for growth and advancement? Do they have an agreed-upon plan for how they are going to reach their potential? And to what extent are senior managers expected to identify and mentor their successors?	1 2 3 4 5 6 7 8 9 10
Institutionalized reflection and continuous learning	Does the organization carve out time for individual and collective reflection and learning from experience? To what extent does the organization allocate time, space and other resources to get diverse perspectives on how work could be done better?	1 2 3 4 5 6 7 8 9 10

Self-Quiz Two

You can ask these questions at an individual, group/team, or organizational level.

QUESTION	Always	Sometimes	Never
Are you curious?			
Are you willing to change your practice in order to serve people better?			
Do you make a conscious effort to reflect on your practice in order to improve?			
Do you talk with colleagues about ways to solve work-related challenges?			
Would you describe yourself as innovative?			
Do you try to learn from the experiences of your colleagues?			
Do you try to keep your knowledge up to date?			
Do you know how and where to access good quality research that is relevant to your practice?			
Do you actively engage service users in deciding about best avenues for action?			
Do you consider the context in which you are going to implement new actions?			
• Do you consider the ability of your organization to act?			
• Do you assess the suitability of the action for the community and people to be served?			
• Do you assess the political environment to understand where you might leverage support or run into obstacles?			
Do you monitor or keep track of how things are going as you try something new?			
• Do you use that information to decide on "next steps"?			
Do you formally evaluate the effectiveness your efforts?			

If you answered "always" or "sometimes" to the first two questions, you are definitely on the path of becoming an evidence-informed practitioner/team/agency. And if you answered "always" or "sometimes" to most or all of them, you are definitely there!

The psychology of change

The Institute for Healthcare Improvement (IHI) in the United States recently released a document called "the *IHI Psychology of Change Framework*". This framework is about the human side of change – the underlying psychology of change and using this to strengthen quality improvement efforts. This may be a helpful resource for you as you embark on your journey of implementing EIPs and innovations.

The framework is directed toward advancing and sustaining improvement by working collaboratively with people directly and indirectly affected by improvement efforts – service users and families, service providers, community members, policymakers and others. It emphasizes the inherent value of each person and finding ways for them to meaningfully contribute to the solution.

The framework, based on a literature review and interviews with key experts, is centrally premised on creating the conditions that enable individuals and groups exercise power (the ability to act with purpose) and courage to act in the face of uncertainty or difficulty. To establish these conditions, the framework outlines five domains of practice:

- Unleash intrinsic motivation – tapping into sources of intrinsic motivation (doing something for the inherent satisfaction that comes from engaging in the activity) galvanizes people's individual and collective commitment to act. What matters to *them*?
- Co-design people-driven change – those most affected by the change have the greatest interest in designing it in ways that are meaningful and workable for them. How can we work *with* them in an authentic and participatory manner?
- Co-produce in authentic relationship - change is co-produced when people inquire, listen, see, and commit to one another. *How can we nurture and sustain mutually respectful and trusting relationships?*
- Distribute power – people can contribute their unique assets to bring about change when power is shared. *What are the power dynamics in our collaborative? How can we ensure power is shared?*
- Adapt in action – acting can be a motivational experience for people to learn and iterate to be effective. *Let's just start!*

About resistance to change

Your shift to an evidence-informed practice or innovation will mean that something has to change in your organization. Whether that is something big or small, you can expect some people will be uncomfortable with this change. People may respond with apathy, hopelessness, complacency, self-doubt or perhaps even outright rejection of the change[18].

Many models for implementation and change conceive of resistance to change as something that "just needs to be managed", but people resist for a reason and it's important to understand why. Perhaps they fear uncertainty or losing control or that their way of working is being threatened. Or there may be some constructive insights about why the innovation may not work in your setting.

Rather than relying on "telling and selling" the new practice or intervention, taking the time to hear people's concerns honours who they are and lets them know you are listening; and, you may learn something, perhaps how people view the innovation or something you hadn't thought of, or maybe some of the barriers to success. This is foundational to a relational approach to learning in organizations – taking the time to listen and understand the perspectives of people who are affected by the change.

"Often those who resist have something important to tell us. We can be influenced by them. People resist for what they view as good reasons. They may see alternatives we never dreamed of. They may understand problems about the minutiae of implementation that we never see from our lofty perch atop Mount Olympus.[19]"

"The voices of dissent are naysayers, the skeptics, who not only question this initiative but question whatever is on the agenda for the day. They are the princes of darkness, often resting on the negative. But they are valuable for implementing adaptive change because they are canaries in the coal mine, early-warning systems, and …they have the uncanny capacity for asking the really tough key questions that others have been unwilling to raise.[20]"

Some resources that might be helpful…

Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence*. London: Oxford University Press.

Edmondson, A. (1999). Psychological safety and learning behaviour in work teams. *Administrative Science Quarterly,* 44(2), 350-383.

Edmondson, A. (2012). *Teaming. How organizations learn, innovate, and compete in the knowledge economy*. San Francisco: Jossey-Bass.

Edmondson, A. (2013). *Teaming to innovate*. San Francisco: Jossey-Bass.

Fullan, M. (1999). *Change forces. The sequel*. Philadelphia: Falmer Press

Fullan, M. (2008). *The six secrets of change. What the best leaders do to help their organizations survive and thrive.* San Francisco: Jossey-Bass.

Heifetz, R., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership. Tools and tactics for changing your organization and the world*. Boston, MA: Harvard Business Press.

Hilton, K., & Anderson, A. (2018). *IHI psychology of change framework to advance and sustain improvement*. Institute for Healthcare Improvement.

Hutchens, D. 1998/2016. *Outlearning the wolves. Surviving and thriving in a learning organization.* Author.

Innis, J., & Booher, D. (2018). *Planning with complexity. An introduction to collaborative rationality for public policy (2nd Ed)*. London: Routledge.

Lewis, S., Passmore, J., & Cantore, S. (2011). *Appreciative inquiry for change management. Using AI to facilitate organizational development*. Philadelphia: Kogan Page.

Wheatley, M. (2005). *Finding our way. Leadership for uncertain times*. San Francisco: Berrett-Koehler.

Wheatley, M. (1999). *Leadership and the new science. Discovering order in a chaotic world*. San Francisco: Berrett-Koehler.

Tools for creating a culture for innovation and learning

Preskill, H., & Mack, K. n.d. *Building a strategic learning and evaluation system for your organization.* FSG.

Readiness for Organizational Learning and Evaluation Instrument (ROLE)

Maher, L., Plsek, P., Price, J. & Mugglestone, M. (2010). *Creating the culture for innovation. A practical guide for leaders.* NHS Institute for Innovation and Improvement.

Hilton, K., & Anderson, A. (2018). *IHI psychology of change framework to advance and sustain improvement*. Institute for Healthcare Improvement.

Thinking differently

NHS Institute for Innovation and Improvement. n.d. *Thinking differently*. Author.

IDEO.org. (2015). *The field guide to human centered design*. Design Kit.

Resistance to change

Hilton, K., & Anderson, A. (2018). *IHI Psychology of Change Framework to Advance and Sustain Improvement*. Institute for Healthcare Improvement.

Kanter, R. (2012). Ten reasons people resist change. *Harvard Business Review*.

Endnotes

[8] Harvey, G., & Kitson, A. (2016). PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice. *Implementation Science*, 11:33.

Savignac, J. & Dunbar, L. (2014). *Guide on the implementation of evidence-based programs. What do we know so far?* Public Safety Canada.

[9] Edmondson, A. (2012). *Teaming. How organizations learn, innovate, and compete in the knowledge economy*. San Francisco: Jossey-Bass.

[10] Edmondson, A. 1(999). Psychological safety and learning behaviour in work teams. *Administrative Science Quarterly,* 44(2), 50-383.

[11] Edmondson, A. (2012). *Teaming. How organizations learn, innovate, and compete in the knowledge economy*. San Francisco: Jossey-Bass; pg. 125.

[12] Edmondson, A. (2013). *Teaming to innovate.* San Francisco: Jossey-Bass; pg. 93-94.

[13] Adapted from:
Edmondson, A. (2012). *Teaming. How organizations learn, innovate, and compete in the knowledge economy*. San Francisco: Jossey-Bass; pg. 125.

Abercrombie, R., Harris, E., & Wharton, E. (2015). *Systems change. A guide to what it is and how to do it*. Lankelly Chase.

[14] Abercrombie, R., Harris, E., & Wharton, E. (2015). *Systems change. A guide to what it is and how to do it*. Lankelly Chase.

[15] Edmondson, A. (1999). Psychological safety and learning behaviour in work teams. *Administrative Science Quarterly,* 44(2), 50-383.44(2), 50-383.

Preskill, H., & Mack, K. (2013). *Building a strategic learning and evaluation system for your organization*. FSG

Westley, F., Zimmerman, B., & Patton, M. (2006). *Getting to maybe: How the world is changed.* Random House Canada.

[16] Heifetz, R., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership.* Boston, MA: Harvard Business Press, pg. 106-107.

[17] Adapted from: Heifetz, R., Grashow, A., Linsky, M. (2009). *The practice of adaptive leadership. Tools and tactics for changing your organization and the world.* San Francisco: Jossey-Bass; pg. 108.

[18] Hilton, K., & Anderson, A. (2018). IHI psychology of change framework to advance and sustain improvement. Institute for Healthcare Improvement; pg. 6.

[19] Maurer, R. (1996). *Beyond the wall of resistance*. Austin TX: Bard Books; pg. 49; cited in Fullan, M. (1999). *Change forces. The sequel.* Philadelphia, PA: Falmer Press, pg. 23.

[20] Heifetz, R., Grashow, A., Linsky, M. (2009). *The practice of adaptive leadership. Tools and tactics for changing your organization and the world.* San Francisco: Jossey-Bass; pg. 145.

Resources Part 4. What are "innovations" and "evidence-informed practices"?

In this Part, we define and describe the terms, "innovation" and "evidence-informed practice."

To successfully promote mental health, support people in their journey to resilience and recovery, and tackle system challenges, we benefit by drawing upon multiple forms and sources of wisdom. In addition to understanding what formal research and evaluation tell us, we also need to understand the experiences and knowledge of the people we serve, and we need to understand the community, cultural, political, economic and organizational contexts in which we're working. As organizations and practitioners, we have our own deep well of knowledge and wisdom gained from experience to draw upon. And then, we have to consider the capacity that we and our organizations have to act on evidence and implement new ideas. If we can embrace all of these forms of wisdom and be willing to learn, adapt and change along the way, we will be well equipped to serve people with excellence.

For all of these reasons, in *Shared Wisdom* we adopt a broad view of "evidence" and use the concept of evidence-*informed* practice rather than evidence-*based* practice which has a narrower focus (click here for more information about the difference between evidence-*based* practice and evidence-*informed* practice [Appendix B).

Innovation

Using various forms of evidence and innovating are key ways of improving practice and serving people more effectively – making the difference we want to make. When good and relevant evidence is available, we can apply it in our local context and see how it works. **Where there isn't enough evidence to inform the way through an issue or opportunity, then it's time to innovate – to try something quite different.**

An innovation is any product, action, service, relationship or policy that is novel and useful to a practitioner or organization and, for our purposes, that has the potential to enhance mental health and wellbeing[21]. Innovation and creativity go hand-in-hand, but they are not the same thing. Creativity is about dreaming up the "big new idea". Innovation is about bringing the idea to life – making it happen.

> "Creativity is about coming up with the big idea. Innovation is about executing the idea[22]."

"Without innovation, public services costs tend to rise faster than the rest of the economy. Without innovation, the inevitable pressure to contain costs can only be met by forcing already stretched staff to work harder[23]."

There are many definitions of innovation, but common to all is that something new or different is being put into practice. This can entail some degree of risk and so it can generate some anxiety, too. And yet, this is how new and better ways to serve people come to life. We might consider innovation to be the escape hatch out of the status quo into a new world of inquiry, learning and improvement - a new way of seeing and doing things.

Innovating often means failing, maybe several times, before you get it right. But, that's actually a good thing if you dedicate yourself to critically reflecting upon and learning from your experiences.

"Failure is an incredibly powerful tool for learning."

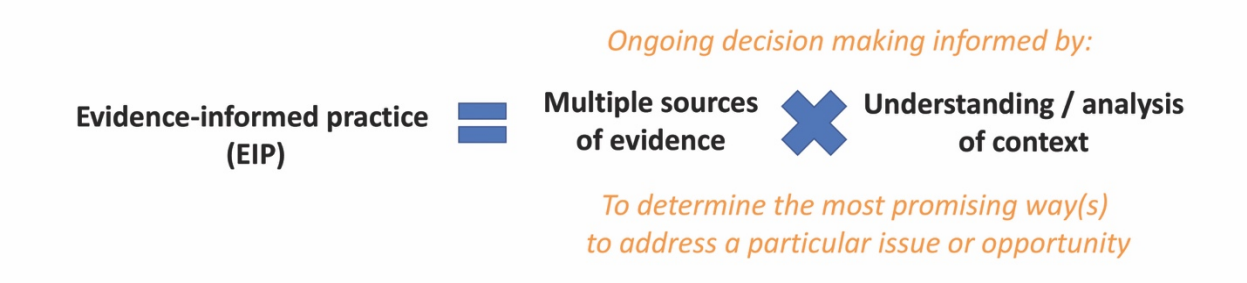
[Tim Brown, IDEO.org]

"I made 5,127 prototypes before I got it right. But I learned from each one, so I don't mind failure."

[Sir James Dyson]

Evidence-informed practice

We use the term "evidence-informed practice" (EIP) to describe an ongoing decision-making process *informed* by many kinds and sources of evidence, weighed in light of the context in which one is working, in order to determine the most promising way(s) to address a particular issue or opportunity[24]. This is depicted in the figure below.



The term "informed" means that that decisions are *guided* by formal research (i.e. research conducted by academic institutions, government bodies and other organizations) whenever it is available and relevant, but they are not based *solely* upon such research. EIP is a broader concept than that of "best practices" – a term that originated in medicine in the 1990s. [See Appendix B to read more about the differences between EIPs and "best practices" and why we focus on EIPs.]

Multiple forms and sources of evidence

Evidence-informed practice draws on many different kinds and sources of evidence and knowledge. These include:

- Findings from published research and evaluations. Information that can be found in academic journals and textbooks - particularly the findings from sound research and evaluations that are relevant to the problem or opportunity of interest – have traditionally been the key source of evidence that is emphasized.
    - Findings reported in the "grey literature". Evidence can also be found in the "grey" literature which includes things like reports, working papers, newsletters, government documents, white papers and evaluation reports. These are often produced by government and non-government agencies to report on their activities or to share their ideas and information. Because this literature doesn't go through a peer-review process it can be more current than academic research; however, because it's not peer-reviewed, the quality of grey literature can be variable.

- The wisdom, expertise, culture, values, and preferences of people living with mental health issues. Service users' voices and an understanding their unique characteristics, needs and values are a critical source of information in deciding how to proceed. Interventions that don't match their needs or characteristics are less likely to succeed.

- Knowledge derived from theory. We also draw upon theory, such as theories of human development, brain development, social and cognitive psychology, clinical or social views of mental illness, and organizational change to guide decision making. Theories underlie our focus and the things we do in our day-to-day work. They also serve as a filter through which other forms of evidence are appraised. And, they inform the way that agencies are structured and how they function (e.g., their philosophy of service, what services they provide, and how they allocate resources).

- Information generated as we try out something new – this includes, for example, early observations or data collected that provides insights about the implementation process and how well the approach seems to be working.

- The wisdom and expertise of practitioners. Over time, practitioners gain considerable wisdom and intuition, and this is a key source of knowledge to inform decision making. Practice-based wisdom is gained through practical experience, critical reflection or examination of one's practices, and conversations with others.

Practice-based wisdom[25] includes:

- Tacit knowledge - knowledge that exists in a person's mind and is manifested in one's actions but is not easily articulated – like riding a bicycle, for example. Some people call this, "knowing more than we can say"; it is knowledge generated from practice.
- Critical reflection – a process of questioning one's beliefs and practices with an openness to changing them. Critical reflection yields new insights that inform change.
- Conversations with other people – knowledge has a "social life" and thus, people often learn best through conversations with others. For example, talking with others about how they implemented a practice can be a powerful way of sharing knowledge and experience. In this way, we think about it, discuss it and decide how suitable that evidence is for our own practice. (That's what many of the stories in *Shared Wisdom* are about – how people and agencies in Alberta have implemented innovations or evidence informed practices in their settings.)

Context matters!

Context matters; it can often make or break an initiative…Pay particular attention to contextual factors; seek to understand, describe and/or respond to changes as they occur[26]."

In evidence-informed practice, the evidence arising from these sources is weighed in light of the circumstances and environment – the context – in which a new approach is to be implemented. Contextual factors and dynamics to consider include, for example:

- The unique nature of the communities in which the approach will be implemented (community and cultural context). Culture is a system through which communities or societies structure the way people view the world; it is grounded in particular sets of beliefs, norms and values that shape ideas about relationships, how people live their lives and the way people organize their world. In any community, people belong to multiple cultural groups[27]. Every community is unique in terms of, for example, culture, history, demographics, economic status, the natural environment, strengths and assets. The issues facing one community may not be a priority in another. There may be unique ways of working with different communities and community agencies.

- An understanding of how well-equipped one's organization is to implement something new (organizational context/capacity). Managers and practitioners have to consider what is possible within the context of their agency. They aren't free to do simply whatever they want; instead, whether they are able to do something or not depends on their agency's mission, values, mandates, policies, resources (e.g., people, skills, time, money, information, physical structures) and its ability and readiness to try something new.

"Lack of understanding about the important role of organizational context, or unwillingness and lack of skill in doing something to make it more receptive, leads to much of our current frustration with the relatively slow and uneven adoption of innovations in health care[28]."

- The policy context in which we work (policy context). The policy context includes local city/municipal, provincial/territorial and federal policy environments in which community-based human services and related organizations are situated. Policy contexts shape what problems and solutions are more likely to be palatable to government and funders. Policy contexts may also offer windows of opportunity for an organization to advance its goals.

  In addition to policy per se, *politics* and *power dynamics* can significantly shape and impact problems, opportunities, solutions and implementation efforts.

The overall process of evidence-informed decision making is depicted in the figure below, with the process of decision making located in the centre, informed by several kinds of evidence, and shaped by consideration of the community, cultural, organizational, and policy environments or contexts in which the work is undertaken.

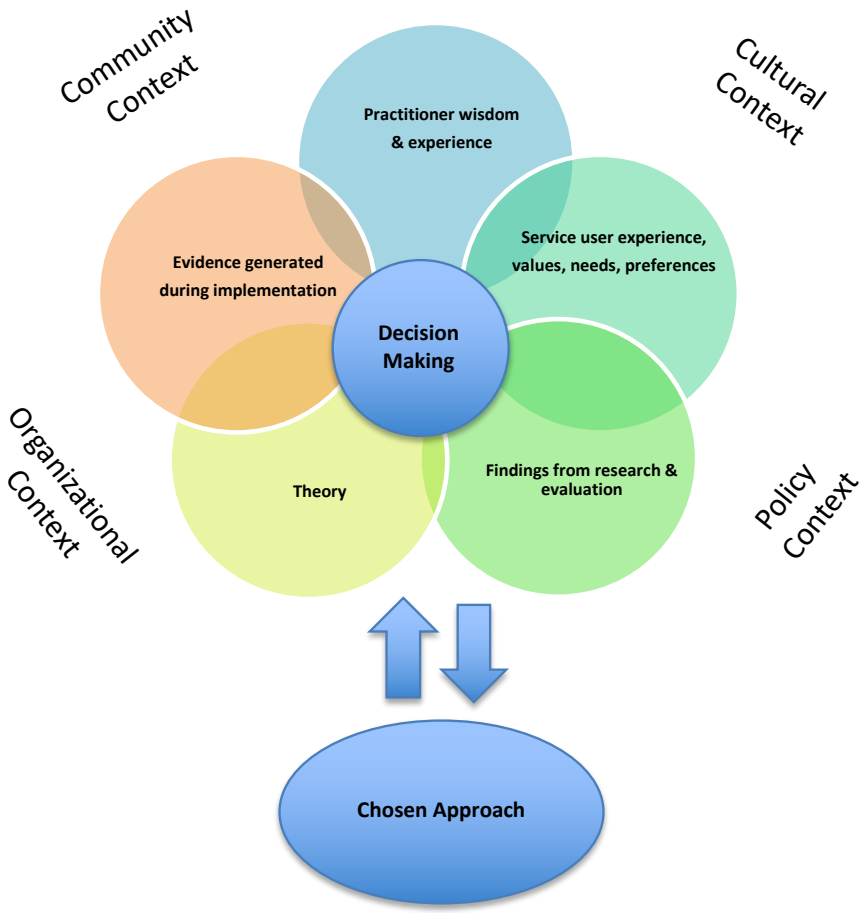


Figure: Evidence-informed decision making: Multiple sources of evidence and contextual considerations[29]

Some resources that might be helpful…

Evidence-informed practice

Braithwaite, J., Churruca, K., Ellis, L., Long, J., Clay-Williams, R…Ludlow, K. (2017). *Complexity science in healthcare – Aspirations, approaches, applications and accomplishments: A white paper.* Sydney, Australia: Macquarie University - Australian Institute of Health Innovation.

Davies, H., Nutley, S. & Walter, I. (2008). Why "knowledge transfer" is misconceived for applied social research. *Journal of Health Services Research and Policy,* 13(3), 188-190.

Dodd, S., & Savage, A. (2016). Evidence-informed social work practice. *Encyclopedia of Social Work,* May 2016.

Gabbay, J., & Le May, A. (2011). *Practice-based evidence for healthcare. Clinical Mindlines*. London: Routledge.

Green, L. (2006). Public health asks of system science: To advance our evidence-based practice, can you help us get more practice-based evidence? *American Journal of Public Health,* 96(3), 406-409.

Kemm, J. (2006). The limitations of "evidence-based" public health. *Journal of Evaluation in Clinical Practice,* 12(3), 319-324.

Livingood, W., Allegrante, J., Airhihenbuwa, C., Clark, N., Windsor, R…Green, L. (2011). Applied social and behavioral science to address complex health problems. *American Journal of Preventive Medicine*, 41(5), 525-531.

McCall, R. (2009). Evidence-based programming in the context of practice and policy. *Social Policy Report,* XXIII(III).

Nevo, I., & Slonim-Nevo, V. (2011). The myth of evidence-based practice: Towards evidence-informed practice. *British Journal of Social Work,* 41, 1176-1197.

Petersen, A. & Olsson, J. (2015). Calling evidence-based practice into question: Acknowledging phronetic knowledge in social work. *British Journal of Social Work*, 45, 1581-1597.

Plsek, P. (2003). Complexity and the adoption of innovation in health care. Paper presented to the conference: *Accelerating Quality Improvement in Health Care – Strategies to Speed the Diffusion of Evidence-Based Innovations*, Washington, CD, 27-28 January.

Schorr, E. (1997). What works and why we have so little of it. In, *Common purpose: Strengthening families and neighborhoods to rebuild America*. New York: Anchor books; pg. 3-21.

Schorr, E. (2016). *Reconsidering evidence: What it means and how we use it.* Stanford Social Innovation Review.

Sterman, J. (2006). Learning from evidence in a complex world. *American Journal of Public Health*, 96(3), 505-514).

A short and very basic video about evidence-informed practice presented by Ontario Centre of Excellence for Child and Youth Mental Health can be found at: https://www.youtube.com/watch?v=Xiv75BLGtrs

Endnotes

[21] Adapted from Mental Health Commission of Canada. (2014). *Innovation to implementation*. Author; and, Govindarajan, V., & Trimble, C.(2013). *Beyond the idea. How to execute innovation in any organization.* New York: St. Martin's Press.

[22] Govindarajan, V. (2010). *Innovation is not creativity*. Harvard Business Review, Online, August 3, 2010.

[23] Mulgan, G. & Albury, D. (2003). *Innovation in the public sector.* Strategy Unit, London, cited in Maher, L., Plsek, P., Price, J., & Mugglestone, M. (2010). *Creating the culture for innovation. A practical guide for leaders.* NHS Institute for Innovation and Improvement, pg. 3.

[24] Adapted from Dodd, S., & Savage, A. (2016). Evidence-informed social work practice. *Encyclopedia of Social Work.*

[25] Gabbay, J., & Le May, A. (2011). *Practice-based evidence for healthcare. Clinical mindlines*. London: Routledge.]

[26] FSG, n.d. *Systems Thinking Toolkit*, pg. 3.

[27] SAMHSA. (2014). *TIP 59: Improving cultural competence*. Author; pg. xvi.

[28] Plsek, P. (2003). Complexity and the adoption of innovation in health care. Paper presented to the conference: *Accelerating Quality Improvement in Health Care – Strategies to Speed the Diffusion of Evidence-Based Innovations*, Washington, DC, 27-28 January.

[29] Adapted from Dodd, S., & Savage, A. (2016). Evidence-informed social work practice. *Encyclopedia of Social Work*

Part 5A. A simple model for implementing EIPs and innovations "on the ground"

In this Part, we outline a simple model for implementing EIPs and innovations, including:

- Engaging and building relationships with service users and other key stakeholders
- Understanding the issue or opportunity or context
- Exploring relevant evidence and deciding where to start
- Planning and preparing
- Implementing through ongoing cycles of acting, learning and adapting.

Implementing is the process of bringing an evidence-informed practice (EIP) or innovation into effect[30]. In essence, it is about introducing change. Change doesn't simply occur through the passive sharing of new knowledge; rather, it requires active, ongoing efforts and supports. Even the most well-designed and researched interventions may miss their mark if they are poorly implemented. It is well established that high quality implementation will increase the likelihood than an innovation or evidence-informed practice will succeed, and yield intended outcomes[31]. However, knowledge of "what works" to implement new ideas in health services is still limited[32].

To frame the discussion about implementing innovations and EIPs, we describe a general approach for putting new ideas and EIPs into action "on the ground" – in your organization, and with the people and communities you serve. This approach is based on a review of research about implementing evidence in practice, combined with ideas about learning and change in professions and organizations, and organizations as complex adaptive systems[33]. Essentially, it is a basic problem solving and decision-making process that we all use in one form or another. Being very generic, it can work for individuals and teams as well as whole agencies although at the individual or team level, the breadth and range of activities and the degree of effort required may be much simpler.

Again, the intent is not to be prescriptive – every organization will have its own way of implementing change. Rather, the intent is to describe and share some of the processes commonly discussed in the literature, along with insights provided by local practitioners, in order to stimulate thought about what implementation in your own context might entail.

Processes and principles for implementing innovations and EIPs

Putting a new practice or innovation into place involves a number of overlapping processes that can be impacted (for better or for worse) by factors in your agency and beyond. This means that selecting the most appropriate approach/intervention/innovation for you or your agency requires careful thought about what is most likely to work *in your context and with the people you serve,* with the capacity and resources available to you, all underscored by a basic understanding of complexity.

Typically, the process begins with some kind of impetus for change. This might be:

- An epiphany – a sudden insight or realization that things could be different and it's time to change.
- A new issue or opportunity to address.
- A new group of people to serve.
- A change imposed upon you by funders or other stakeholders.
- An innovative practice that you've heard about and that you think might work in your context.
- Findings from ongoing monitoring that suggest something could be improved.

> "'Aha' moments… are the heart of insight, epiphany and creativity. Those moments occur when suddenly ideas come together, integrate and become a cohesive whole and you see a problem in a way you never have before… These 'aha' moments… prepare us to move down entirely different pathways in our minds and in our actions and that means we stop ending up in exactly the places where we started and instead, we begin to explore new possibilities[34]."

No matter the impetus for change, most models for implementing something new converge on a number of basic, iterative and overlapping processes. After a review of the literature, we landed on the following:

- Engaging and building relationships with service users and other key stakeholders.
- Understanding the issue or opportunity and context.
- Exploring relevant evidence in light of the local context and deciding where to start.
- Planning and preparing.
- Implementing through ongoing cycles of acting, learning and adapting.

Of course, the general idea is to move forward from idea to planning to action and getting results, but implementation is rarely a linear process. Things might not go as planned; you might learn something new about the issue or context; you might run into a roadblock or the situation might change somehow.

So, you might wind up re-assessing the issue or context and re-thinking your original plan after you've begun implementing, for example – hence the iterative nature of this work. This is normal! The central process weaving all of these activities together is continual gathering of information to help you understand how things are going and to adjust as necessary – or what we call ongoing acting, learning and adapting.

The model below depicts the general processes involved in innovating and implementing evidence-informed practices. At the heart of the model is engaging and building mutually respectful and trusting relationships with the people you are serving and other key stakeholders.

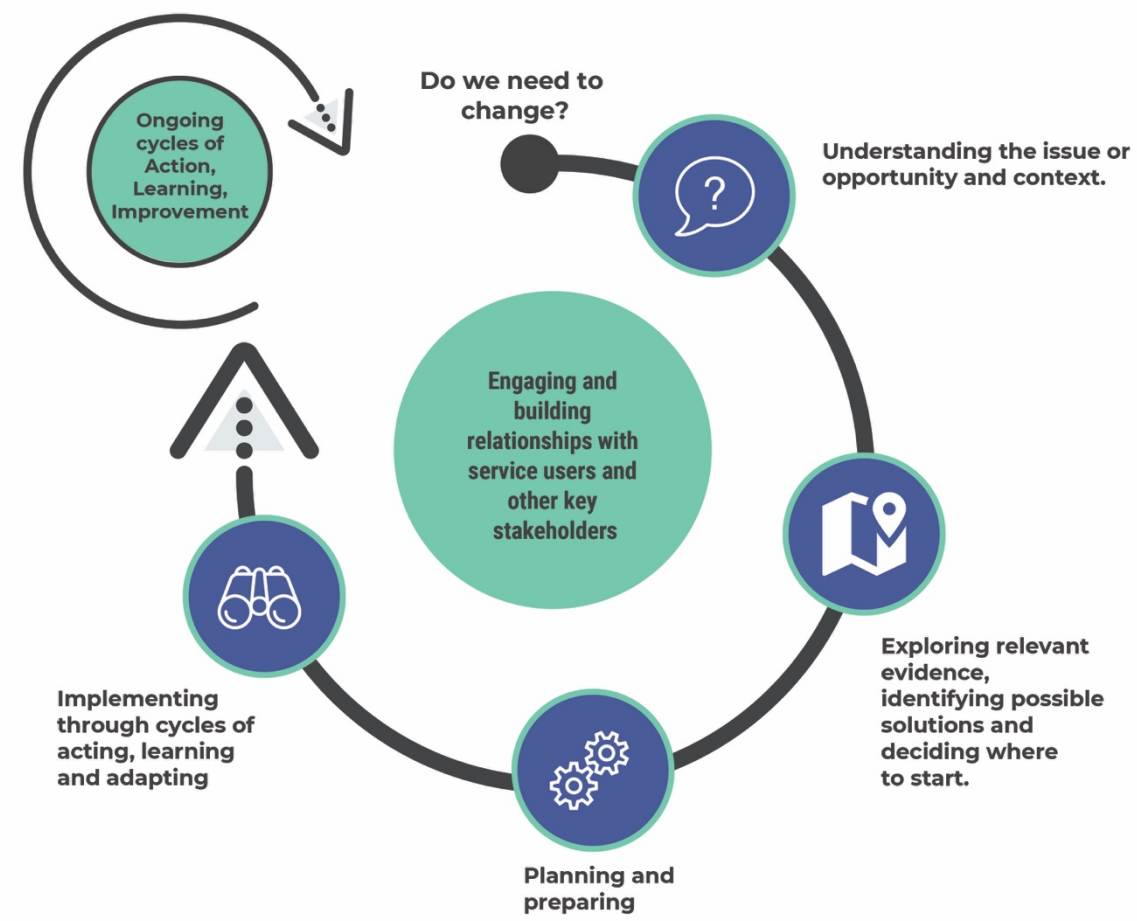


Figure. Processes of designing and implementing innovations and evidence informed practices

The remainder of this Resources section of *Shared Wisdom* is occupied with describing each of these processes in more detail. For each process, there is a brief description, along with sets of questions to guide thinking. Links to additional resources are also provided.

First, however, we present some commonly described principles for implementing innovations and EIPs in complex environments. Again, what is offered here is ideas to consider as you decide to make change. The intent is not to provide a comprehensive prescription but rather to share ideas from the literature and that others have found to be helpful in their contexts. **Feel free to take what works for you and leave the rest. What seems most important is to proceed mindfully with an attitude of curiosity, courage, and commitment to learning as you go in order to optimize your efforts.**

Principles for implementing innovations and EIPs

Proponents of a complexity worldview describe implementation as ongoing cycles of acting and evaluating, learning and adapting. Some suggest that rather than detailed steps, a number of guiding principles inform the implementation process. **Principles provide direction but not detailed description and so while they can guide decisions, they also give room to adapt to different contexts, changing understandings and varied challenges – "they are the rudder for navigating complex systems[35]".**
We synthesized the following principles for navigating change from a complexity worldview based on a review of literature regarding complexity thinking and specifically, complex adaptive systems[36].
(Click here for more information [Appendix A])

- **Understand as much as possible about the issue/opportunity to be addressed, and the context in which you're working.** Knowledge of existing evidence needs to be combined with knowledge of unique local context, people and circumstances.
    - **Gather and understand diverse perspectives**. Different stakeholders will have distinguishable views about what's happening; few if any will have a full picture.
    - **Take time to investigate relevant history of the situation -** that is, what has happened in the past and the patterns of behaving, interacting and doing things that will shape the success of your current efforts.
    - **Take time to understand the local context.** While we can be informed by what worked elsewhere, we must take account of local conditions and context when implementing change. Any new intervention or practice has to be in line with the local "rules of the game" – it must be perceived as being better than what currently happens, and it must be feasible and customizable to local contexts.
- **Engage the people affected, define parameters and allow freedom to innovate.** Successful implementation depends on commitment and insights from those people affected by and responsible for making the anticipated changes. These people should be actively engaged in the process from beginning. When anticipated changes align with their interests and motivations, they are more likely to become engaged.
- **Build and sustain mutually respectful and trusting relationships**. Take every opportunity to bolster communication, trust and interpersonal relations[37] . In this way you learn about the past, shape approaches that are more likely to work that also are owned by people and get more information about what is working and what is not.
- **Weave together, with others, a vision for change**: involve many and diverse perspectives and think through consequences systematically.

- Sometimes it may be better to start small and grow from there (e.g., plan-do-study-act (PDSA) cycles, small pilots), or try out several options. You can never be entirely sure what will work and what will not until you try things out.
- Allow for customization – goals might be common, but how to achieve them may depend on local circumstances, so allow for variation in how to do things.
- Invest in ongoing learning and improvement and expect to learn and adapt as you try things out. Unintended consequences and unexpected changes in the wider world are normal. Processes for meaning making and understanding what is happening are necessary. Build in iterative processes for dialogue, review and adaptation. Build in more time and resources to support adaptation for better results. Capture and share what you're learning.
- Keep looking for change – around and ahead. Take note of things that are interesting or different and triangulate these observations with what others are noticing. Keep scanning widely for new factors emerging in the wider world; take a range of opinions, particularly from those close to the issues; think about the future; think a few steps ahead. You will be more attuned to change as it emerges and better able to anticipate and adapt and seize opportunities.

Each step of our simple model is described in further detail in the following sections:

- **Part 5B.** Engaging and building relationships with service users and other key stakeholders.
- **Part 5C.** Understanding the issue or opportunity and context.
- **Part 5D.** Exploring relevant evidence in light of the local context and deciding where to start.
- **Part 5E.** Planning and preparing.
- **Part 5F.** Implementing through ongoing cycles of acting, learning and adapting.

Endnotes

[30] Mental Health Commission of Canada. (2014). *Innovation to implementation*. Author.

[31] Parenting Research Centre. (2016). *Implementation best practice: A rapid evidence assessment.* Sydney, AU*:* Royal Commission into Institutional Responses to Child Sexual Abuse.

[32] Braithwaite, J. (2018). *Changing how we think about healthcare improvement. BMJ (British Journal of Medicine).*

Green, L. (2006). Public health asks of systems science: To advance our evidence-based practice, can you help us get more practice-based evidence? *American Journal of Public Health*, 96(3), 406-409.

Parenting Research Centre. (2016). *Implementation best practice: A rapid evidence assessment.* Sydney, AU: Royal Commission into Institutional Responses to Child Sexual Abuse.

Reed, J., Howe, C., Doyal, C., & Bell, D. (2019). Successful Healthcare Improvement From Translating Evidence in complex systems (SHIFT-Evidence): Simple rules to guide practice and research. *International Journal for Quality in Health Care*, 31(3), 238-234.

[33] Damschroder, L., Aron, D., Keith, R., Kirsh, S., Alexander, J., & Lowery, J. (2009). *Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. Implementation Science,* 4(50).

Fixsen, D., Naoom, S., Blase, K., Friedman, R. & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, Florida: University of South Florida.

FSG, n.d. *Systems thinking toolkit. Putting systems thinking into practice in your organization.* Author.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *The Milbank Quarterly,* 82(4), 581-629.

Savignac, J., & Dunbar, L. (2014). *Guide on the implementation of evidence-based programs: What do we know so far?* National Crime Prevention Centre.

[34] Bloom, S., & Farragher, B. (2011). *Destroying sanctuary. The crisis in human service delivery systems.* New York: Oxford University Press; pg. 5.

[35] Patton, M. 2018. *Principles-focused evaluation. The guide.* New York: Guilford Press, pg. 10.

[36] See, for example:
Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press.

Braithwaite, J. (2018). *Changing how we think about healthcare improvement. British Medical Journal*. 361.

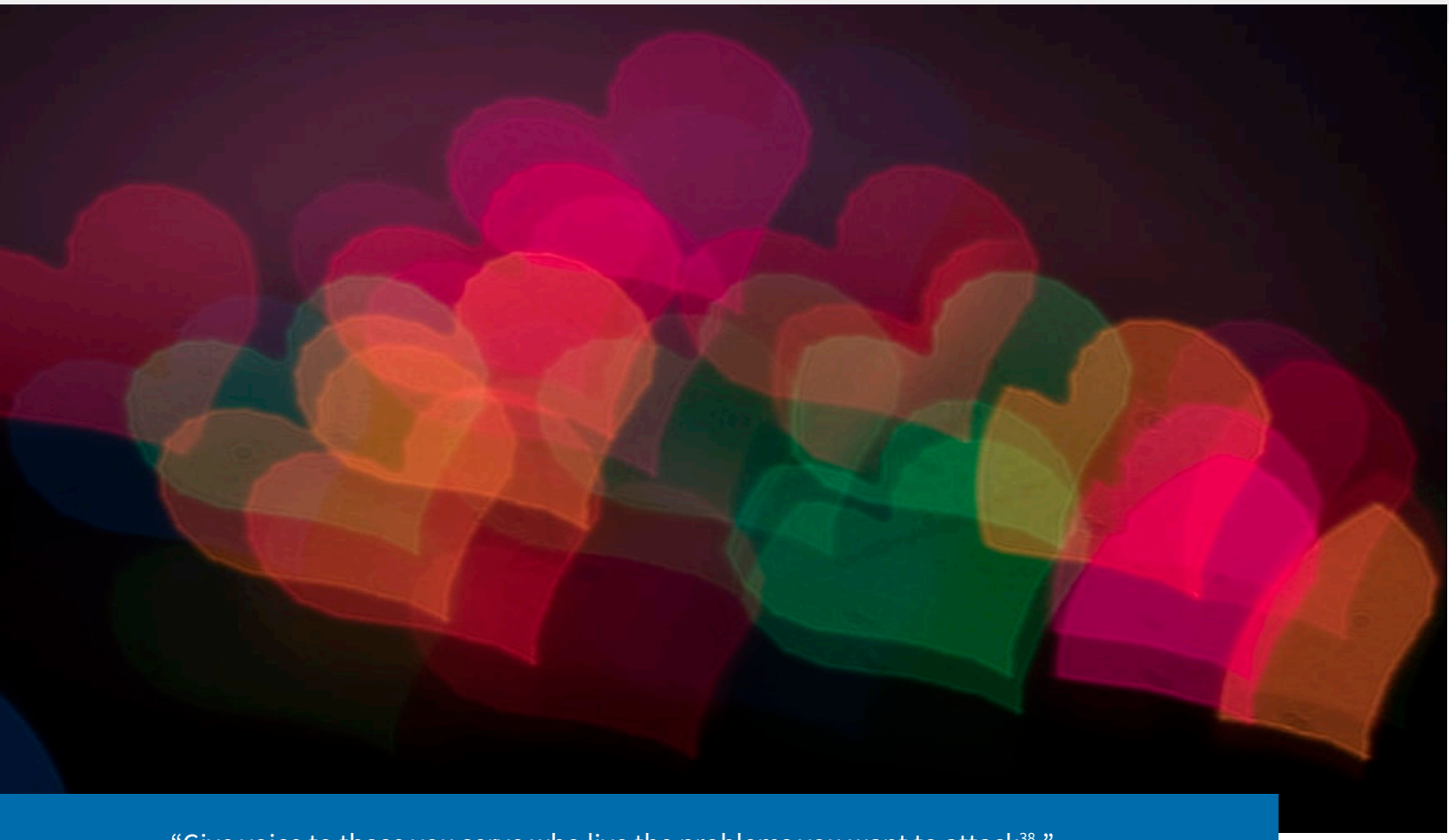
Braithwaite, J., Churruca, K., Long, J., Ellis, L., & Herkes, J. (2018). When complexity science meets implementation science: A theoretical and empirical analysis of systems change. *BMC Medicine,* 16:63;

Braithwaite, J., Churruca, K., Ellis, L., Long, J., Clay-Williams, R…Ludlow, K. (2017). *Complexity science in healthcare – Aspirations, approaches, applications and accomplishments: A white paper.* Sydney, Australia: Macquarie University - Australian Institute of Health Innovation.

[37] Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Presss

Part 5B. Engaging and building relationships with service users and other key stakeholders

In this Part, we describe why engaging and building relationships with service users is so important when implementing EIPs and innovations, and offer a list of possible questions to consider in relation to this. We also similarly also offer a set of questions for consideration when engaging other key partners and stakeholders.



"Give voice to those you serve who live the problems you want to attack[38]."

"Those most affected by change, particularly those most vulnerable or marginalized, have the greatest interest in designing improvements that are most meaningful to and workable for them.[39] "

Wherever we work in community-based health and human services, at the heart of our work is the people we serve, whether they be individuals, families, communities, specific populations or the general public.

"Engaging and building relationships with service users and other key stakeholders" means that the people we serve are, as much as possible and wherever relevant, active participants in defining issues, designing and implementing solutions, and determining how well they work. This is based on the philosophy that those who are affected by a decision have a right to be involved in the decision-making process – "*nothing about us without us*."

Beyond participating in decision making processes, people with lived or living experience of mental health issues can be powerful change makers, with or without us. These people are known by some as "experts by experience: Social change makers who have used their lived experiences to drive and lead positive change in society".[40]

In a person- and family-centred model of care, service users are actively engaged in all stages of innovation – from exploring and understanding the issue, sharing their wisdom and looking at other kinds of evidence, deciding what to do, taking action and learning and adapting efforts along the way. This way of working, often described as, *"working with",* rather than *"doing to"* or *"doing for",* is a powerful way of ensuring that the actions taken are deemed important and acceptable to users and that they agree have the best chance of success. [To learn more about the difference between "working with", "doing to" and "doing for", see Appendix C]

"Co-design occurs when people are designed with, instead of designed for. The idea is that empathy regarding a problem is not the same as experiencing a problem. Those most affected by change, particularly those most vulnerable or marginalized, have the greatest interest in designing improvements that are most meaningful to and workable for them. Co-design espouses a simple operating principle: **Everyone who touches or is touched by an improvement, at every level, has something to contribute**: [the Institute for Healthcare Improvement] refers to this as, 'All teach, all learn'[41]."

30 REASONS TO AUTHENTICALLY ENGAGE THE PEOPLE WE SERVE[42]…

BENEFITS TO THE PEOPLE WE SERVE:

1. *Realization of human rights*. People have the right to be involved in their own service planning and to be involved in decisions that impact the services they access.
2. *Empowerment.* Having control over one's life, including having an authentic and powerful voice in what happens, is foundational to mental wellbeing, resilience and recovery. Empowerment is fundamental to mental wellbeing and occurs when people find their own power from within. Authentic engagement in decision making and other processes can help them find this power.
3. *Equality and dignity, self-determination, value and respect, the right to participate* in decisions that affect their lives. All of these give a sense being a valued citizen within society.
4. *Having a voice; being valued, heard, and appreciated*; not feeling that expressing concerns was a waste of time; understanding that one's opinions hold value and matter to others.
5. *Social inclusion*. Studies have shown a positive link between social inclusion and mental health and wellbeing. Participation promotes social inclusion because it connects individuals and groups with services and activities in the communities where they live and increases the responsiveness of services to the needs of marginalized individuals.
6. *Enhanced community connectedness, involvement and belonging*. Social inclusion also provides a sense of connection to others and to one's community, and inclusion in civic life in addition to opportunities to develop shared identity, friendship, social networks and connections, and the mutual sharing of problems.
7. *Improved access to care and services,* especially for those people who are marginalized and/or underserved.
8. *Improved mental and physical health* that is associated with more active participation in appropriate care and services.
9. *Increased personal capacity, improved wellness, decreased risk behaviours*. *More appropriate use of mental health and substance use supports and services.*
10. *Developing a sense of purpose*, realizing the value and benefits of supporting and helping others and creating change that results in wider benefit to others and communities.
11. *Developing, improving and/or enhancing personal skills* through meaningful activities and by building confidence, increasing self-confidence/respect/self-efficacy, enhancing self-esteem and self-worth, developing life skills, increasing personal expectations and being the focus of positive attention.
12. Stability and safe spaces, resulting in improved trust in and understanding of services and community and greater hope and optimism.
13. *An increased role in information sharing, awareness raising*, signposting and public education, allowing people to challenge stigma and discrimination.

14. ***Development of strategies that will work for them.*** The wisdom of the people being served is needed to arrive at solutions or strategies that will work for them. They are the experts on their experiences and needs and thus they provide a unique and crucial perspective.
15. ***Development of solutions that emerge from group interactions*** between people who had previously been alienated from each other can help generate new solutions that no single person may have developed on their own. Bringing people together helps establish and achieve mutually agreed and desirable goals and outcomes.

BENEFITS TO OUR ORGANIZATIONS:

16. ***Ensures a focus on person/family centred services***. The participation of people with lived experience in the planning, delivery and evaluation of services and supports can help make sure that the system is taking a person/family centred approach and is more effective at addressing people's needs.
17. ***Ensures that the activities and services reflect the needs of communities*** and benefit the communities that agencies serve.
18. ***Allows agencies to design and develop high quality, effective and relevant policies***, projects, interventions, services and initiatives.
19. ***Strengthens agency identity and gain credibility and legitimacy*** within communities, the social sector, government and wider society.
20. Enables the ability to "***humanize" activities and services.***
21. ***Improves equal opportunities, inclusiveness of all members of society***, and representation of people from diverse backgrounds, experiences and talents.
22. ***Enables organizations to draw upon and make use of peoples' unique skills***, capabilities, diverse perspectives, experiential knowledge and insights, allowing this to contribute to decision-making.
23. ***Improves and enhances the ability of organizations to bring policy issues to life*** by illustrating, for example, the scale of disadvantage that people are facing, the real life and practical challenges in implementing laws, policies and strategies efficiently and effectively.
24. ***Adds value to service/activity planning, development, delivery and improvement.***
25. ***Helps all employees and volunteers to develop their skills and knowledge*** beyond theoretical and textbook learning.
26. ***Improves sensemaking and sense-checking***; inspires innovation and rejuvenates and invigorates activities.
27. ***Helps set priorities, identify issues and outline solutions*** which might not occur to or be valued by those who are not experts by experience.
28. ***Gives early opportunities to test ideas and make decisions*** as they arise.
29. ***Helps with learning***, and grounding of decision making in that learning.
30. ***Builds relationships and trust with communities***, increasing the reach, leverage and traction of activities and services; generate social capital.

Working in a "community development" way

Jean Dalton
Manager, Community Strategies, United Way of the Alberta Capital Region

Community development is a process where community members come together to take collective action and generate solutions to common problems.

Many community mental health issues cannot be addressed alone. People are complex, so a one-size approach cannot meet the needs of everyone. The community development (CD) approach brings people of varying backgrounds, skills and experiences together to address a community issue they all share. A leadership team is established to plan, organize, implement and evaluate the work.

The CD process is relationship-focused, so time is needed to build authentic and respectful relationships that create a safe atmosphere for the type of work and learning environment necessary to find common ground. Listening to community members helps to deeply understand the context regarding the issue and to co-develop a common vision to address the issue.

The CD process encourages co-designing and co-producing of an action plan and its implementation. Identifying specific community action items for changes may be one of the most important practices implemented as well as building on community strengths and leveraging opportunities through the participation of diverse groups of people.

It is also important to keep a record of what was done and how it was done. Documentation of process, reflection and evaluation of results from actions undertaken are critical to understand the impact of changes. It helps to identify learning opportunities and where adaptations may be required. It is also vital to ensure people are appreciated and successes are celebrated at times throughout the process.

Some questions to consider about engaging service users

A number of questions for consideration when engaging and building relationships with service users are listed in the boxes below. These are merely sample questions; there is no need to answer them all!! They are just ideas to spark your own thinking.

Engaging and building relationships with service users. Some questions to consider about who to engage[43]…

- Who are the people/groups that we want to engage? [See also the questions re: understanding the issue or opportunity, in the next section.]
- Why are we engaging service users/people with lived or living experience of mental health issues? What is our purpose and intent? What will we do with the information we gain from engaging these people? What's in it for them?
- What level of engagement is realistic and possible in this particular circumstance? How will we make this clear to people?
- How homogeneous or diverse is this group? How can we honour and respect this diversity? What different approaches might we need to successfully engage each group?

Engaging and building relationships with service users. Some questions about your capacity to engage people…

- What is our level of capacity for engaging people/groups? What resources, skills do we have for this? What is our level of cultural humility with regard to diverse populations and groups?
    - What is our knowledge/skill re: leading practices in equity and inclusion? If we are lacking in this area, are we prepared/able to learn more?
    - How do we promote diversity across our structures, processes and activities?
    - Do we know how to create safer spaces that support all members to feel comfortable and included?
    - Do we recognize that it takes sufficient financial resources to support people with lived/living experience to participate (e.g., to provide food and to reimburse transportation costs)?
    - Do we have representation of people with lived/living experience of mental health challenges or illnesses (e.g., as part of committees, teams)?
    - Do we offer opportunities for people with lived/living experience to inform our work?
    - Are we willing to invest in training opportunities for all members about how to respectfully collaborate with people with lived/living experience?
    - Are we willing to invest in skill- and capacity-building opportunities for people with lived/living experience of mental health issues and that support meaningful engagement?
    - Are we prepared to open up decision-making processes to people with lived/living experience?
    - Have will we ensure that feedback from people with lived/living experience will lead to action?

Engaging and building relationships with service users. Some questions to consider about how you might engage people…

- How can we build mutually respectful and trusting relationships with service users?
- How can we create safe, inclusive spaces where people feel comfortable to share their views and ideas?
- Have we included all relevant service user groups and their supports in the process? How can we make sure we haven't missed any critical service user groups or stakeholders?
- How can we ensure service users and their supports are meaningfully engaged and have a real voice in the processes of understanding the issue, exploring the evidence, planning, implementing and learning/adapting/evaluating the effort?
- How can we ensure there is equal footing amongst participant voices – that is, that each person/group has an equal say?
- What barriers might stop people from participating (e.g., stigma; transportation costs; lack of trust; timing; unequal power relationships; previous history; our lack of cultural humility; our professional jargon; our lack of organizational capacity to support engagement (supportive values, leadership, resources, knowledge/skills/competencies)?
- Through our language or thinking, are we inadvertently marginalizing people? Are we exercising "power over"? Or "power with"? Or a combination of both? How? How can we work in a more equitable and just fashion?
- How might our privilege and position be shaping our perceptions and the actions we deem suitable?
- How can we remove or get around barriers to participation?

About cultural humility and safety…

When working with diverse individuals and groups, it is important to exercise cultural humility in order to achieve cultural safety.

Cultural safety is:

> *"An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care[44]."*

Cultural humility is:

> *"A process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience[45]."*

Cultural safety requires professionals to examine the cultural, historical and structural differences that shape peoples' experiences, and to critically reflect upon the ways in which their own culture and social location shape their actions and others' responses to those actions[46]. It also requires service providers to develop beneficial and non-paternalistic partnerships with people and communities[47] and to critically examine power differentials.

From a First Nations perspective, the Assembly of First Nations[48] states this in the simplest of terms:

> *"Essentially cultural humility and safety is about those people in positions of power becoming comfortable with not knowing, not being the expert, and maybe even never really understanding the culture and lived experience of First Nations people."*

Some resources that might be helpful …

Facilitating public participation

The International Association for Public Participation (IAP2) has created numerous strategies and documents used by agencies that seek to involve stakeholders in their decision-making processes. See:

Core Values, Ethics, Spectrum – The 3 Pillars of Public Participation

Foundations spectrum of public participation

Other resources:

Legare, J., van der Woerd, K., Simces, Z., & Ross, S. (2014). *Successful stakeholder engagement: focus on mental health and substance use clients*. Commissioned by the Community Action Initiative (British Columbia)

National Institute for Health and Care Excellence (NICE). (2016). *Community engagement: Improving health and wellbeing and reducing health inequalities*. Author.

Engaging people with lived/living experience

Homer, A. (2019). *10. Engaging people with lived/living experience. A guide for including people in poverty reduction*. Tamarack Institute.

The state of New South Wales in Australia recently released its "*Lived Experience Framework*" – in response to a call for embedding lived experience of mental health problems across the sector and system processes. See:

Sandhu, B. (2017). *The value of lived experience in social change: The need for leadership and organizational development in the social sector.* The Lived Experience.

Weinstein, J. (Ed.) (2010). *Mental health service user involvement and recovery*. London: Jessica Kingsley Publishers.

Patient and family-centered care

Institute of Families for Child and Youth Mental Health. The importance of family-centred care

Institute for Patient and Family-Centered Care

Frampton, S., Guastello, S., Brady, C., Hale, M., Horowitz, S., Bennett Smith, S., & Stone, S. (2008). *Patient-centred care improvement guide*. Planetree, Inc. & Picker Institute.

Deepening the approach: Experts by experience as changemakers

A recent study of social sector workers in the UK and US regarding the extent to which "experts by experience" are actually engaged by social sector agencies as change makers. The question of focus is: "How does the UK social sector currently cultivate, develop and evolve its social impact work through the work of experts by experience in modern society? The report outlines barriers to change-making roles to experts by experience and describes ways to move forward.

Sandhu, G. (2017). *The value of lived experience in social change: The need for leadership and organizational development in the social sector.* The Lived Experience.

Cultural safety, cultural humility, being an ally

Bishop, Anne. (2015). *Becoming an ally. Breaking the cycle of oppression in people*. 3rd Ed. Halifax: Fernwood Publishing.

Harvard University Implicit Assumptions Test (IAT). The Implicit Assumptions Test (IAT) measures attitudes and beliefs that people may be unwilling or unable to report.

Indigenous Perspectives Society

San'yas Indigenous Cultural Safety Training Program – Provincial Health Services Authority, BC

The program also offers a national webinar series which can be accessed at: www.icscollaborative.com

	Okun (n.d.): *From White Racist to White Anti-Racist: The Life-Long Journey* *Fakequity* – a blog about racial equity and "its nemesis, Fakequity Chavez, V. (2012). *Cultural humility: people, principles and practices* (YouTube video) Ontario Centre of Excellence for Child and Youth Mental Health. (2014). Striving for equity: Anti-oppressive practice in child and youth mental health. AOP Journal. **Gender and diversity analysis** Canadian Centre on Substance Abuse. (2010). *Bringing gender and diversity analysis to our work. A checklist.* Government of Canada. *Gender based analysis+*. Status of Women Canada.
	Emerging practice: Co-production and experience-based co-design of health services. An emerging practice is experience-based co-design of health services. Experience based co-design brings together the experiences of service providers with the experiences of service users to inform the design of more effective health services. For more information and tools see: Bak, K., Moody, L., Wheeler, S., & Gilbert, J. (2018). Patient and staff engagement in health system improvement: A qualitative evaluation of the experience-based co-design approach in Canada. *Healthcare Quarterly*, 21(2), 24-29. Hilton, K., & Anderson, A. (2018). *IHI Psychology of Change Framework to Advance and Sustain Improvement*. Institute for Healthcare Improvement. Mulvale, A., Miatello, A., Hackett, C. & Mulvale, G. (2016). : Lessons from a systematic review of methods to involve patients, families and service providers in child and youth mental health service improvement. *Patient Experience Journal* 3(1), Article 15. new economics foundation (nef). N.d. *Co-production. A manifesto for growing the core economy*. Author. NHS Online. *The ebd approach. Experience based co-design. Using patient and staff experience to design better healthcare services*. Author. Prestantia Health. Online. *Experience based co-design. A toolkit for Australia.* Author. Slay, J. & Stephens, L. (2013). *Co-production in mental health: A literature review*. New economics foundation.

Engaging partners and other key stakeholders, too…

"Stakeholder engagement involves bringing together individuals, groups and communities to address and influence decisions on issues that impact them; internationally, stakeholder engagement processes are used to enhance the relevance and appropriateness of services, to support the development of healthy communities, and to improve the quality and effectiveness of health services and systems[49]."

Stakeholders are other individuals, teams or organizations that are directly impacted by our decisions and actions, or that can impact them. Partners are also stakeholders, but with more formal arrangements for working together.

The purpose of stakeholder engagement is to increase effectiveness through collaboration and integration; and to understand the unique position of each stakeholder and how that might influence the work you do together or how well your work is received in the community. From a complexity perspective, the more diverse the array of stakeholders, the better as this affords a broad and deep understanding of the issue, workable solutions and the local context.

"Initiators of a collaborative process are often resistant to the idea of inclusion. It is easier to make a decision if one does not include a difficult stakeholder or an interest that seems antithetical to the goals the organizers have… contrarian and disadvantaged stakeholders are necessary, however, to achieve robust agreements that break open the unacceptable status quo that brought people to the table in the first place.

These individuals and interests see the world from a different perspective than others and they ask the questions that make the challenges more mainstream stakeholders do not[50]."

Some questions to consider about engaging other stakeholders

A number of questions for consideration when engaging and building relationships with other stakeholders are listed in the boxes below. These are merely sample questions; there is no need to answer them all!! They are just ideas to spark your own thinking.

Partner/stakeholder engagement. Some questions to consider[51]…

- What stakeholders or possible partners might be interested in or affected by the issue or opportunity we want to address?
  - Why might they be interested? What is their stake in the issue or opportunity?
  - How might they be affected?
  - How might our work benefit their work? How might it negatively impact their work?
  - What do they value? (What are their commitments and beliefs?)
  - How much do they care about the issue and your organization?
  - What resources do they control and who wants those resources?
  - What do they value? What do they fear?
- What are the relationships amongst these stakeholders or partners? How are they connected? Loyalties or obligations to others? Hidden alliances with others? What degree of trust exists amongst them?
- What are the characteristics of the stakeholders/partners who will be affected by or who are being targeted for collaboration on the project (e.g., mandate/interests/agenda, priorities, funding, structure, personnel, philosophy/approach)?
- Which stakeholders or partners should be directly involved in the work we are going to do, and to what extent will they be involved?
- Which ones should be informed or might support our work?
- Which stakeholders are we comfortable engaging now, and what are their motivations for change?
- By contrast, which stakeholders might we not choose to engage at the outset, and why? What might we miss by not involving them initially, and what strategies do we have for engaging them over time?
- How do we create common ground among the stakeholders we engage now?
- How do we increase people's understanding of the issue in a way that integrates the richness of diverse perspective with the simplicity required to act?

- How do we build support for an analysis that might be difficult to communicate or that challenges people's underlying beliefs and assumptions?
- What are our current relationships and mechanisms for engagement with these stakeholders/partners?
- Are there any power/political dynamics we should be aware of or that might impact our work with these various stakeholders or partners? How might we navigate these?

Some resources that might be helpful…

Stakeholder engagement

Legare, J., van der Woerd, K., Simces, Z., & Ross, S. (2014). *Successful stakeholder engagement: focus on mental health and substance use clients*. Commissioned by the Community Action Initiative (British Columbia).

Collaboration

Canadian Centre on Substance Abuse. (2012). . Author.

Community Toolbox Online. *Section 4. Developing multisector collaborations*. Author.

Huxham, C. & Vangen, S. (2005). *Managing to collaborate. The theory and advantage of collaborative advantage.* London: Routledge.

Kahane, A. (2017). *Collaborating with the enemy. How to work with people you don't agree with, or like or trust.* Oakland California: Berrett-Koehler.

Prevention Institute. Online. *Enhancing the effectivenesss of multi-field collaboration*. Author.

Endnotes

[38] Westley, F., Zimmerman, B., & Patton, M. (2006). *Getting to maybe. How the world is changed.* Random House; pg. 49.

[39] Hilton, K., & Anderson, A. (2018). *IHI Psychology of Change Framework to Advance and Sustain Improvement.* Institute for Healthcare Improvement, pg. 12.

[40] Sandhu, G. (2017). *The value of lived experience in social change: The need for leadership and organizational development in the social sector.* The Lived Experience.

[41] Hilton, K., & Anderson, A. (2018). *IHI Psychology of Change Framework to Advance and Sustain Improvement.* Institute for Healthcare Improvement.

[42] Adapted from:
Canadian Centre on Substance Abuse. (2013). *Systems approach workbook. Valuing people with lived experience.* Author.

Legare, J., van der Woerd, K., Simces, Z., & Ross, S. (2014). *Successful stakeholder engagement: focus on mental health and substance use clients*. Commissioned by the Community Action Initiative (British Columbia).

Sandhu, G. (2017). *The value of lived experience in social change: The need for leadership and organizational development in the social sector.* The Lived Experience.

Zappelli, R., & Ardiles, P. (2013). *Taking Action on Stigma and Social Inclusion in British Columbia.* Commissioned by the Public Health Association of BC, on behalf of the Healthy Minds Healthy People Directorate (BC Government).]

[43] Adapted from:
Canadian Centre on Substance Abuse. (2013). *Systems approach workbook. Valuing people with lived experience.* Author.

Legare, J., van der Woerd, K., Simces, Z., & Ross, S. (2014). *Successful stakeholder engagement: focus on mental health and substance use clients*. Commissioned by the Community Action Initiative (British Columbia);

Sandhu, G. (2017). *The value of lived experience in social change: The need for leadership and organizational development in the social sector.* The Lived Experience.

Zappelli, R., & Ardiles, P. (2013). *Taking Action on Stigma and Social Inclusion in British Columbia.* Commissioned by the Public Health Association of BC, on behalf of the Healthy Minds Healthy People Directorate (BC Government).]

[44] First Nations Health Authority, n.d. *#itstartswithme FNHA's Policy Statement on Cultural Safety and Humility*, pg .11

[45] First Nations Health Authority, n.d. *#itstartswithme FNHA's Policy Statement on Cultural Safety and Humility*, pg .11

[46] McNally M. & Martin, D. (2017). First Nations, Inuit, and Metis health: Considerations for Canadian health leaders in the wake of the Truth and Reconciliation Commission of Canada report. *Healthcare Management Forum*, 30(2), 117-122.

[47] Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2), 117-125.

[48] Assembly of First Nations (AFN). (2017). *The First Nations Health Transformation Agenda.* Author.

[49] Legare, J., van der Woerd, K., Simces, Z., & Ross, S. (2014). *Successful stakeholder engagement: focus on mental health and substance use clients*. Commissioned by the Community Action Initiative; pg. 5.

[50] Innis, J., & Booher, D. (2018). *Planning with complexity. An introduction to collaborative rationality for public policy. 2nd Ed.* London: Routledge; pg. 102.

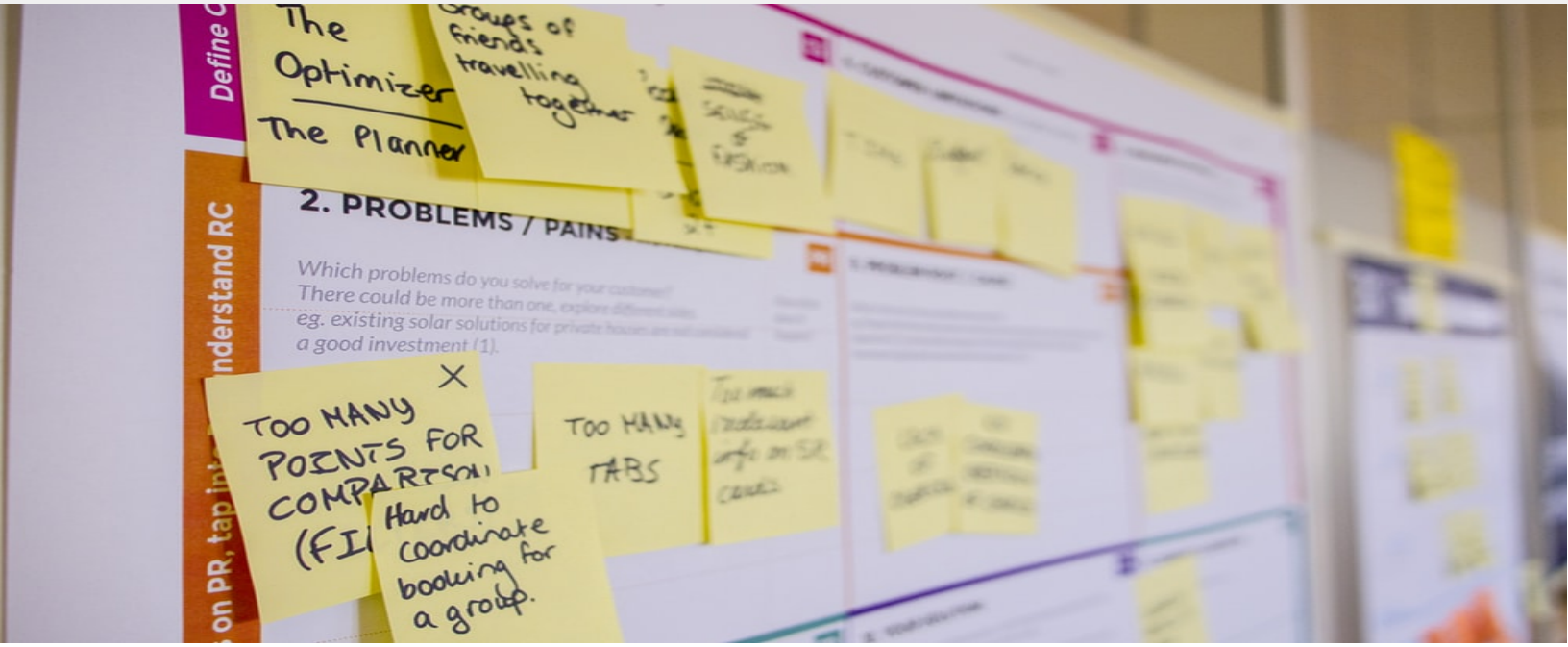
[51] Adapted from:
Brach C., Lenfestey, N., Roussel, A., Amoozegar, J., & Sorensen, A. (2008*). Will It Work Here? A Decisionmaker's Guide to Adopting Innovations*. Prepared by RTI International under Contract No. 233-02-0090. Agency for Healthcare Research and Quality (AHRQ) Publication No. 08-0051. Rockville, MD: AHRQ;

Stroh, D. (2015). *Systems thinking for social change. A practical guide to solving complex problems, avoiding unintended consequences and achieving lasting results*. White River Junction, Vermont: Chelsea Green Publishing; pg. 211-212.

Heifetz, R., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership.* Boston, MA: Harvard Business Press.

Resources Part 5C. Understanding the issue and context

In this Part, we provide information and tools to help you gain a solid understanding of the issue or opportunity you are addressing, and the context in which you're working. A deeper understanding of these things will increase the likelihood of coming up with an effective response.



There are many ways in which the value of a "new idea" might strike you. Maybe it's just an epiphany that strikes you: *This is not right! We need to change!* Or, maybe you're not really seeking anything new, but you nevertheless keep your eyes open for ways to improve your services. Sometimes we come upon solutions to issues we don't know we have. On the other hand, there might be a specific issue or known need for change. Perhaps staff or service users have complained that services aren't working, or there is a gap between what you offer and what they need. Or perhaps you can tell from your monitoring and evaluation activities that something needs to change or could be improved.

In any case, once you have decided that something needs to change, a good understanding of the situation – the challenge or opportunity; its history; the people affected and the contexts in which they live, work, learn, worship and play; and, the ability of your organization to address it - will give you a solid foundation for taking action.

Better understanding of the issue and context = better decisions and solutions

"There is a need to spend time understanding 'what is' and where it has come from before deciding how to attempt to change things[52]."

"Time must be invested at the design stage to explore problems and opportunities, clarify the improvement goal, and prepare to learn[53]."

However, especially with complex problems, you will never have a complete understanding of the situation. This is just a starting point that will need to be revisited from time to time. So, you'll likely have to balance the gathering of as much relevant information as you can without becoming overwhelmed. Trust that you will continue to learn more about the situation. And things will probably change over time anyway – so starting with a basic understanding and then moving forward with a plan to learn and adapt as you go should serve you well.

Some questions to consider re: understanding the issue

To get you started, some questions you might want to consider are presented in the boxes below. The list is long, but you don't have to answer all of the questions, and you might have your own very specific questions. Consider this to be a smorgasbord of ideas – take what's helpful and leave the rest!

Understanding the issue or opportunity. Some questions to consider[54]…

ABOUT THE PEOPLE INVOLVED

- Who are the actors? What are their interests and methods? What do they value? What do they fear? Who has what degree and type of power?
- What are the roles of the key actors within the system (e.g., service users and their supports, partner agencies, policy makers, community group(s), other relevant organizations that affect or are affected by the issue)?
- How does each group of affected people describe and experience the issue? How do they deal with or respond to it? What matters to *them* in regard to this issue? What are their ideas for resolving the issue?
- What role is played by race, ethnicity, gender, age, sexual orientation, language?
- Does this issue disproportionately impact certain racial, ethnic or other specific demographic groups? Who benefits? Who misses out?

ABOUT THE ISSUE OR OPPORTUNITY

- What is the nature of this issue or opportunity (e.g., is it about a specific issue faced by a particular group of people; or is it about quality, efficiency, access to care, coordination of care, workforce, client satisfaction, financial, etc.)?
- What are the root causes of the issue? What are the problems? Where do they come from?
    - What is the history of this issue? How has it been addressed in the past?
    - What factors and/or dynamics contribute to the issue?
    - Is this issue merely a symptom of deeper issues?
    - Can we identify any patterns of behaviours that give us more insight into the issue?
    - Are there structures (e.g., norms, values, organizational structures, infrastructure) that underlie this issue?
    - Could this be due in part to the mental models upon which our system/structures are based (e.g., our worldviews, what we see as the "right" way to do things)?
- How often does this issue occur and how severe is it?
- Is there a geographic area that is more affected by this issue?
- Are there things/dynamics in the local context that contribute to the problem, or that might be part of the solution?
- What are the contradictions? What is the larger context?
- Have there been any previous efforts to address the issue? How did those efforts turn out? Were any insights or "lessons learned" generated from those efforts?
- Are there any projects in place or planned to be in place (in our organization or other organizations) that might impact the issue?
- What have others in similar situations done? In what context? How well did their approach work? What were their "lessons learned"?
- Do we have any information/data to help us understand the issue? If yes, what does the information tell us?

ABOUT THIS ISSUE OR OPPORTUNITY IN RELATION TO OUR ORGANIZATION:

- How does this issue or opportunity fit with or impact our values, mission, other initiatives?
- How important is it for us to address this issue or opportunity? *Why* is it important to address? What would happen if we didn't address it?
- How do *we* feel about this issue? Why? What do *we* value? What do *we* fear? Why?
- Are we doing anything now to address this issue or opportunity?
- Are we doing anything that contributes to the issue or makes it worse?
- What power do we have? What are our leverage points?
- Are there people who share similar aspirations to ours but have a very different view about the nature of the problem/opportunity and/or the approach to address it? If so, what can we do to help align our respective efforts more effectively?
- What would we like to have happen? What needs to change?
- What would success look like in relation to this issue? How would we know when we've achieved that success?
- Do we need to find out more? What else do we need to know and how will we find out

The Iceberg Model

One helpful resource for understanding an issue is called the Iceberg Model (see the Figure below). There are several variations of this model, but the basic premise is that **delving below the surface of events or behaviours can help us to see the bigger picture of how and why things are actually working, and we can use that information to identify leverage points for action** – places where a small change might lead to a large shift in behaviour. The deeper below the surface of the iceberg, the more effective the shift is likely to be; however, the more difficult it will be to make that shift.

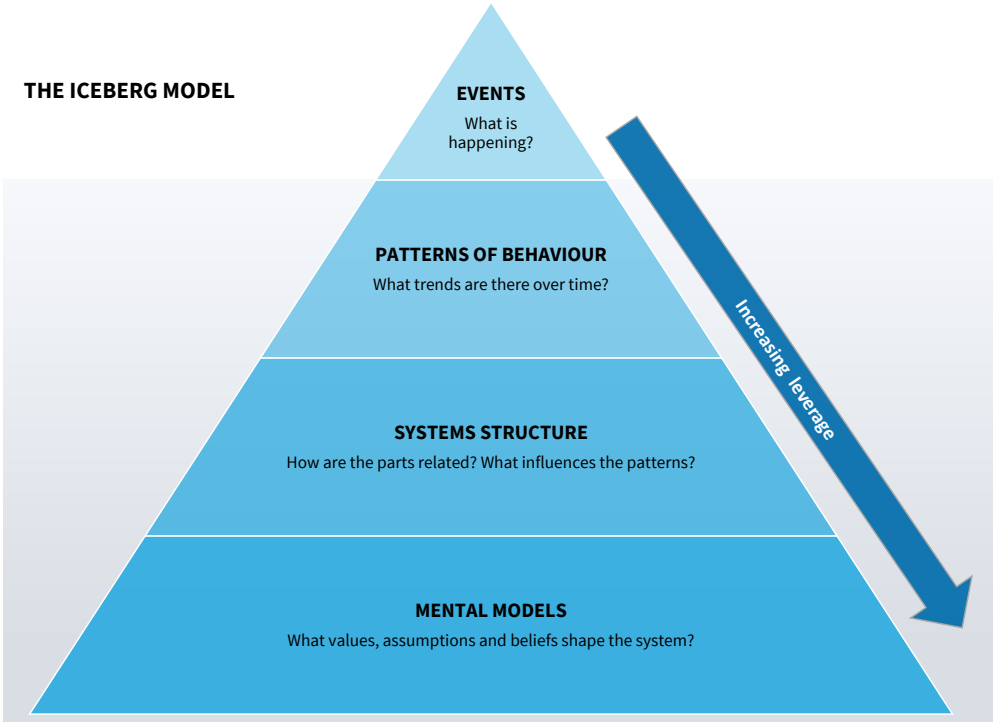


Figure. The Iceberg Model[55]

Events or behaviours: On the surface of things – above the water – we have observable behaviours, practices or events. Sometimes this is the most recent crisis at hand – for example the latest statistics regarding suicide or the opioid crisis, or the number of people on a waitlist to see a psychiatrist.

Patterns of behaviour: Delving immediately below the surface, **we can step back from those observable events or behaviours and try to understand why they're occurring by discerning underlying trends or patterns.** Are there similarities, differences or interconnections across time and/or location? This will help deepen our understanding of what is going on and why.

Systems structure: Going even deeper, **we can try to understand what structures such as norms, infrastructures, policies and power dynamics are shaping the patterns of behaviour we are observing**, as well as those that are impacting our ability to successfully address issues and opportunities. We can also perhaps place the social determinants of health here (e.g., adequate income, safe and secure housing, good working conditions, early childhood development, education, culture, history and so on) as "root causes" of the trends or patterns we've identified.

Mental models or paradigms: Deepest below the surface lies the mental models or paradigms that underlie how we structure systems, processes and actions which in turn shape structures and patterns of behaviour. These mental models need not be shared, explicit or even logical when viewed by others, but they nonetheless contribute to the patterns in a complex system. Deliberately surfacing and changing underlying simple rules such as these can lead directly to innovative ideas.[56] **Once surfaced, these beliefs can be examined and challenged by asking questions such as, "Does this mental model help us achieve what we want now? Are there alternative views? What is our vision of what we want now and the mental model that would support it? How could we test this out?"**[57]

One example is a common rule in the health professions: "First, do no harm". This simple rule might lie behind peoples' reluctance to embrace the risk of innovative change. Another example is the paradigm upon which mental health services are based. Historically, the mental health system has focused on the diagnosis and treatment of mental illness, and the system is structured to achieve this goal (a biomedical mental model). In contrast, paradigms grounded in recovery and client-centredness[58] or social views of mental distress[59] are based on different theories, assumptions, language and practices. A system based on these paradigms would look and operate differently. A third and related example is the shift in thinking engendered by an understanding of trauma, or injury as the foundation of many mental health problems and illnesses. This "trauma-informed" mental model leads to different ways of thinking and working with people experiencing mental health challenges and illnesses[60].

Understanding the context in which you're working

An understanding of the context – the "lay of the land" - in which you're working is another key part of evidence-informed practice, especially when working in complex environments and on complex issues. Understanding the community/cultural, policy, and organizational contexts, any relevant historical factors, existing strengths and so on will afford a "big picture" of the system in which you're working. Understanding this context provides invaluable information in terms of deciding what will work in your environment and with the people you serve.

In addition, analysis of external organizations, including mandates, objectives, clientele and past or current collaborations, will help identify existing relationships and common ground on which to build new partnerships. And an analysis of your own organization – strengths, weaknesses, culture, values, ways of doing things – will help you decide how best to proceed, and possibly to shore up any areas of weakness in order to optimize your efforts.

All of this "up front" work will help anticipate the unexpected, identify allies and resources and will inform development of an implementation plan. It will also illustrate where proposed changes fit with other organization and service-level considerations.

Some questions to consider in understanding context

Again, here is a smorgasbord of questions to get you thinking. The list is long, but you don't have to answer all of the questions, and you might have your own very specific questions. Take what's helpful and leave the rest!

Some questions to help understand the local (and broader) context[61] …

POLITICAL CONTEXT

- What local, regional, provincial, or national political priorities or processes might influence the project (e.g., legislative change, pending elections, politically appointed working groups or commissions of inquiry, specific political directives)?
- What is the political and governance landscape like – who can influence the desired changes? Who owns the decisions that really have an impact?
- What is the "political climate" in terms of receptivity to the issue or opportunity at hand? Is there a policy window or situation that can be leveraged?
- Are there any historical areas of conflict? What are the causes of this conflict?
- What are the dynamics of power and politics in this environment? Who has power? How do they use that power? Are there formal or informal (and invisible) alliances? How might these dynamics influence how we address the issue or opportunity?

  For each stakeholder:

  - How will they be affected?
  - What would they like to see happen?
  - How much do they care about the issue?
  - What resources do they control? Who wants these resources?
  - What are their values?
  - What are their loyalties?
  - What do they fear losing (status, resources, image) if things should change?
  - What shared interests do they have with people from other stakeholder groups that could lead them to form an alliance that could build influence?
- If applicable – what drives actors who actively cause, reproduce or maintain the problem (e.g., interest, habit, lack of knowledge, power)?

- How can we help to create or promote more empowering and horizontal power dynamics?
- How can we ensure that decision making processes recognize and integrate the diversity of perspectives, identities and knowledge that exists amongst different stakeholders?

SOCIAL CONTEXT AND TRENDS

- What is the history and other past circumstances that contribute to current economic, political and social status?
- How are the social determinants of health influencing mental health and wellbeing and peoples' ability to engage in and benefit from the work we wish to do? [Consider, for example gender, culture, age, income, housing, education, employment, food security, equity, justice, healthy childhood development.]
- Immigration and migration history and patterns.
- What current or emerging trends might affect the issue or the population we're working with?

COMMUNITY/CULTURAL CONTEXT

- What are the characteristics (socio-demographics) of the community in we're working with, particularly for those affected by the issue or opportunity we're addressing? (Consider, for example, economics, politics, natural environment, social environment, resilience, resources, capacity for working effectively together.)
- What are the community's strengths and assets in relation to the issue/opportunity we're addressing? What are its' challenges or limitations?
- Socioeconomic status and education; access to and ability to use resources and opportunities such as health care, schools, employment.
- What is the cultural context for those affected by the issue/opportunity we're addressing? Consider, for example:
    - Perspectives on health, mental health, illness, healing practices. For example:
        - Are psychological, physical and spiritual health or wellbeing seen as separate entities or as unified aspects of the whole person?
        - How are illnesses and healing practices defined and conceptualized?
        - What are acceptable behaviours for managing stress?
        - How do people in this culture typically express emotions and emotional distress?
        - What behaviours, practices or customs do people in this culture consider to be preventive?

- Where do people typically seek help?
- What are the roles of family members in providing health care and in making decisions?
    - Cultural identity and degree of acculturation.
    - Religion and spirituality, traditions, spiritual beliefs and traditions.
    - Language and styles of communication (verbal and non-verbal).
    - Worldview, values (e.g., collectivistic, individualistic/competitive).
    - Family and kinship – hierarchy, roles, rules, traditions, parenting norms.
    - Gender identity and sexuality – attitudes toward sexuality and sexual identity.
- Other things to consider might include, for example:
    - Ceremonies, celebrations and traditions.
    - Social groupings.
    - Assumptions, prejudices, stereotypes and expectations of others.
    - Reward or status systems.
    - Means of establishing trust, credibility and legitimacy.
    - Sources for acquiring and validating information, attitudes and beliefs.

[See "Planning and preparing" for questions re: organizational context.]

Some resources that might be helpful…

Tools for understanding the issue and context

FSG. *Systems thinking toolkit. Putting systems thinking into practice in your organization*. Author.

Canadian Centre on Substance Abuse. (2012). *Systems approach workbook: Context analysis template.* Author.

System mapping tools

HSD (Human Systems Dynamics) Institute – Systems mapping

Canadian Centre on Substance Abuse. (2012). *Systems approach workbook: system mapping tools.* Author.

CoLab. Online. *Follow the rabbit. A field guide to systemic design.*

Actor mapping (exploring relationships and connections among actors and their relationship to a given issue or project)

FSG. *Guide to actor mapping*. Author.

The Iceberg Model (Donella Meadows) - a systems thinking tool that helps think below the surface – to identify stronger leverage points for action:

http://donellameadows.org/wp-content/userfiles/iceberg-model.pdf

https://www.academyforchange.org/impacts-endure-using-systems-thinking-organize-large-scale-collaboration/

Some other simple tools to help identify where small, focused actions will lead to significant, sustainable improvements (but beware, these tools may not always be helpful especially when addressing complex issues).

- Five whys - asking "why" five times can help get to the bottom of an issue
  (but this is probably only useful for simplistic problems rather than complex ones.)
  - http://www.ihi.org/resources/Pages/Tools/5-Whys-Finding-the-Root-Cause.aspx
- Fishbone analysis – another tool to get below the surface of issues
  - http://www.ihi.org/resources/Pages/Tools/CauseandEffectDiagram.aspx
  - https://improvement.nhs.uk/resources/cause-and-effect-fishbone-diagram/
- Force field mapping
  - https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2018/06/Force-Field-Analysis-Instructions.pdf
- SWOT (strengths, weaknesses, opportunities, threats) analysis
  - https://www.betterevaluation.org/en/evaluation-options/swotanalysis

Endnotes

[52] Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press; pg. 132.

[53] Reed, J., Howe, C., Doyle, C., & Bell, D. (2019). Successful Healthcare Improvements From Translating Evidence (SHIFT-Evidence): simple rules to guide practice and research. *International Journal for Quality in Health Care,* 31(3), 238-244; pg. 242.

[54] Adapted from: Brach, C., Lenfestey, N., Roussel, A., Amoozegar, J., Sorensen, A. (2008). *Will It Work Here? A Decisionmaker's Guide to Adopting Innovations.* Prepared by RTI International under Contract No. 233-02-0090. Agency for Healthcare Research and Quality (AHRQ) Publication No. 08-0051. Rockville, MD: AHRQ.

Bishop, A. (2015). *Becoming an ally. Breaking the cycle of oppression in people. 3rd Ed.* Halifax: Fernwood Publishing.

[55] Adapted from: *Donella Meadows Academy for Systems Change*, Online.

[56] Plsek, P. (2003). Complexity and the adoption of innovation in health care. Paper presented to the conference: *Accelerating Quality Improvement in Health Care – Strategies to Speed the Diffusion of Evidence-Based Innovations*, Washington, CD, 27-28 January.

[57] Stroh, D. (2015). *Systems thinking for social change. A practical guide to solving complex problems, avoiding unintended consequences and achieving lasting results*. White River Junction, Vermont: Chelsea Green Publishing.

[58] See, for example:
Slade, M., Oades, L., & Jarden, A. (2017). Why wellbeing and recovery? In M. Slade, L. Oades & A. Jarden (Eds.) *Wellbeing, recovery and mental health.* New York: Cambridge University Press; pg. 1-5.

Leader, T. (2016). *It's not about us. The secret to transforming the mental health and addiction system in Canada.* Cathydia Press.

[59] Tew, J. (2005). Introduction. In J. Tew (Ed.) *Social perspectives in mental health. Developing social models to understand and work with mental distress.* London: Jessica Kingsley; pg. 9-31.

[60] See for example, Bloom, S., & Farragher, B. (2013). *Restoring sanctuary. A new operating system for trauma informed systems of care.* New York: Oxford University Press.

[61] Adapted from:
SAMHSA, (2014). *TIP 59: Improving cultural competence*. Author

Heifetz, R., Grashow, A., Linsky, M. (2009). *The practice of adaptive leadership. Tools and tactics for changing your organization and the world.* San Francisco: Jossey-Bass; pg. 90-91.

Resources Part 5D. Exploring the evidence and deciding where to begin

In this Part, we offer a number of question sets and tools to find and critically examine different kinds and sources of evidence that you might draw upon to address the issue or opportunity you are facing.

Once you have a good understanding of the issue or opportunity you're facing, then you can start to look for possible responses or solutions. Some people call this process "exploration and adoption" because it focuses on finding and exploring possible solutions or approaches, weeding them out, and ultimately arriving at a specific approach to put into place. Or, in other words, finding the most appropriate solution for you, your organization and the people you serve. **This includes looking to see what others have done, or it may involve a creative process of generating novel ideas.**

Some questions to consider when exploring evidence

As discussed in the section about evidence-informed practice **– there are many sources of knowledge and information to consider. No matter the source, you will want to get a good understanding of a number of things including those listed in the boxes below.** Remember, this is a smorgasbord of ideas and you don't have to try everything! You don't have to answer all of these questions. Take what's helpful and leave the rest!

Some questions you might ask when trying to understand an evidence-informed practice (EIP) developed and implemented elsewhere…

- What is the scope of the EIP? Some EIPs are simple; others are much more complex and involved, involving a greater degree of change.
    - Will the EIP require small bits of change, or will it require transformational and organization-wide change?
    - Is the change required by the EIP a natural progression from current practice?
- Where has the EIP been implemented? Understanding this can provide insights about how well it will fit/work in your setting. Consider, for example:
    - Culture (community, organizational) in which the EIP was implemented, compared to the culture in which we're working.
    - What kinds of participants were attracted and how do they compare with our intended "target" population?
    - Inpatient versus community-based care.
    - Independent versus multisite organizations.
    - Urban, suburban, rural, remote settings.
    - Diverse versus homogeneous population.
- What problem were the researchers/practitioners trying to address? How similar is that problem to the issue we're addressing?
    - What population was being served?
    - In what setting or context – geographic location, kind of organization, community, culture, economic, political context?
    - With what resources/capacity?
        - How large is the organization that was implementing the intervention? What kinds of resources/capacity does it have? How does that compare with our organization?

- What intervention did researchers introduce to solve the challenge? What, specifically was done? By whom? How? With what resources? (The more specific the better here so you can judge whether or not that might work in your situation.)
- If the intervention was deemed a success, how was success defined and what were the results, specifically? What was it about the intervention that worked? What are the critical parts of the intervention for success? What didn't work? Why? (Again, the more detail the better so you can judge whether and how the intervention might work in your situation.)
- How did the EIP work, and what is the evidence that the EIP worked?
    - Which components of the EIP were effectively implemented? Which were difficult to implement? Why?
    - What elements of the innovation have turned out to be essential, while others could be discarded or adapted without negatively affecting results?
    - Is there more than one viable option for action? What tradeoffs are associated with each alternative?
    - Are there any critical unsolved problems and things still to be learned?
    - What are the downsides or disadvantages of the EIP?
- Remember that evidence that an EIP did *not* work is as helpful as evidence that it did work.
- How could the EIP address our issue within our context?
    - Does it address the root cause of the issue?
    - Does it provide a long-term solution to the issue?
    - Will it create other problems?
    - Is it congruent with other things we're doing?
    - Does it fit with our norms, values, beliefs, mission?
    - Will it require a radical change in thinking or process?
    - Can it be adapted, refined or modified to meet local needs and still achieve the same outcomes?
    - How risky is adoption of the innovation?
    - Is there a large cost upfront (e.g., training, supplies, etc.)?
    - How big a change would this be to individual worker practice, and to the organization as a whole?

Exploring different kinds of evidence

Below are some brief descriptions of how you might access and explore various kinds and sources of evidence that may help address the issue or opportunity you are facing.

Evidence from academic research

A valuable source of information will be any published research relevant to the issue you are addressing. The most common way of exploring this research is through a literature search and review. A literature search is a systematic search of academic literature to find articles that are relevant to the issue you are addressing. Broadly there are three processes:

1. Defining what you want to know; that is, what question do you want to have answered? Break the question down into key words. These will become your "search terms" – the words you enter into a website or database of articles. It will be helpful to think of various synonyms and short phrases for your search terms in order to broaden the range of articles you find. It can be helpful to learn the logic of search terms. [Click here for a detailed guide to searching the literature.]

2. Searching for relevant articles. A helpful overview can be found at: How to find scholarly articles online. There are many ways to access published academic research reports. If you have access to a college or university library and its databases, you will be able to access the broadest array of articles, and possibly also the help of a research librarian. If you don't have access to these resources, there are many other ways to find research articles including for example:

   - Google Scholar
   - Directory of Open Access Journals (DOAJ)

   You can also search:

   - Government webpages – pages operated by provincial/territorial/national governments
   - International and non-governmental organizations (e.g., World Health Organization, Mental Health Commission of Canada, American Psychological Association, Ontario Centre of Excellence for Child and Youth Mental Health, SAMHSA)
   - Discipline-specific search engines (e.g., mental health, psychology, health promotion)
   - Websites of individual academics
   - Webinars, presentations, conferences
   - Books
   - Annual reports
   - Reports to funders

3. **Reviewing the article for quality, relevance and application to your situation**. Things to look for when you're reviewing an academic article are listed in the box "Some questions you might ask when trying to understand an innovation or evidence-informed practice (EIP) developed and implemented elsewhere" A helpful guide for reviewing published research articles can be found at: How to read psychology journal articles

Evidence grounded in what other people or agencies have done

You may also hear about innovative practices implemented by others but that may not yet have been fully evaluated or researched. You might find out about these things through conversations with colleagues and people doing similar work – perhaps in meetings or at conferences. Or you might find out about these things through an environmental scan – a search for and review of other organizations or practitioners who have done relevant work. You'll want to answer the same kinds of questions we outlined above (e.g., how it works, for whom it was intended and so on).

Evidence grounded in practitioner experience and judgment

And, what is your own experience with this issue, the people being served, the setting in which you're working, and the capacity of your organization to address the issue? What does your gut tell you? What have you learned in your practice? But remember, sometimes we fall into the trap of just doing what we've always done. It's important to challenge your thinking and your assumptions. If something isn't working, why is that? Tools for critical reflection might be helpful here. Click here for more information.

Evidence from theory

Often our thinking is grounded in theories we have learned in our practice or education. For example, if we are grounding our practice in the theory of trauma informed care, we are more likely to view mental health problems and illnesses through the lens of traumas experienced in one's life: "not what's wrong with you, but what happened to you[62]". What theories are you aware of that might be relevant to your issue? Google and Google Scholar can certainly be helpful for finding out what kinds of theories might be worth considering.

Evidence grounded in the culture, values, needs and preferences of service users

Service users are critical contributors to defining issues, gathering evidence and making decisions. The diversity and experience of service users constitutes a wealth of essential information for care and service delivery. Respect for and appreciation of their voices and of their unique characteristics, needs and values as well as the cultural and community contexts in which they live are critical factors in the evidence-informed model[63]. As outlined in Part 5B. *Engaging and building relationships with service users*, it is wise to engage service users from the outset.

Innovating

Chances are you may not find a solution that fits your unique issue/opportunity, context or circumstances, including in particular, the scarcity of financial resources. In this case – it's time to get creative and innovate. Creativity is about dreaming up a new idea – a new product, practice, action, service, relationship, or policy, for example. Innovating is executing the idea.

"If you want innovative ideas from any collection of individuals, set aside the resource of time, nurture productive relationships among a diverse group of thinkers who will find the conversation intrinsically rewarding, use good group process and tools, agree on an ambitious goal, bring in new knowledge, and be willing to take risks[64]."

Brainstorming

Here are some simple rules for generating new and better ideas (brainstorming):[65]

- Criticism is ruled out - there are no bad ideas when brainstorming; "everything goes"; there will be time to critique ideas later.
- Go for quantity – don't just settle for three or four ideas. Aim for 10-20 or more.
- Encourage wild ideas – it's the wild ideas that often provide the breakthrough insights that lead to further ideas that are not so far-fetched.
- Build on the ideas of others – What can you add? What else? What other ideas come to mind?
- One conversation at a time – This way, all ideas can be heard and built upon.

What is "groupthink" and how can we avoid it?

"Groupthink" is *"when people in a tightly knit culture go along uncritically with the group and/or squelch dissent.*[66]" Avoiding this drain to creativity and innovation requires a healthy respect for diversity and the ability to constructively embrace conflict alongside an openness and learning orientation. Much of this can be achieved by nurturing a learning environment where people feel safe to say what they're really thinking (see Part 3. Leading for learning). Here's a few other ideas; you can probably come up with others:

- Ensure that people with a variety of diverse perspectives are included.
- Assign someone the role of "devil's advocate"– someone who contradicts all popular ideas surfacing in the conversation in order to encourage generative debate.
- Put every idea to the test – examine each one thoroughly according to the same pre-established criteria.
- Divide people into small groups to work on the same problem.
- Invite an outside expert in to participate in the discussion.
- Make sure there is fulsome discussion and debate before coming to a decision.

Some resources that might be helpful…

Finding/searching for relevant academic research

Alberta Health Services (2019). *Systematic literature searching: A resource guide*. Edmonton, AB: Author.

Fostering creativity and innovation in your organization

DeBono, E. (n.d.) *DeBono describes the six thinking hats*. YouTube video.

Miller, A. (n.d.) *Edward DeBono's six thinking hats*. YouTube video.

Maher, L., Plsek, P., Price, J., & Mugglestone, M. (2010). *Creating the culture for innovation. A practical guide for leaders.* NHS Institute for Innovation and Improvement.

NHS Institute for Innovation and Improvement. N.d. *Thinking differently*. Author.

Maher, L., Plsek, P. & Bevan, H. n.d. *Making a bigger difference.* NHS Institute for Innovation and Improvement.

Von Oech, R. (1983/2008). *A whack on the side of the head. How you can be more creative.* New York: Warner Books.

Design thinking

CoLab. Online. *Follow the rabbit. A field guide to systemic design*

IDEO.org. (2015). The field guide to human centred design. Design Kit.

Deciding where to begin…

Once you have a good sense of the evidence and context, and perhaps have come up with your own innovative solution, it's time to decide where you want to start. This conversation should include key stakeholders and diverse perspectives, including service users. Inclusion in this process (and all other processes) offers the best chance that an approach satisfactory to all stakeholders will be adopted; this in turn will facilitate buy-in for the change by stakeholders. Some possible questions to guide this discussion are listed below.

Key questions for deciding where to begin…

- Do any existing interventions suit our needs? Or, do we need to innovate – design something new and unique to meet our needs?
- Which intervention(s) (i.e., EIP/innovation) could enable us to achieve sustainable, break-through change?
- Which are most congruent with our values, mission, service model, other initiatives and priorities?
- How will this intervention meet our needs? What benefits will it generate?
- What is the knowledge/evidence base for this intervention?
    - Do we feel the evidence is solid enough to warrant trying it here?
    - Can we defend the decision to use this intervention to our stakeholders?
    - Is there agreement amongst stakeholders that this is a good place to begin?
- Is the information we have about the intervention specific enough – do we know enough about how it is supposed to work so that we can put it into place here?
- And, how and why do we expect it to work? What is our logic or theory about how the intervention will work and for whom, and in what contexts?
- Is the target for practice change achievable and feasible?
- What might be the unintended consequences of our proposed solutions? How would we detect them? How could we prevent or mitigate them?
- Do we have the capacity to do this? Can we realistically implement it given our available financial, human and organizational resources and given the context in which we are working?
  [See Part 5E. Planning and preparing.]
    - What resources would we need and what would will it cost?
- Could this approach be sustained over time based on the priorities of our agency and the target population?

Endnotes

Note: Question sets are adapted from:
Brach, C., Lenfestey, N., Roussel, A., Amoozegar, J., & Sorensen, A. (2008). *Will It Work Here? A Decisionmaker's Guide to Adopting Innovations*. Prepared by RTI International under Contract No. 233-02-0090. Agency for Healthcare Research and Quality (AHRQ) Publication No. 08-0051. Rockville, MD: AHRQ.

[62] Barnett Brown, V. (2018). *Through a trauma lens. Transforming health and behavioural health systems.* New York: Routledge; pg. 65.

[63] Dodd, S., & Savage, A. 2016. Evidence-informed social work practice. *Encyclopedia of Social Work;* pg. 10.

[64]Maher, L., Plsek, P., Price, J., & Mugglestone, M. (2010). *Creating the culture for innovation. A practical guide for leaders.* NHS Institute for Innovation and Improvement, pg.40.

[65] Adapted from NHS Institute for Innovation and Improvement. N.d. *Thinking differently*. Author; pg. 25.

[66] Fullan, M. (1999). *Change forces. The sequel.* Philadelphia: Falmer Press; pg. 16.

Resources Part 5E. Planning and preparing

In this Part, we outline some key considerations in planning and preparing and highlight known enablers and facilitators of successful implementation. And, we include questions you might want to consider as you're planning to implement your EIP or innovation.

Having made a decision about what you're going to do and where you're going to start, it's time to make a plan and prepare for implementing your intervention (i.e., EIP or innovation). **Like all other processes, this one involves working actively with diverse stakeholders, including service users wherever relevant and possible, to agree on goals, develop a plan and prepare for moving forward.** Although we discuss them as separate processes, planning, preparing and implementing through ongoing cycles of acting, learning and adapting are integrally intertwined activities.

The way that planning is discussed in the literature differs depending on which mental model is in play. Traditional mechanistic views of implementation, commonly found in implementation science and knowledge translation research, tend to emphasize detailed planning and preparation up front, with checklists and detailed matrices outlining the steps and tasks to be completed, and controlling for contingencies as much as possible.

On the other hand, **complexity advocates place less emphasis on exhaustive planning and preparation upfront, and more emphasis on flexibility, experimentation, learning and adaptation[67] along the way. A flexible approach anticipates that there will inevitably be challenges and problems and affords the space to understand and tackle them. Planning is described as a more emergent, organic process** where goals are established up front but plans for achieving them are fleshed out in greater detail as implementation progresses and it becomes possible to see how things are going and what adaptations might be required. Some complexity scholars even argue for simply outlining the general direction and some principles for getting there[68].

"A complexity-informed approach finds a new middle ground between pre-planning, analysis and persistence on the one hand, and agility, experimentation and adaption on the other hand. This can be compared with traditional approaches which emphasize the former over the latter[69]."

"Being clear on goals and persisting in their achievement remains of central importance. What changes with a complexity worldview is how to plan for greater degrees of flexibility in responding to the unexpected, how to seize opportunities, and how to adapt to changing circumstances[70]."

The degree of specificity of plans may vary depending on how stable and predictable (or complex and dynamic) the issue, the context and your intervention are. Where things are certain and there is a high level agreement amongst people about what to do, more specific and detailed plans make sense; but where things are "far from certain" and there is less agreement about "the best way forward", adaptability, openness to learning and changing approaches are more likely to be helpful. [See the box below for more information about simple, complicated and complex problems.]

SIMPLE, COMPLICATED AND COMPLEX PROBLEMS – THE CYNEFIN MODEL

Complexity thinkers David Snowden and Mary Boone[71] introduced the Cynefin model - a Welsh term pronounced ku-nev-in - that is descriptive of the multiple factors in our environment and our experience that influence us in ways we really can't understand. They developed a model that separates out different levels of complexity, each of which requires a different approach to arriving at a response or solution.

- Simple problems are clearly identifiable; it is clear that one thing directly causes another. There are well-known solutions to these problems. Simple problems are often equated with baking a cake – there are recipes to follow and when you do, you generally get the same results no matter where you are. This is the world of "best practices" or standard operating procedures – practices based on known and simple problems in known environments.

- Complicated problems are more challenging. It's harder to tell what causes what, but it is nevertheless possible given enough expertise and study. An often-cited example of complicated problems is sending a rocket to the moon. It's complicated, and there are many ways to do things and solve problems, but experts have figured out how to make it happen. This is the world of "good practice".

- Complex problems, in contrast are very messy. They occur when the environment is continually evolving, and events are not necessarily predictable. Here, there are a variety of opinions about possible actions and no clear agreement on the best way forward, and there a lot of stakeholders with different philosophies. An example is raising a child – raising one child provides experience but does not guarantee success with the next. This is the environment in which we live and work – families, communities, organizations, and the health and human services system. It is the world of "emergent practices" – experimenting with possible solutions.

Planning advice from a complexity perspective

Typical planning advice from complexity theorists includes[72]:

- View planning as providing a basis and guide for decision making throughout the implementation process.
    - Plans should not be rigid, but rather, adaptable to address new developments, challenges and opportunities.
    - This means shorter planning cycles and frequent review to respond to the dynamic nature of change and the potential for the context (or something else) to change.
- Spend less time on detailed upfront planning.
- Spend more time on processes to monitor how implementation is going and feed this information back to inform ongoing implementation efforts.
- View deviations from plans as providing information about the reality of what it takes to implement the EIP or innovation.
- View unforeseen effects, contradictions or puzzles as clues about relevant changes, new challenges or innovative ways to handle a situation – all of which can improve implementation.
- Integrate learning strategies into the planning and implementation processes, including building capacity to continuously adapt to evolving circumstances.

"As challenges emerge, learning and evaluation are key to inform understanding of the system and the iterative development of change ideas. Learning and evaluation should therefore be considered in the design phase in partnership with local stakeholders. The design phase should anticipate that improvement is not about one-off interventions but building local capacity and capability to continuously adapt to dynamic and evolving contexts[73]."

Key activities in planning

No matter which approach is taken, however, planning typically includes a number of key activities:

- Continuing efforts to engage and build relationships with service users and other key stakeholders through the planning and preparing process.
- Defining and reaching agreement across key stakeholder groups (especially those most affected by the change) on the purpose and goal of the effort – the desired change and outcome.
- Designing the solution, or at least the initial steps.
- Ensuring supportive senior leadership for the intervention and its implementation.
- Identifying and supporting champions to inspire and lead the way. Who are respected champions? Will they be in support of this change?
- Forming an implementation team to oversee and guide the work. Implementation requires a team effort. Initially this team might include people with the authority to make a decision, and content expertise along with stakeholder representation. As implementation gets underway, membership may shift to people who can inform the more practical matters of the effort and provide day-to-day leadership[74].
- Assessing and building organizational capacity to carry out the work (e.g., leadership, resources, skills, knowledge, training, policies, technology, physical space, capacity to learn and adapt).
- Building buy-in for the change, including planning for and communicating with stakeholder groups about the change, which may require different messaging and methods for different groups.
- Developing a budget (note that complexity researchers suggest including a contingency budget to accommodate unexpected events, changes).
- Developing a high-level implementation plan that sets out key goals and directions.
- Developing a learning and evaluation plan that includes ongoing monitoring, critical reflection and evaluation. This should be grounded in discussion and understanding of how things are expected to work, and why; what success will look like and how you will know when you've succeeded (what signs, markers or indicators of success will you be looking for?)
- Beginning to think about how the innovation or EIP, if successful, could be sustained and scaled up.

Known facilitators and enablers of successful implementation

Planning can be fruitfully informed by current research regarding factors that enable and constrain successful implementation of EIPs and innovations. These include:

- Characteristics of the EIP or innovation itself.
- Characteristics of individual practitioners ("adopters").
- Factors internal to the organization that is implementing them.
- Factors external to the organization that is implementing them.

This literature tends to be grounded primarily in mechanistic world views that focus on implementing clinical practices, and what is often missing is an understanding of how the factors interact and influence one another, and how local context impacts them[75]. Nevertheless, these research findings provide insights into things that may be important to attend to in the planning and implementing processes.

Some of the most commonly cited "drivers" of successful implementation[76] are the following:

- Competency drivers – mechanisms for implementing, maintaining and delivering an EIP or innovation in order to achieve desired effects. This includes things like selection of staff, training and coaching.
- Organizational drivers – the mechanisms that create and sustain a favourable environment for effective care and services. These include linkages with external networks and partnerships, engagement and commitment from management and data systems to support decision making and evaluation.
- Leadership drivers – strategies put into place to resolve various challenges, make decisions, provide advice and support organizational operations.

In addition to these core drivers, implementation science researchers have identified numerous other enablers of successful implementation. We have listed many of these here in the boxes below as things you might want to think about and possibly address in planning and preparing. Remember – it's a smorgasbord of ideas, not a prescription for what you must consider or have in place!

Known enablers of successful implementation[77]…

CHARACTERISTICS OF THE EIP ITSELF.

Evidence-informed practices are more likely to be adopted when:

- They are **compatible with the intended adopters' values, norms and perceived needs**.
- **Adopters believe they are grounded in a high quality of evidence**.
- They are perceived as **simple to use**.
- They **can be broken down into more manageable parts** and **adopted over time**.
- Users **can experiment with them on a limited basis and "reverse course"** if warranted.
- The **benefits are visible** to intended adopters (efforts to make the benefits visible increase the likelihood of adoption).
- Adopters **can adapt, refine or otherwise modify them to suit their own needs** (while maintaining the core components that make the practice work).
- They are **relevant to the performance of the intended users' work** and they **improve task performance**.
- The **knowledge required to use them can be explicitly described and transferred from one context to another**.
- Adopters **perceive there are more advantages to the EIP rather than other possible solutions**.

Characteristics and competencies of individual practitioners ("adopters") who are likely to take up EIPs:

- **Psychological characteristics –** tolerance of ambiguity, sense of self-efficacy, competencies, learning style; motivation and ability to use the EIP or innovation.
- **Context-specific psychological characteristics** – degree of commitment to the organization and its goals, values.
- **Meaning** – the meaning of the innovation for the intended adopter has a powerful influence on the adoption decision. If the meaning of the innovation is similar amongst individual adopters, top management, service users and other stakeholders, the EIP is more likely to be adopted.
- **The adoption decision** – the decision to adopt an EIP is rarely independent of other decisions. Adoption is a process with different concerns being dominant at different stages.

Enablers related to the team, department or organization (the organizational context)

Adoption at the team, department or organizational level has been found to be consistent with an organic and often messy model in which organizations move between initiation, development and implementation, punctuated by shocks, setbacks and surprises. Organizational factors that enable successful implementation include:

- Organizational norms, values and basic assumptions that support learning and change.
- Innovation – system fit – an EIP that fits with the organization's existing values, norms, strategies, goals, skill mix, supporting technologies and ways of working is more likely to be assimilated.
- Capacity to absorb new knowledge and to change – organizations that are able to identify, capture, interpret, share, reframe and recodify new knowledge and link it with its existing knowledge base will be better able to take up new interventions. This includes being a learning organization and proactive leadership directed toward sharing knowledge and learning.
- Organizational structure – an adaptive and flexible organizational structure and processes that support devolved decision making.
- Organizational and team stability – greater stability is associated with more success in implementation.
- Leadership, management and facilitation – top management support, advocacy for the implementation process and continued commitment to the EIP.
- Motivated and competent staff – successful adoption requires motivation, capacity and competence of individual practitioners. The early and widespread involvement of staff at all levels enhances success of implementation.
- Dedicated and ongoing time and resources for implementation – if implementation starts out with an adequate and continuing budget, the EIP is more likely to be adopted.
- Networks of positive relationships, social capital and effective communications – positive relationships and effective communications across the organization support implementation success.
- Tension for change – if staff perceive the current situation is intolerable, a new intervention is more likely to be successfully adopted.
- Assessment of implications – if the supporters of the EIP outnumber and are more strategically placed than its opponents are, it is more likely to be adopted.
- Capacity to evaluate the innovation – if the organization has systems and appropriate skills in place to monitor and evaluate the impact of the EIP (anticipated and unanticipated), it is more likely to be adopted and sustained.
- Feedback and reflection– accurate and timely feedback about progress and quality of implementation accompanied with personal and team debriefing about progress and experience increases the chance of successful implementation.

- Adaptation/reinvention – if an innovation is adapted to the local context, it is more likely to be successfully implemented.

Implementation enablers related to the broader, external environment:

- The needs of service users – service user needs as well as barriers and facilitators to meet those needs are accurately known and prioritized within the organization. Patient-centred organizations are more likely to implement change effectively.
- Cosmopolitanism – the degree to which an organization is networked with other organizations. Organizations that support and promote external boundary-spanning roles of their staff are more likely to implement new practices quickly.
- Peer pressure – when other organizations adopt a new innovation or EIP, other organizations may feel pressure to similarly adopt it.
- External policies and mandates, recommendations and guidelines that recommend or support the EIP.

Assessing readiness and capacity to implement

Based on all of the above, here is another smorgasbord of questions[78] you might ask while you're planning your approach.

Some questions for consideration in planning…

Who should lead the effort? Will they be able to generate staff/stakeholder buy-in?

- Who are the key agents of change for this innovation?
- Which people have the most credibility in relation to the innovation?
- Which people have the most credibility to the particular people involved?
- Which people are most likely to persuade actors to adopt new actions?
- Are staff open to change?
    - What are their values, attitudes and beliefs about change?
- Is there a widespread perceived need to change amongst staff?
    - Are they dissatisfied with how things are currently done?
    - Do they think the organization could be doing a better job?
    - Do they believe that work is done inefficiently?
    - Do they believe there are inequities that should be addressed?
    - Do staff members think there are gaps in the services provided?
- Has the case for change been made effectively? To what extent are people "buying-in" to this change?
- How have staff responded to similar changes in the past?
- Do staff trust the people who will be leading the change effort?
- Who is most likely to resist change? Why? What can we learn from them? How can their perspective be honoured?

Readiness of other stakeholders for change (e.g. service users/families, board members, community organizations and others that have a stake in the issue)

- Who are the key stakeholders?
- What are their perceptions of the change?
    - What do they think will happen?
    - How might they oppose the innovation?
    - How might they support it?
    - What would constitute a "win" for them?

Do we have sufficient capacity to carry out this EIP/innovation?

- Supportive values, culture, policies?
- Leadership from the top?
- Respected champions in a position and with the skills to influence and support others?
- Necessary knowledge, skills, competencies?
- Training capacity and ongoing mentorship capacity?
- Resources – people, money, physical space, technology, information and information gathering systems (consider resources to implement and resources to sustain the innovation or EIP)?
- Structures and processes to support the EIP/innovation and its implementation (e.g., planning and decision making, policies, evaluation, human resources processes)?

How will we communicate the change to others?

- What needs to be communicated, and with whom? How often?
- What strategies/methods will we use to communicate with each group?
- Who will be responsible for communicating?
- How will we know our communication efforts are working?

Do we have capacity for ongoing learning and adaptation?

To what extent do we have:

- Leadership support for ongoing learning and adaptation, including allocating the time required to do this work?

- A safe environment for learning and changing?
- Built in time and resources for reflection, evaluation, learning?
- The skills/knowledge to learn as individuals and as a collective/group/team/organization?
- Systems for gathering information/data that will help us understand how well things are going as we implement this intervention?

How will we know if we're making progress or not? If we're succeeding?

- What will success look like? How will we know when we've succeeded? What are some key indicators that we have succeeded?
- What are our evaluation goals? Learning and improvement? Assessing outcomes? Who are the key audiences for evaluation findings?
- What are our evaluation questions? What do we want to know in the end?
- What data/information can we use to inform the evaluation? How will we gather it? Who will gather it? When? What will we do with it once it's gathered? How will it be used?
- Who will do the evaluation?

Some resources that might be helpful…

Implementation frameworks

Reed, J., Green, S., & Howe, C. 2019. Translating evidence in complex systems: a comparative review of implementation and improvement frameworks. *International Journal for Quality in Health Care*, 31(3), 173-182. [Note that this is one of the first implementation frameworks grounded explicitly in complexity and thus offers interesting insights for implementation.]

Implementation guides

Canadian Centre on Substance Use. 2012. *Systems approach workbook: systems thinking and complexity.* Author.

Canadian Centre on Substance Abuse. 2012. *Systems approach workbook. Change management module: Implementation.* Author.

Canadian Centre on Substance Abuse. 2012. *Systems approach workbook: Working with teams.* Author.

Canadian Centre on Substance Abuse. 2012. *Systems approach workbook: Implementation plan template.* Author.

Canadian Centre on Substance Abuse. 2012. *Systems approach workbook : Developing a communications plan.* Author.

Ontario Centre of Excellence for Child and Youth Mental Health. *Implementing evidence-informed practice. A practical toolkit.* Author.

Questions for implementing innovations

Brach, C., Lenfestey, N., Roussel, A., Amoozegar, J., & Sorensen, A. (2008*). Will It Work Here? A Decisionmaker's Guide to Adopting Innovations*. Prepared by RTI International under Contract No. 233-02-0090. Agency for Healthcare Research and Quality (AHRQ) Publication No. 08-0051. Rockville, MD: AHRQ.

Endnotes

[67] Zimmerman, B., Lindberg, C., & Plsek, P. (2008). *Edgeware. Lessons from complexity science for health care leaders.* Authors; pg. 27.

Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press.

[68] Zimmerman, B., Lindberg, C., & Plsek, P. (2008). *Edgeware. Lessons from complexity science for health care leaders*. Authors.

Fullan, M. (1999). *Change forces. The sequel*. Philadelphia: Falmer Press.

[69] Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press; pg. 134.

[70] Boulton, G., Allen, P., & Bowman, C. 2015. *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press; pg. 131.

[71] Westley, F., Zimmerman, B., & Patton, M.Q. (2006). *Getting to maybe: How the world is changed.* Random House Canada.

Snowden, D., & Boone, M. (2007). *A leader's framework for decision making.* Harvard Business Review.

[72] Adapted from:
van Es, M., Gujit, I.; & Vogel, I. (2015). *Hivos ToC guidelines. Theory of change thinking in practice*. Hivos; pg. 73.

[73] Reed, J., Howe, C., Doyle, C., & Bell, D. (2019). Successful Healthcare Improvements From Translating Evidence (SHIFT-Evidence): simple rules to guide practice and research. *International Journal for Quality in Health Care*, 31(3), 238-244; pg. 242.]

[74] Walsh, C., Rolls Reutz, J., & Williams, R. (2015). *Selecting and implementing evidence-based practices: A guide for child and family serving systems.* California Evidence-Based Clearinghouse for Child Welfare.

[75] Parenting Research Centre. (2016). *Implementation best practice: A rapid evidence assessment, Royal Commission into Institutional Responses to Child Sexual Abuse*. Sydney: Commonwealth of Australia.

[76] Fixsen, D., et al. (2013). *Implementation drivers: Assessing best practices (Vol. 4).* National Implementation Research Network.

Savignac, J. & Dunbar, L. (2014). *Guide on the implementation of evidence-based programs. What do we know so far?* Public Safety Canada.

[77] These tables are derived from a review of:
Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *The Milbank Quarterly*, 82(4), 581-629.

Damschroder, L., Aron, D., Keith, R., Kirsh, S., Alexander, J. & Lowery, J. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science,* 4:50.

[78] These questions are adapted from:
Brach, C., Lenfestey, N., Roussel. A, Amoozegar, J., & Sorensen, A. (2008). *Will It Work Here? A Decisionmaker's Guide to Adopting Innovations.* Prepared by RTI International under Contract No. 233-02-0090. Agency for Healthcare Research and Quality (AHRQ) Publication No. 08-0051. Rockville, MD: AHRQ.

Damschroder, L., Aron, D., Keith, R., Kirsh, S., Alexander, J. & Lowery, J. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science,* 4:50

Resources Part 5F. Implementing through cycles of acting, learning and adapting

In this Part we outline key activities in implementing and then focus on two complementary learning strategies for ongoing acting, learning and adapting: evaluation and reflective practice.

"Just take the first step and see what happens. What's the worst that could go wrong? And taking that step gives others permission to do it too."

[Pam Brown, Safety & Security Manager, Oxford Properties Group, Edmonton City Centre]

After all the up-front work of engaging people, understanding the issue, exploring the evidence, deciding what to do, and making a plan, shifting to implementing might seem daunting. But, have courage! Dive in! You don't have to be an expert or master. You just have to be committed and curious and interested in how things are working. Start small, strive to learn from your efforts, and you will grow your own wisdom and expertise over time.

Key activities in implementing an EIP or innovation

Some of the major activities in putting your plan into action "on the ground" include:

- Continued leadership support and championing of the effort.
- Continued engagement of service users and other stakeholders in implementation and learning processes.
- Ongoing project management and maintaining momentum.
- Ongoing communications about the effort - internal to the initiative and externally to the broader community.
- Ongoing training, coaching and mentoring for those delivering the intervention.
- Problem solving and trouble shooting.
- Refining implementation and evaluation plans.
- Pulling in additional resources and expertise as needed.
- Ongoing learning, adapting and improving – through evaluation and other learning strategies.
- Sharing lessons learned– what you've learned through implementing and evaluating the EIP or innovation.
- Thinking about sustaining and/or scaling up the innovation or EIP.

"The point is to simply try things and see what happens. It's easy to stay in the conceptual plan – to talk about ideas and possibilities forever. A key to successful innovation is making frequent small forays into action. After taking action, it's critical to take some time to understand what happened, what worked and what didn't.

Reflection is about digging into failures…reflecting on failures is rarely fun, but it's essential to figuring out the true causes of a failure in order to determine what gets tried next. Don't shortchange reflection in the desire to move quickly to the next experiment, because high-quality reflection can help avoid predictable failures in subsequent actions[79]."

Starting small and going from there…

If you're implementing something pretty simple and straightforward and in a stable environment, you may be able to fully implement your EIP or innovation (intervention) right away. But, when embarking on an initiative that is complex or focused on systems change, complexity and organizational learning, experts typically advise starting small and testing out a new practice or intervention[80]. One approach is **"safe-to-fail probes"[81] – small-scale experiments that approach issues from different angles in small and safe-to-fail ways. The intent is to approach issues in small and contained ways and see what emerges.** The emphasis is not on ensuring success, but rather on allowing ideas that aren't useful or workable to fail in a safe, contained and tolerable way. Ideas that do work can be expanded upon[82].

Similarly, organizations unwilling to commit to full-scale adoption right off the bat may also find that pilot testing an innovation is an acceptable risk. **A pilot may serve as a small test of change on which you base the larger adoption decision. It can also provide an opportunity to assess fit and the need to adapt an EIP or innovation before applying it more broadly.**

Plan-Do-Study-Act cycles are also often recommended. These cycles of acting, learning and adapting are one of the mainstays of ongoing quality improvement. They are grounded in basic questions about what you are trying to accomplish, how you will know a change is an improvement, and what changes could be made to result in improvement. The process begins with planning: *What do we expect will happen? Who will do what? What information will we need to know to determine if the effort is working?* This is followed by carrying out the plan, then studying how things went, followed by planning the next cycle by deciding if the change can be fully implemented or if adaptations are needed. See the figure below.

It has been pointed out, however, that these cycles might seem simple, but their successful use requires strong leadership support and adequate resourcing[83] - as do all of these strategies of experimentation.

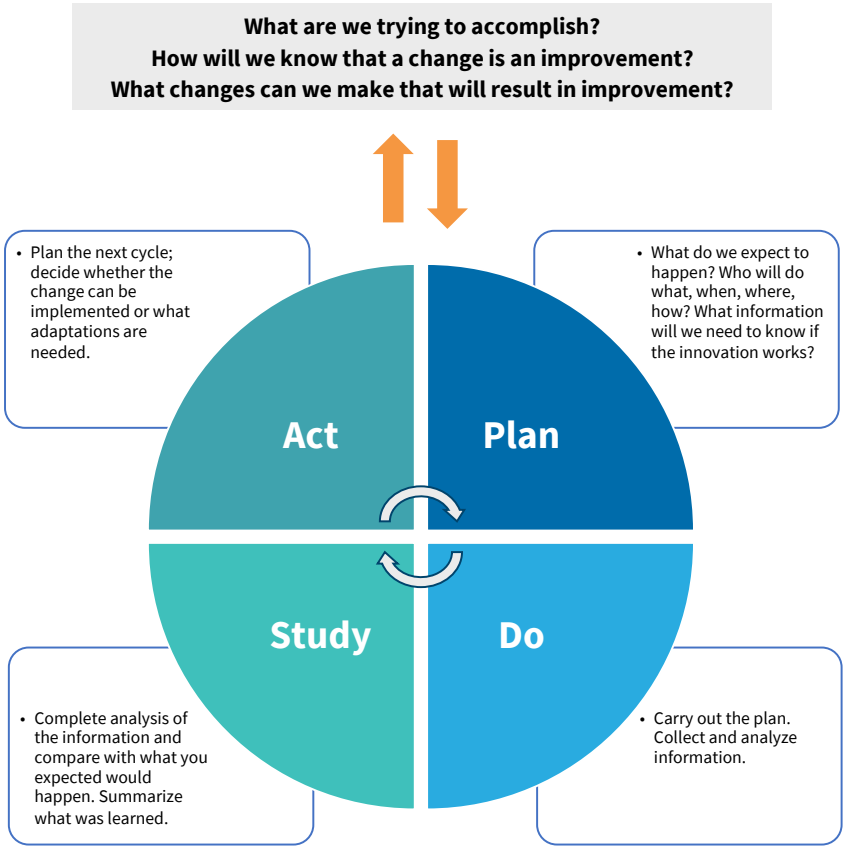


Figure. One cycle of Plan, Do, Study, Act[84]

Optimizing efforts and results: Learning and adapting during implementation

Underlying any of these smaller, "safe to fail" adventures are the deeper processes of ongoing learning and adapting. Learning is foundational to the entire process of implementing something new; it is particularly critical when working in complex systems on complex issues given that predictability and control are unlikely. This is why we describe implementation as ongoing cycles of acting, learning and adapting in order to optimize efforts and results.

There are many ways to understand how implementation efforts are going, and how to adapt them accordingly. We focus on two dominant and interrelated strategies: evaluation and reflective practice. We discuss them separately for ease of description.

The evil dreaded "E" word: Evaluation. It doesn't have to be scary or difficult

The word "evaluation" strikes fear in some peoples' hearts because it is often associated with judgment by outsiders – funders, for example. That kind of judgment can feel intimidating, especially where continuation of your work is at stake or where "not meeting the bar" or "failing" is frowned upon. But, stepping back and assessing (aka judging) your own efforts can help you to learn and improve along the way. And that will keep you on the path to doing your very best and making a difference for the people you serve – *and* facing the judgment of funders and other external stakeholders with confidence!

In other words, evaluation is your friend. We evaluate every day: *"Was that what was supposed to happen?" "What difference did that make?" "Should we do that again?"* When you bake a cake and it doesn't turn out right, next time you will make an adjustment. There is nothing different between improving your cake baking and improving your professional or organizational practice. In both instances, you gather "evidence" about how things are going (the cake was too dry and crumbly – nobody ate it), adapting your practice (less flour, more butter, perhaps) and trying again. Evaluation for the intent of learning and using the results to adapt and improve is no different. It's messier, but the thought processes are the same.

Evaluation helps you understand your efforts and progress toward desired ends as you try out something new. It generates the evidence[iii] you need in order to determine what's working and what's not working and how you might be able to adapt your efforts for better success. Maybe you need to revise your staff training or add more mentoring and coaching. Or maybe you need to try something different to better engage the people you want to reach. Or maybe there is something going on in your environment (context) that is interfering with your efforts. Only by knowing these kinds of things can you improve your efforts. And most importantly, evaluation can help you assess your outcomes – to see what you have achieved, and if and how things are changing as a result of your actions. Ultimately, this is what matters most. Are things getting better? If not, why not? You really want to know this!

If all of this is new to you, just start small. Look at one or two things only and ask only a limited number of questions. The more you do this, the more you'll learn and the better (and wiser!) you'll get.

[iii] If you recall the model of evidence-informed practice presented in Part 5C, information generated during implementation is a key source of evidence in evidence informed practice.

Key tasks and considerations in designing and conducting an evaluation

Designing an evaluation begins in the planning and preparing phase and continues through implementation. **There is no one single best way to do an evaluation – what you design will depend on your unique circumstances and needs**. Every intervention is unique - the people served; the approaches adopted; the outcomes to be achieved; its scale and scope; its simplicity or complexity; the context in which it is implemented; and its phase of development. What and how you evaluate will also depend on what funders might require and what resources are available to you.

What matters is that your evaluation is helpful to you and your initiative; that is, that it will generate the information you need to continually learn, refine or adapt your approach and improve the results you get. Finally, evaluation is not a "once and done" kind of thing! Rather, it is an ongoing process which is why we prefer to simply call it "learning"! Each cycle of action and evaluation leads to changes in practice which then raise further evaluation questions.

Our intent here is not to provide an "evaluation manual"; but, rather, to "hit the highlights" of evaluation so you'll have a general sense of the process. Below, we offer a brief description of logic models and theories of change, and key tasks and considerations in designing and conducting an evaluation.

You will find a proliferation of detailed evaluation guides and information online. Several are listed in the resources list at the end of this evaluation section.

About logic models and theories of change

One of the most important parts of planning and evaluating is having a very clear sense of what you want to achieve, and what that will look like in actual practice:

What do we want to achieve?
What will success look like?
How will we know when we've achieved it?

Logic models and theories of change are often used in planning and evaluation. Logic models are illustrations of an intervention's resources, activities and expected outcomes. They are rather mechanistic, linear little beasts - simple models of how we expect things to happen: *If we do "x" using these resources/inputs, we expect "y" to happen.* In our experience, the process of developing logic models is instrumental in building a shared understanding of how a chosen intervention will actually generate the intended effects, and what is needed for that to occur – at least with interventions that are fairly straightforward and in predictable environments.

The terms "logic model" and "theory of change" are often used interchangeably, but from our perspective, theories of change are a higher-level concept and, in some formulations, more effectively embrace complexity. They focus on the bigger picture – the ideas and beliefs that people have about why and how the world and people change[85] and why a particular set of activities will result in a particular outcome. These beliefs are deep drivers of people's actions and the choices they make. As such, developing a theory of change is an ongoing process of reflection to explore change, how it happens, how what we are doing is contributing to that change.

In either case, there is great richness in a fulsome discussion with diverse stakeholders about what change is desired, how to get there, why we think it will work, the signs that indicate we're getting there and also, whether or not we've succeeded. These conversations are particularly important in the planning stage but revisiting them is also important as implementation proceeds. *How accurate was our thinking about how and why things would work? Do we need to revisit our assumptions?*

Thinking through how you expect your intervention to work, and why, and what success will look like is thus a valuable starting point for designing your evaluation. Once you've got that figured out, then planning your approach will be a lot easier.

Tasks and considerations in designing an evaluation

In general, there are a number of tasks and things to consider when designing your evaluation[86]. These include:

- Engaging service users and key stakeholders in the process. All evaluations are strengthened when the people most involved with an effort – service users, staff, community members, partners – are able to meaningfully participate. This includes, for example, determining the theory of change and the purpose of the evaluation, providing their own perspectives, interpreting data, and acting on the findings[87]. And, including the perspectives and interests of stakeholders will increase the likelihood that your evaluation findings will be accepted and used[88].
- Agreeing on the purpose(s) of the evaluation and what to focus on. Broadly speaking, two of the most common purposes of evaluation (which often intersect) are:
    - Ongoing learning and improvement. Here the focus is on understanding and improving implementation efforts and the intervention itself. This kind of evaluation can include a look at early or short-term outcomes as well and is particularly helpful in the early stages of implementation.
    - Determining whether your intervention is making a difference. Here, the focus is on understanding what changes and impacts have resulted from your intervention. *Just what kind of difference are we making? For whom? How and why?* While looking at short-term outcomes can help during implementation, once your initiative is well-established and stable, then it's probably time to start assessing whether you're getting the longer-term changes/outcomes you'd anticipated.
- Developing key evaluation questions. *What do we need to know?* The purpose(s) of your evaluation will determine what you focus on and the kinds of questions you ask. It's probably better to develop a small number of really good questions – those that will give you the information you need to assess how well things are going and what kinds of results you're getting – rather than to develop a long list of ambiguous questions. We have included in this section a number of sample questions to inform your thinking (see below).
- Determining what information is needed to answer your evaluation questions. The information you collect – is called "data". It should be useful, accurate and informative. Generally speaking, there are two basic kinds of data for answering evaluation questions:
    - Quantitative (numerical) data. These are numbers of things and how things occur, such as that collected through surveys. This data can be put into categories or measured in different ways such as percentages. It can be presented in graphs or tables of numbers.

- Qualitative data. This kind of data focuses on the lived experiences of people: *How did they experience the practice or initiative? What did it feel like? What do they think about it? Why? What, if anything, are they doing anything different as a result of the initiative?* Examples of qualitative data include interviews, focus groups, stories, documents, art, photographs, poetry, journey maps, videos, and sound recordings.
- Using both kinds of information is preferable. Qualitative data yields rich information about peoples' actions, insights and perspectives, while quantitative data conveys information about larger numbers of people.

A LITTLE LEXICON OF EVALUATION TERMS

Here are some common evaluation terms and definitions[89]:

ACTIVITIES: The day-to-day tasks and efforts of your initiative (EIP/innovation) that are intended to produce benefits for participants, groups, communities, and/or partners.

OUTPUTS: "Counts" of program activities and participation (e.g., number of participants in a training session; number of training sessions). Outputs help you understand if your initiative is being implemented as planned.

OUTCOMES: Meaningful, beneficial changes experienced by participants, groups or communities associated with your initiative.

SHORT-TERM OUTCOMES (fairly immediate benefits or changes that are expected as a result of your initiative; such as changes in knowledge or skills or attitudes) happen first and lead to ***intermediate outcomes*** (e.g., changes in practices resulting from new knowledge) and then to ***long-term outcomes*** - the more distant benefits or changes that are expected as a result of your initiative. Generally, long-term outcomes are the changes that result from successful achievement of short- and intermediate outcomes over time.

INDICATORS:[90] Indicators help us to know whether an outcome has been achieved – they are signs of success. They are specific, observable and measurable characteristics or changes that show the progress an initiative is making toward achieving a specified outcome. *What does the outcome look like when it occurs? How do you know the outcome has happened? What do you see when the outcome has happened?*

- Determining how to gather the needed information. This includes figuring out what tools and/or methods:
  - Will best capture the information you need to answer your evaluation questions.
  - Will capture high quality information.
  - Are most appropriate given the values and capacities of those collecting the information and those being asked to provide it.
  - Are not overly invasive or uncomfortable for people to provide (e.g., people may not want to share personal information).
  - Are affordable and easy to do.
- Determining who will analyze the data and how. The information you gather won't necessarily speak for itself; you will need to figure out how to interpret it and make some conclusions.
  - Analyzing the data. This involves organizing, then taking a careful look at the data you have gathered. What patterns can you see in the numbers and in the lived experiences that you heard from people?
  - Making sense of the data. Then you have to interpret or make sense of those patterns. *What do they mean? Who is being impacted by your efforts? How? Who isn't being impacted or is being impacted in unhelpful ways? Why? What did you learn? What needs to continue? What needs to be changed?* This is where your efforts actually have the greatest power and potential to shift your efforts in ways that will be more effective. Having people from diverse positions and perspectives (including the people who provided the data) look at the data can significantly enrich your analyses and interpretation.
- Determining how to use and share the findings. Who should receive the findings? In what format? What is the most effective way to share the findings for each audience? Sharing findings with those who provided information is not only a courtesy, but also makes it more likely they would contribute again.

Questions for ongoing learning and improvement: Assessing and improving the intervention and implementation efforts

Understanding how things are going during implementation is crucial for ensuring you're on track with things and for capturing early insights about how workable and useful your intervention is. Maybe it needs "tweaking" or full-on changes and it's good to know that as early as possible. Essentially, you want to know **what is working well and what is not working so well and why.** And from that, **what to keep doing, do more of, start doing, or stop doing**.

This often includes a look at immediate or short-term outcomes as well as what's happening in the initiative (e.g., Are staff changing their practices in ways that will increase the chance of achieving desired objectives? Are service users changing what they do?). Often, these kinds of questions need to be answered fairly quickly in order to provide useful feedback for short-term adjustments.

Some sample questions are listed below. **Remember, they're only examples! You will need to develop questions that are specific to, and useful for your intervention.**

Some sample evaluation questions for ongoing learning and improvement[91]:

- What did we originally propose and intend in terms of the implementation process?
- Is the intervention being implemented as intended? If not, why not?
- What are the key characteristics of the intervention? How do we expect it to produce the changes/outcomes we want to see? [What is our 'theory of change'?]
    - What assumptions did we make when deciding to implement this intervention? Do they still hold true? What assumptions are problematic?
- How is the intervention *actually* working?
    - What's working well? Why? What's not working so well? Why?
    - What adaptations to the EIP/innovation were *actually* made? Why? With what results?
    - What other adaptations to the EIP/innovation might be needed? Why?
- Who did we originally intend to reach with this EIP/innovation? Who are we *actually* reaching?
- How do actual resources, staff competencies and timelines compare to what was expected?
- What challenges and barriers have emerged? How have we responded to them and with what level of success?
- What do participants like and dislike? What are their perceptions of what's working and what's not working? What suggestions do they have for improvements?

- Is the intervention being perceived as better than what is already in place?
- To what extent are we moving toward the results we want to get? Are we still on track with what we set out to do? If not, why not?
- What have been some unanticipated impacts of the intervention? For whom? Why?
- What is happening in the context in which we are working and how is this influencing our efforts? How are things changing? [What's happening in our organization? In the community we are serving? In the broader environment?]
- Do we need to rethink any decision we made?
- If necessary, what corrective action can we take? What should we continue doing, or do more of? What should we stop doing? What should we start doing?
- What else can we do to support the change at this point in time?
- Do we need additional help or resources to move forward?
- What have we learned so far? What do we still need to understand?
- How will we used what we've learned to move forward?

Questions for determining whether the initiative is making a difference

The main focus here is on examining outcomes or changes arising from your intervention and determining its' merit or worth. You can look at short-term, intermediate and/or long-term outcomes resulting from your efforts. This kind of evaluation can also help justify the need for further funding and support. **The questions below are examples only. You will need to develop questions that are specific to, and useful for your intervention.**

Some sample evaluation questions for assessing outcomes[92]

Here are some examples of evaluation questions commonly asked in assessing outcomes:

- What are the objectives and expected outcomes of the intervention?
- What results will count as "success"?
- To what extent were our objectives and expected outcomes achieved?
- How can we be sure that positive (or negative) findings are a result of our efforts and not something else?
- Is the intervention beneficial to the intended participants? How?

- Are there any unintended benefits or harms to participants? What are they? Who do they impact? How? Why?
- What worked, for whom? Under what circumstances? Why?
- What was the context of implementing this intervention and how did the context influence achievement of objectives and expected outcomes?
- What changes have occurred as a result of the intervention?
    - Expected
    - Unexpected
    - Positive/negative
- Why did the intervention have the impact it did?
    - What influenced its success or failure? (Note that this requires ongoing evaluation of processes.)
- What could have been done differently?

Evaluating complex issues in complex environments: Developmental and principles-focused evaluations

If you're tackling something more complex, traditional evaluation approaches can certainly inform your efforts, but will likely be insufficient in and of themselves. Evaluating complex initiatives and system change initiatives is rather new in health and human services, and there is less guidance available to us. But there is some helpful work available and that we draw upon here.

From a complexity worldview, the implementation process is even more reflective in nature; that is, there is a heightened degree of vigilance as to what is happening – beyond what you *expect* to happen - and from diverse perspectives.

"The most effective way to try to gain evidence of contributions to change is for the project team to look out for signs of emerging change or changing conditions and start to monitor such changes as implementation proceeds… the focus of questions is on what is happening, what maybe is changing, and what seems new or noteworthy. It can be helpful to work separately with differing groups of stakeholders – different levels of seniority, different external groups with differing interests and perspectives. The approach is to notice differences and similarities and the frequency of what is being said between the groups.[93]"

Constant learning is critical in complex initiatives and contexts because it informs efforts to adapt. This also requires a flexible approach to evaluation – one that can change along with the initiative.

"The development of a comprehensive evaluation plan that overly specifies the evaluation's key questions, evaluation approach, design, data collection and analysis methods, timeline and budget may not be particularly helpful for evaluating complex initiatives or initiatives in complex environments…the longer-term nature of complex initiatives and the dynamic environments in which they live requires periodic "refreshes" of an evaluation plan as new insights and lessons emerge[94]."

"A key to success of complex initiatives is their ability to learn constantly; this learning allows the system's actors to adapt and evolve as they implement the initiative's strategies and activities. The regular flow of data and information is critical to running the system's "learning engine" and enabling adaptation and innovation[95]."

Developmental and principles-focused evaluations for complex endeavours

In the case of complex and more open-ended, evolving initiatives, developmental and principles-focused evaluations can be more helpful than traditional mechanistic approaches.

Developmental evaluation (DE)[96] is used for initiatives that are in a state of continuous development and adaptation and that are unfolding in changing and unpredictable environments. DE supports innovation by bringing data to inform and guide ongoing decision making as part of the development process. It can draw upon multiple kinds of data – qualitative and quantitative.

Principles-focused evaluation[97] - focuses on principles as the object of evaluation. This form of evaluation is well-suited for complex endeavours because it emphasizes principles rather than specific practices. Grounding actions in principles rather than prescriptions for specific practices allows opportunities to adapt to different contexts, changing understandings and varied challenges. Principles-based evaluation answers three main questions: *To what extent have meaningful and evaluable principles been articulated? If principles have been articulated, to what extent and in what ways are they being adhered to in practice? If adhered to, to what extent and in what ways are principles leading to desired results?*

An example is work cited some time ago by Lisbeth Schorr[98], who articulated a set of principles about "what works and why we have so little of it" in child and family development. Some of these principles were:

- *Successful programs see children in the context of their families*
- *Successful programs deal with families as parts of neighbourhoods*
- *Successful programs operate in settings that encourage practitioners to build strong relationships based on mutual trust and respect*
- *Staffs of successful programs are trained and supported to provide high-quality, responsive services*

These make it possible to imagine that such principles could be applied across settings and programs to improve child/family wellbeing, and that these principles could be evaluated across sites.

For more information about evaluating in complexity, see Appendix D.

Some resources that may be helpful…

Evaluative thinking

Baker, A., & Bruner, B. (2012). *Integrating evaluative capacity into organizational practice*. Bruner Foundation.

Daniels, J., & Kingsley, B. (2018). *Nerd's corner: A short guide to evaluative thinking*. Community University Partnership for the Study of Children, Youth and Families and the Evaluation Capacity Network. (University of Alberta; PowerPoint presentation)

Evaluation guides

See the links below for two comprehensive lists of evaluation resources. The first is an excellent description of helpful evaluation resources; the second provides descriptions of, and links to various evaluation websites.

https://www.edmonton.ca/programs_services/documents/PDF/EvaluationResourcesforFCSS.pdf

https://www.edmonton.ca/programs_services/documents/PDF/EvaluationResourcesForFCSSWebsiteLinks.pdf

Other guides:

Better Evaluation. (2014). *Rainbow framework*. Author.

MacDonald, G., Starr, G., Schooley, M., Yee, S., Klimowski, K., & Turner, K. (2001. *Introduction to program evaluation for comprehensive tobacco control programs.* Atlanta: Centers for Disease Control and Prevention.

Patton, M. (2013*). Utilization-focused evaluation checklist*. Author.

Public Health Agency of Canada. (2012). *Evaluating outcomes of community food actions: A guide*. Author.

Logic models, theories of change, outcomes, indicators and measures

Hivos. (2015). *Theory of change thinking in practice*. Author. [Very detailed, probably better for advanced practitioners.]

Kellogg Foundation. (2004). *Logic model development guide*. Author.

Public Health Ontario. (2016). *Logic model – a planning and evaluation tool*. Author.

Evaluation in complexity

Preskill, H., Gopal S., Mack, K., & Cook, J. n.d. *Evaluating complexity Propositions for improving practice*. FSG.

Developmental evaluation

Dozois, E., Langlois, M., & Blanchet-Cohen, N. (2010). *DE 201 : A practitioner's guide to developmental evaluation*. J.W. McConnell Foundation and the International Institute for Child Rights and Development.

Gamble, J. (2008). *A developmental evaluation primer*. J.W. McConnell Family Foundation.

Horne, T. (n.d) *The view through the kaleidoscope: Developmental evaluation*. Wellquest Consulting.

Patton, M.Q. (2011). *Developmental evaluation. Applying complexity concepts to enhance innovation and use.* New York: Guilford Press.

Principles-focused evaluation

Patton, M.Q. (2018). *Principles-focused evaluation. The guide*. New York: Guilford Press.

Patton, M.Q. & Cabaj, M. (2018). *Webinar: Principles focused evaluation featuring Mark Cabaj and Michael Quinn Patton*. Tamarack Institute.

Complexity based theory of change development

Hivos. (2015). *Theory of change thinking in practice*. Author. [Very detailed, probably better for advanced practitioners.]

	Evaluation and strategic learning Coffman, J., & Beer, T. (2011). *Evaluation to support strategic learning*. Centre for Evaluation Innovation. Preskill and Mack (2013). *Building a strategic learning and evaluation system for your organization.* FSG; pg. 27. **Evaluating systems change** Cabaj, M. n.d. *Evaluating systems change results. An inquiry framework*. Tamarack Institute. **Tools for learning** Ramalingan, B. (2006). *Tools for knowledge and learning. A guide for development and humanitarian organizations*. Research and Policy in Development (rapid). **PDSA cycles** Reed, J. & Card, A. (2016). *The problem with plan-do-study-act cycles. British Medical Journal Quality and Safety*, 25: 147-152. Institute for healthcare Improvement. n.d. *OI Essentials toolkit: PDSA worksheet*. Author. NHS. N.d. *Online library of quality service improvement and redesign tools. Plan, Do, Study, Act (PDSA) cycles and the model for improvement*. Author.

"The voyage of discovery is not in seeking new landscapes but in having new eyes."
[Marcel Proust]

"Reflective practice is understood as the process of learning through and from experience towards gaining new insights of self and/or practice…This often involves examining assumptions of everyday practice. It also tends to involve the individual practitioner in being self-aware and critically evaluating their own responses to practice situations. The point is to recapture practice experiences and mull them over critically in order to gain new understandings and to improve future practice[99]."

Reflective practice

Like evaluation, reflective practice emphasizes learning for the purpose of understanding and improving individual, team and organizational practice. Some might say we reflect all the time, but reflective practice is different – it is a "conscious and purposeful effort that builds capacity for more effective action on the part of the individual or group participating in the reflection[100]". **The goal is to become more aware of one's own thinking and reasoning – to surface new insights that can inform our understanding of what is happening and how we might best respond.** In so doing, reflective practice builds capacity or more effective action.

Always, the focus is on ongoing learning and improvement. The most powerful aspect is identification and questioning of taken-for-granted assumptions – this is how new insights, ideas and pathways for action can be generated. Reflective practice focuses inward – on individual, team, organizational ways of thinking and doing things. As part of evaluation, it can be integrated into the lifecycle of a project starting from the beginning and continuing at regular intervals along the way. Reflection along the way allows for early identification of need for adjustments or rethinking the work. Reflection when things seem to be going off track or down some unexpected path allows for problem solving and adaptation, and reflection at the end of a project helps identify lessons learned that can be integrated into future efforts.

Reflective practice involves consciously and tangibly creating space to slow down, pay attention, develop new patterns of thinking, and create alternative interpretations of what is going on. In collective reflection, people engage in dialogue to work together to find common ground, listen to understand one another, re-examine all positions, search for strengths and value in others' positions. They ask questions, seek clarification; examine assumptions, reason and evidence; illuminate different viewpoints and perspectives and probe the implications and consequences of various ideas. They also surface mental models and seek evidence. And, they ask for and provide feedback on experiences, assumptions, perceptions and actions[101] .

Boud[102] calls this "productive reflection", where:

- **The focus is on reflection that leads to action** with and for others.
- **Reflection generates insights that lead to more effective ways of doing things**, or changing course as needed.
- **The process involves multiple stakeholders and connects people**.
- **Reflection aims to generate possibilities** to put into action.
- **Reflection serves as a developmental tool** – it solves today's problems, but also equips people to better navigate future challenges (e.g., by building confidence in working together to solve problems and build a broader repertoire of approaches).
- **The process is an unpredictable and dynamic one** that changes over time because it deals with matters that don't have ready solutions.

Finally – **it is not enough to simply "just talk" about things. The whole intent is to foster change**; that is to improve, based on what is learned through reflection. Unless changes in mindset, perspectives, attitudes or practices occur, reflective practice will not have served its purpose.

Some sample questions for critical reflection

Zimmerman and colleagues[103] identify three different kinds of reflection: foresight reflection, insight reflection, and hindsight reflection. Note that **the questions below are sample questions only**, presented to provide a sense of what kinds of questions might be involved in reflective practice for individuals, teams and organizations. **Each situation will be unique, and thus the questions to be asked will be unique. They should provoke thought, and examination of assumptions and the status quo.**

Foresight reflection: Some sample questions[104]…

Foresight reflection – involves imaginatively playing out events into the future for the purpose of understanding more about what to do in the present.

- Where do our best intentions fall short of achieving what we really care about?
- Why are we not as successful as we want to be despite our best efforts?
- What might be our responsibility for the obstacles we encounter and shortfalls we experience?
- How effective are our current systems for delivering products and services to our patients/clients in helping us meet our goals?
- What can we do differently to improve our processes or practices?
- Is there a perceived need to change?
- Are there opportunities for improvement that we're missing?
- What is the case for the status quo?
- What might we have to give up in order for the whole to succeed?
- How do we ensure continuous learning and improvement?
- What actions can we take to become better systems thinkers?

Another approach is appreciative inquiry (AI), which focuses on what gives life to human systems when they function at their best[105]. AI is grounded in the assumption that questions and dialogue about hopes and dreams, strengths, successes, values are transformational in and of themselves. Rather than focusing on problems (but not ignoring them), AI focuses on appreciating "what is"; imagining "what could be"; determining "what should be"; and creating "what will be". Here are some sample AI questions:

Appreciative inquiry. Some sample questions[106]...

- What things give life to our organization when it is most alive, most effective, and most in tune with our overarching vision?
- What are we doing that should be preserved as we make changes?
- If we could transform the ways in which we do our work, what would it look like and what would it take to happen?
- Describe a time when you were forced to do more with less and the results exceeded your wildest expectations. Who was involved? How were the results achieved?
- When you think of a time when you collaborated with another group and did so successfully, what comes to mind? What circumstances allowed the collaboration to occur?
- Where might we have planted seeds that may sprout? What would things look like if these seeds did sprout and grow? What can we do to further support this growth?

Insight reflection. Some sample questions[107]...

Insight reflection – is a subtle skill that involves being both in a present situation and yet detached from that situation – simultaneously participating in a situation, adjusting the situation and learning from the situation.[108]

- What assumptions are we making?
- What pressures seem to be at play in the system?
- What role am I/are we playing?
- What am I/are we thinking and feeling?
- What leads me/us to think and feel the way I/we do?
- What am I/are we going to do with this insight?
- How do you think (a specific person or group) would see that?
- That's one way of seeing it. What are others?

- Appreciative inquiry:
  - What's taking shape? What are you hearing underneath the variety of opinions being expressed? What seems to be at the heart of the matter?
  - What's emerging here for you? What new connections are you making?
  - What has real meaning for you from what you've heard? What surprised you? What challenged you?
  - What's missing from this picture so far? What is it we're not seeing? What do we need more clarity about?
  - What's been our major learning, insight or discovery so far?
  - What's the next level of thinking we need to do?
  - If there was one thing that hasn't yet been said in order to reach a deeper level of understanding or clarity, what would that be?
- So, what have we learned and what are we going to do now?

Hindsight reflection. Some sample questions[109]…

Hindsight reflection – is about looking back on events, possibly reinterpreting them and drawing out lessons learned.

- What do we think is going on here?
- What did we intend to happen? What actually happened?
- What are five things we would do again? Why? What are five things we wouldn't do again? Why?
- How is what I am/we are observing connected with deeper theories about how things work?
- "WHAT?"[110] - What has happened? What changes have occurred? What is the same as before? What is different? [Just describe the 'facts' of the situation without judging or interpreting.]
  - THEN - What are we feeling about what has happened?
- "SO WHAT?" - What does this mean in terms of moving forward with the project? What is good about it? What is bad about it?
  - What were our assumptions about how things were going to work? To what extent were these assumptions confirmed or denied?
  - What is another way of viewing and understanding the situation?
  - What options do we have for doing things differently?
  - What insights or "lessons learned" have we gained?
- "NOW WHAT?" - What are we going to do now, and how? What messages should we send to others? What outcomes might we expect? What information do we need?

Some resources that might be helpful…

Books relevant to reflective practice

Berger, W. (2014). *A more beautiful question. The power of inquiry to spark breakthrough ideas.* New York: Bloomsbury. [This is a book about asking better questions to spark creativity and innovation.]

Boud, D. (2010). Relocating reflection in the context of practice. In H. Bradbury, N. Frost, S. Kilminster & M. Zukas (Eds.). *Beyond reflective practice. New approaches to professional lifelong learning.* London: Routledge; pg. 25-36.

Eoyang, G. & Holladay, R. (2013). *Adaptive action: Leveraging uncertainty in your organization*. Stanford: Stanford University Press.

Schein, E. (2013). *Humble inquiry. The gentle art of asking instead of telling*. San Francisco: Berrett Koehler.

Schon, D. (1983). *The reflective practitioner. How professionals think in action.* Basic Books [A classic!]

Zimmerman, B., Lindberg, C., & Plsek, P. (2008). *Edgeware. Lessons from complexity science for health care leaders*. Authors. [This is a broader set of tools for navigating complexity.]

Reflective practice tools

Critical reflection in supervision (Research in Practice for Adults (RIPFA); UK)

A critical reflection framework (University of Victoria)

Gibbs' Reflective Cycle (University of Edinburgh)

Reflective practice (CIPD; UK)

Group learning/reflection activities

Preskill, H., Gutierrez, E., & Mack, K. N.d. *Facilitating intentional group learning. A practical guide to 21 learning activities*. FSG.

ORID Focused Conversation Method (A method for guiding reflective practice)

- https://www.bridgew.edu/sites/default/files/relatedfiles/ORID-discussion-method-6.3.14.pdf

After Action Reviews (Assessments conducted during or after a project that allow people to learn what happened and why, reassess direction, and review successes and challenges)

- Darling, M., Parry, C., & Moore, J. (2005). Learning in the thick of it. *Harvard Business Review*. July/August https://hbr.org/2005/07/learning-in-the-thick-of-it (A critique of AARs as typically adopted by organizations, but shows how the US Army ensures the utility of this approach.)
- USAID (2012). *After-action reviews*. Online.

  https://usaidlearninglab.org/library/after-action-review-aar-guidance-0
- Salem-Schatz, S., Ordin, D., & Mittman, B. (2010). *Guide to the after action review.* Vanderbilt University.

Failing forward

https://failforward.org

Emergent Learning

Darling, M., Guber, H., Smith, J., & Stiles, J. (2016). Emergent learning: A framework for whole-system strategy, learning and adaptation. *The Foundation Review*, 8:1, Article 8.

Sustaining your EIP or innovation

And at last, if you're going to implement something different, it makes sense to think in advance about how your change will be sustained in the long run so that you don't slide back into old and less effective patterns. So, there are some practical matters to consider such as how resourcing will be maintained, and so on.

Ironically, and from a complexity perspective, for a change to be sustained it needs to change and evolve. Given the dynamism of the environments we work in, if the EIP or innovation is to remain relevant and effective, it will need to evolve accordingly. And, there will likely always be room to improve as you move forward. Thus, sustaining a change is an iterative and long-term process[111]. Whatever is implemented will continue to need to be assessed for whether it is achieving what we intend it to, and to be adapted in response to our assessments.

Some questions for consideration about sustaining an innovation are listed below.

Sustaining your EIP or innovation. Some questions to consider[112]...

- How can we embed the EIP/innovation into our day-to-day work and operations?
- Is there strong buy-in by agency leadership to create a climate conducive to continued use of the EIP/innovation?
- How will leadership support be managed during future agency or program leadership changes?

- Are there policies in place to sustain the EIP/innovation in the agency?
- Will there be additional funding to sustain the EIP/innovation?
- Is the EIP/innovation used consistently by the staff who implemented it?
- When does change management leave off and plain old management kick in?
- How much staff time and other resources does the EIP/innovation require in the maintenance phase?
- Is training support reliant on external expertise or have internal trainers been developed? If internal, how has this been institutionalized to support sustainment?
- How will funding be obtained to compensate for staff turnover and the need for additional training?
- How can we keep staff engaged?
- What ongoing technical support is in place across the network?
- How will we celebrate success?
- Is there a mechanism for continued involvement of multiple stakeholders?
- Is there a mechanism for ongoing troubleshooting and problem solving across the various partners?

  How will we spread the innovation to other parts of the organization (if applicable)?

Endnotes

[79] Edmondson, A. (2013). *Teaming to innovate*. San Francisco: Jossey-Bass; pg. 102-103.

[80] Edmondson, A. (2012). *Teaming. How organizations learn, innovate, and compete in the knowledge economy*. San Francisco: Jossey-Bass.

[81] Cognitive Edge. Online. *Safe-to-fail probes*.

[82] For an example of how the Canadian Centre on Substance Abuse has used safe-to-fail probes, see: Canadian Centre on Substance Use. (2012). *Systems approach workbook: systems thinking and complexity.* Author; pg. 13.

[83] Reed, J. & Card, A. (2016). *The problem with plan-do-study-act cycles*. British Medical Journal Quality and Safety, 25: 147-152.

[84] Adapted from: Institute for healthcare Improvement. n.d. *QI Essentials toolkit: PDSA worksheet*. Author.
NHS Improvement. n.d.. Author.

NHS. N.d. *Online library of quality service improvement and redesign tools. Plan, Do, Study, Act (PDSA) cycles and the model for improvement*. Author.

[85] Hivos. 2015. Theory of change thinking in practice. Author; pg. 12. [A resource for advanced practitioners.]

[86] Better Evaluation. (2014). *Rainbow framework*. Author.

Ontario Centre for Excellence for Child and Youth Mental Health. n.d. *Program evaluation toolkit.* Author.

Robert J. McCormick Foundation. N.d. *Program evaluation guide.* Author.

W.K. Kellogg Foundation. (2017). *The step-by-step guide to evaluation. How to become savvy evaluation consumers*. Author.

[87] Public Health Agency of Canada. 2012. *Evaluating outcomes of community food actions: A guide*. Author.

[88] MacDonald, G., Starr, G., Schooley, M., Yee, S., Klimowski, K., & Turner, K. 2001. *Introduction to program evaluation for comprehensive tobacco control programs.* Atlanta: Centers for Disease Control and Prevention.

[89] Adapted from: Public Health Agency of Canada. 2012. *Evaluating outcomes of community food actions: A guide*. Author; pg. 7-9.

[90] Source: Horne, T. n.d. *Developing indicators of success*. Wellquest Consulting.

[91] Adapted from: Brach, C., Lenfestey, N., Roussel, A., Amoozegar, J. & Sorensen, A. (2008). *Will It Work Here? A Decisionmaker's Guide to Adopting Innovations*. Prepared by RTI International under Contract No. 233-02-0090. Agency for Healthcare Research and Quality (AHRQ) Publication No. 08-0051. Rockville, MD: AHRQ.

Patton, M.Q. (1997). *Utilization-focused evaluation (3rd Ed)*. Thousand Oaks: Sage.]

[92] Adapted from: Brach, C., Lenfestey, N., Roussel, A., Amoozegar, J. & Sorensen, A. (2008). *Will It Work Here? A Decisionmaker's Guide to Adopting Innovations*. Prepared by RTI International under Contract No. 233-02-0090. Agency for Healthcare Research and Quality (AHRQ) Publication No. 08-0051. Rockville, MD: AHRQ

Pawson, R., & Tilley, N. (1997/2011). *Realistic evaluation*. Los Angeles: Sage.

Patton, M.Q. (1997). *Utilization-focused evaluation (3rdEd)*. Thousand Oaks: Sage.

[93]Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press; pg. 118.

[94] Preskill, H., Gopal, S., Mack, K., & Cook, J. n.d. *Evaluating complexity Propositions for improving practice.* FSG; pg. 8.

[95] Preskill, H., Gopal, S., Mack, K., & Cook, J. n.d. *Evaluating complexity Propositions for improving practice*. FSG; pg. 12.

[96] Patton, M.Q. (2011). Developmental evaluation. Applying complexity concepts to enhance innovation and use. New York: Guilford Press.

[97] Patton, M. Q. (2018). *Principles-focused evaluation. The guide.* New York, Guilford Press; pg. 221 and pg. ix.

[98] Schorr, L. (1997). *Common purpose. Strengthening families and neighbourhoods to rebuild America*. New York: Anchor Books.

[99] Finlay, L. (2008). *Reflecting on "reflective practice".* Practice-Based Professional Learning Centre; pg. 1.

[100] Zimmerman, B., Lindberg, C., & Plsek, P. (2008). *Edgeware. Lessons from complexity science for health care leaders.* Author; pg. 167.

[101] Preskill, H., & Mack, K. (2013). *Building a strategic learning and evaluation system for your organization.* FSG.

[102] Boud, D. (2010). Relocating reflection in the context of practice. In H. Bradbury, N. Frost, S. Kilminster & M. Zukas (Eds.). *Beyond reflective practice. New approaches to professional lifelong learning*. London: Routledge; pg. 25-36.

[103] Zimmerman, B., Lindberg, C., & Plsek, P. (2008). *Edgeware. Lessons from complexity science for health care leaders.* Authors.

[104] Adapted from:
Stroh, D. (2015). *Systems thinking for social change. A practical guide to solving complex problems, avoiding unintended consequences and achieving lasting results*. White River Junction, Vermont: Chelsea Green Publishing;

Zimmerman, B., Lindberg, C., & Plsek, P. (2008). *Edgeware. Lessons from complexity science for health care leaders*. Authors.

[105] Whitney, D., & Trosten-Bloom, A. (2003). *The power of appreciative inquiry. A practical guide to positive change*. San Francisco: Berrett-Koehler; pg. 1.

[106] FSG, n.d. *Systems thinking toolkit. Putting systems thinking into practice in your organization.* Author; pg. 48-49.

[107] Adapted from:
Zimmerman, B., Lindberg, C., & Plsek, P. (2008). *Edgeware. Lessons from complexity science for health care leaders.* Authors.

Eoyang, G., & Holladay, R. (2013). *Adaptive action. Leveraging uncertainty in your organization*. Stanford, California: Stanford Business Books.

[108] Zimmerman, B., Lindberg, C., & Plsek, P. (2008). *Edgeware. Lessons from complexity science for health care leaders*. Authors.

[109] Zimmerman, B., Lindberg, C., & Plsek, P. (2008). *Edgeware. Lessons from complexity science for health care leaders.* Authors; pg. 167-168.

Eoyang, G., & Holladay, R. (2013). *Adaptive action. Leveraging uncertainty in your organization*. Stanford, California: Stanford Business Books.

[110] Eoyang, G., & Holladay, R. (2013). *Adaptive action. Leveraging uncertainty in your organization*. Stanford, California: Stanford Business Books.

[111] Braithwaite, J., Churruca, K., Long, J., Ellis, L., & Herkes, J. (2018). When complexity science meets implementation science: A theoretical and empirical analysis of systems change. *BMC Medicine,* 16:63.

[112] Adapted from: Brach, C., Lenfestey, N., Roussel, A., Amoozegar, J. & Sorensen, A. (2008). Will It Work Here? A Decisionmaker's Guide to Adopting Innovations. Prepared by RTI International under Contract No. 233-02-0090. Agency for Healthcare Research and Quality (AHRQ) Publication No. 08-0051. Rockville, MD: AHRQ.

Walsh, C., Rolls Reutz, J., & Williams, R. (2015). *Selecting and implementing evidence-based practices: A guide for child and family serving systems.* California Evidence-Based Clearinghouse for Child Welfare.

Appendix A: Implementing evidence and innovations from a complex adaptive systems perspective

Conventional thinking about implementing research-based evidence is usually grounded in a mechanical worldview. You'll likely recognize this position: the world is believed to be predictable, uniform, knowable and controllable. It is assumed that by gathering and analyzing "the facts", we can forecast the future, decide how to intervene, make and execute plans and control and measure outcomes. Knowledge is viewed as something tangible and concrete that can be easily managed, packaged and shared. Thus, what will work in one organization is presumed to work in any other organization, perhaps with a tweak or two here and there.

Within this mechanical mindset, the notion of "best practice" is seductive – people expect that tried and tested approaches exist and can be reliably adopted[113]. Experts (usually academic researchers) are generally deemed to be the originators of new ideas and practices. The process of implementing these new ideas (also informed by academic research about "implementation" and "knowledge transfer") is expected to be planned in great detail by those "in charge", with emphasis on replicating as closely as possible what has worked elsewhere or in controlled research studies (this is referred to as "fidelity"). Sounds great! Just tell people exactly what to do, make sure they do it, and then quality and efficiency will improve: give us the recipe and we can change the world!

While it may be comforting to think this way, it is unfortunately not always so helpful on the ground. Increasingly, researchers and practitioners alike are observing that this view of the world is just too simplistic. Mechanical world views obscure the impact of human idiosyncrasies, relationships and interrelationships, unintended consequences, emergence of the unexpected, learning, how people learn, and the crucial impact of the local context on any effort to change. They seldom account for human agency and will, self-interest and altruism, personalities, conflict, politics, and the energy, excitement and rewards that come from pulling together to make a difference - not to mention the dynamic nature of the world in which we live. In short, mechanical views of the world skip over the messiness of the real world.

Mechanical views of the world

Research in knowledge translation and implementation science[114] has largely been based on the mechanical world view – the "scientific method" - or what Braithwaite and colleagues[115] refer to as, "a linear and mechanistic approach to science". While such an approach has an important place in health research– studying the effects of a new drug or comparing the effectiveness of one drug in contrast to another, for example - challenges arise when this kind of thinking is applied to more complex and context-sensitive matters. Livingood and colleagues[116] argue that the research techniques associated with the mechanical view aren't applicable to the varied and complex interactivity associated with communities and society:

> *"The research to practice model that leads to development of medical innovations such as vaccines, antibiotics and medical equipment undoubtedly will continue to serve society well. However, the application of this model to community problems reflecting complex social determinants and health disparities is likely to be far less effective. There is too little similarity in structure, culture, politics, economics, and function of communities and their populations to suggest that a [randomized controlled trial] in one or more of them could produce highly generalizable results."*

Some researchers have speculated that a grounding in this mechanical view might be why implementation models developed to date haven't made a significant impact on implementation success in health services[117]. While advances have been made and lessons learned, there is no "proven" comprehensive, instructive model for implementing evidence and innovations.

These models tend to privilege evidence arising from academic research, even when that research is conducted in controlled settings, and they often fail to account for the way that practitioners actually learn and how they practice, which is much more complex than simply reading an academic article and then changing one's practice[118].

Complexity views of the world

In recognition of the limitations of mechanistic approaches, an emerging trend in this field is consideration of complexity science. Many have suggested that this alternate worldview may be more realistic and helpful. In short, if we want to implement evidence in practice, we have to come to terms with how complex the world really is – and that means we have to think and do things differently.

Growing attention is being given to a view of organizations and health systems as complex adaptive systems - living, dynamic systems where the parts of the system continually interact, adapt, and evolve.

A complex adaptive system is defined as: "*a collection of individual agents who have the freedom to act in ways that are not always totally predictable and whose actions are interconnected such that one agent's actions change the context for other agents*[119]."

"Complexity thinking presents… a view of the world as organic, adapting, becoming and emerging. We argue that this worldview is more realistic than a mechanical worldview, of a world that is predictable, where change goes according to plan and in which the cogs in the machine, including people, are unchanging and controllable. We have concluded that a view of the world as complex, systemic, full of variety, and one that is able to evolve, is the more realistic[120]."

Such systems have many unique elements or agents (individuals, teams, departments, for example) that interact and share information in multiple ways. The elements themselves can learn, adapt and change. And the connections between the elements can change, loosen, reform. Furthermore, there are "diffuse" factors – like mood, likes, dislikes, culture, history – that also shape relationships and actions within the system. Does this sound more like your workplace?

Key characteristics of complex adaptive systems

Some of the key characteristics of complex adaptive systems[121] are listed in the table below and described in more detail after the table.

Key characteristics of complex adaptive systems
• *Interconnectedness* – everything is connected to everything else, so relationships matter and changes in one part of the system will impact other parts. • *Self-organization and emergence* – no single entity controls the system; things emerge as parts of the system interact. • *History matters* – what has happened in the past will shape what is possible in the future. • *Context matters* - the way change happens and how the future emerges depends on the particular features and events and patterns of relationships in the local situation. • *Each situation is unique* – "best principles" are more appropriate than "best practices" or adhering to a pre-determined set of activities. • *Cause and effect are non-linear* – the relationship between cause and effect is often obscure and understood only in retrospect. • *Continual change, often in unpredictable ways* - things are always changing and evolving. People interact and influence one another. The context evolves in response to opportunities and challenges. Changes in the system affect the initiative, and the initiative changes the system.

- *Different sources of energy and convergence can be seen at different times.* The ongoing interactions among people in the system can result in changed motivations and actions, as well as the distribution of power.
- *Information drives learning and helps systems thrive* – dynamism and unpredictability require ongoing collection of information to inform efforts. This learning allows actors to adapt and evolve as they implement the initiative.
- *Multiple perspectives* – each part of the system has its own viewpoint and can only offer a partial perspective

- Interconnectedness: everything is connected to everything else, and the whole is more important than the sum of the parts. This means that we can't understand the world by looking only at its constituent parts; rather, the *relationships* amongst entities are equally if not more important. For example, we can't understand a family or an organization by looking only at its individuals. The relationships they share, the goals they pursue, their interactions, can't be reduced to a single person, because these are things that emerge in interaction with one another. Interconnectedness also means that changes in one part of the system (e.g., staffing, information systems) will often be felt throughout the entire system. Any action can have far-ranging "ripple effects" throughout the system.

- Self-organization and emergence. No single person or element determines the nature or organization of the system (i.e., there is no single point of control); rather, its nature emerges spontaneously through dynamic interaction of the system's agents and with other system. Emergence is a term used to describe events that are unpredictable, and that result from interactions between parts of the system that no single person or organization can control[122]. Complex systems learn and change based on experiences – people are continually adapting to those around them and their circumstances, giving rise to new and unpredictable events – hence the term complex *adaptive* systems.

- History matters – what has happened in the past will influence how things are today and what is perceived to be possible in the future. This is often referred to as "path dependence". For example, a previous failed attempt at implementing a new practice will flavour peoples' thoughts and feelings about trying something new again. Another way of thinking of this is that you can't unscramble an egg - some things are "undoable" and once done will shape what is possible moving forward.

- Context matters – it can make or break an initiative. The way that change happens and how the future emerges depend on the particular features, events and patterns of relationships in the local situation. So, one size does not fit all. Generalizing across settings risks tossing out the critical information that illuminates why things happen and what might happen next.

- Each situation is unique – best principles are often more likely to be more helpful than best practices. This means that rather than assessing adherence to a pre-determined set of actions, it might be more helpful to identify effective *principles* of practice that can then be applied in different circumstances and settings (contexts).

- Cause and effect is not a linear, predictable or one-directional process; it is much more "loopy" or iterative. The relationship between cause and effect is often obscure and understood only in retrospect. Different parts respond to their environment in different ways. The same stimulus doesn't always produce the same response. The magnitude of an action is not linearly related to the magnitude of the change that will result. Small actions can sometimes result in large changes; and sometimes, large change efforts result in little change. This means that causality should be viewed as an ongoing process that includes consideration of feedback and ripple effects, rather than as a one-time event or relationship

- A complex system is always changing, often in unpredictable ways; it is never static. Change is a constant even if it may sometimes appear on the surface that nothing is happening. Things may percolate underneath the surface for a while and then radical change can happen quickly. New patterns of relationships can self-organize and some completely new features that could not have been predicted may emerge.

- Different sources of energy and convergence can be seen at different times[123]. Interactions and influences of people can result in changes in relationships, motivations and actions and the distribution of power within the system. This can in turn change an initiative's strategy and pace of progress.

- Information is the fuel that drives learning and helps the system thrive[124]. The dynamism and unpredictability of the system require that systems and processes to gather and apply information through ongoing monitoring, evaluation and reflection become integral to implementation efforts.

- Multiple perspectives. Each part of the system will have its own viewpoint and can only hold a partial perspective. This means that all processes to understand and issue, and to plan and implement solutions, should engage actors from multiple locations and perspectives.

So what? What are the implications of applying a complexity lens to implementation?

The worldview we adopt shapes how we make sense of and approach the world. Complexity thinking shifts how we think about implementing innovations and evidence-informed practices. While being clear on achieving intended goals remains important, what changes with a complexity worldview is adding in a greater degree of flexibility in order to seize opportunities, respond to the unexpected, and adapt to changing circumstances[125]. Flexibility is also needed to spot and respond to anticipated and also unanticipated signs of change. This is made possible by embedding processes of reflection, monitoring and evaluation into the change project. And, learning becomes paramount.

Nevertheless, we can learn from mechanistic and complexity worldviews

In actual fact, neither implementation science models nor complexity approaches have been rigorously studied or evaluated enough to provide definitive advice about implementing new practices and ideas to address complex issues in complex environments. Both fields are in their infancy; and both have valuable insights to offer. Mechanistic models might be more suitable for simple solutions to simple problems whereas complexity principles are more relevant to complex issues and contexts.

Understanding organizations and practice through a complex adaptive systems lens doesn't mean we must discard everything we've learned through a mechanical lens. Implementation research has helped to identify many factors and processes that facilitate and hinder implementation. This is valuable information to help us navigate our way forward. The "value add" of incorporating complexity thinking, however, is the broadening and deepening of thinking it affords, helping to better understand issues and the people experiencing them, the contexts in which you're working, being ready to "expect the unexpected", and perhaps most crucially, the importance of implementing learning systems that enable the capture of information in "real time" so as to inform ongoing efforts and any need for adaptation.

Some resources that might be helpful…

Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press.

Braithwaite, J. (2018). Changing how we think about healthcare improvement. *British Medical Journal*. 361. https://doi.org/10.1136/bmj.k2014

Braithwaite, J., Churruca, K., Ellis, L., Long, J., Clay-Williams, R…Ludlow, K. (2017). *Complexity science in healthcare – Aspirations, approaches, applications and accomplishments: A white paper.* Sydney, Australia: Macquarie University - Australian Institute of Health Innovation.

Canadian Centre on Substance Abuse. (2012). *Systems approach workbook: Systems thinking and complexity in substance use systems.* Author.

Dodd, S., & Savage, A. (2016). Evidence-informed social work practice. *Encyclopedia of Social Work*

Kania, J., & Kramer, M. (2013). Embracing emergence: How collective impact addresses complexity. *Stanford Social Innovation Review*.

Livingood, W., Allegrante, J., Airhihenbuwa, C., Clark, N., Windsor, R…Green, L. (2011). Applied social and behavioral science to address complex health problems. *American Journal of Preventive Medicine*, 41(5), 525-531.

Plsek, P. (2003). *Complexity and the adoption of innovation in health care.* Paper presented to the conference: Accelerating Quality Improvement in Health Care – Strategies to Speed the Diffusion of Evidence-Based Innovations, Washington, CD, 27-28 January.

Preskill, H., Gopal, S., Mack, K., & Cook, J. n.d. *Evaluating complexity. Propositions for improving practice*. FSG.

Sterman, J. (2006). Learning from evidence in a complex world. *American Journal of Public Health*, 96(3), 505-514.

Westley, F., Zimmerman, B., & Patton, M. (2006). *Getting to maybe: how the world is changed.* Random House Canada.

Zimmerman, B., Lindberg, C., & Plsek, P.(2008) *Edgeware. Lessons from complexity science for health care leaders.* Authors.

Endnotes

[113] Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press; pg. 123.

[114] Knowledge translation is defined by the Canadian Institutes of Health Research as, "a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system. Implementation science is defined by the National Implementation Research Network as, "the study of factors that influence the full and effective use of innovations in practice"

[115] Braithwaite, J. (2018). Changing how we think about healthcare improvement. *British Medical Journal*. 361. https://doi.org/10.1136/bmj.k2014

[116] Livingood, W., Allegrante, J., Airhihenbuwa, C., Clark, N., Windsor, R. . .& Green, L. (2011). Applied social and behavioral science to address complex health problems. *American Journal of Preventive Medicine*, 41(5), 525-531; pg. 528.

[117] See, for example, Braithwaite, J. (2018). Changing how we think about healthcare improvement. *British Medical Journal*, 361 https://doi.org/10.1136/bmj.k2014.

[118] Gabbay, J., & Le May, A. (2011). *Practice-based evidence for healthcare. Clinical mindlines*. London: Routledge.

[119]Plsek, P. (2003). Complexity and the adoption of innovation in health care. Paper presented to the conference: *Accelerating Quality Improvement in Health Care Strategies to Speed the Diffusion of Evidence-Based Innovations*. Washington, D.C. January 27-28; pg. 2.

[120] Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press; pg. 106.

[121] The following points are based on the work of:
Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence*. London: Oxford University Press.

Braithwaite, J. (2018). Changing how we think about healthcare improvement. *British Medical Journal*, 361.

Braithwaite, J., Churruca, K., Ellis, L., Long, J., Clay-Williams, R. Ludlow, K. (2017). *Complexity science in healthcare – Aspirations, approaches, applications and accomplishments: A white paper*. Sydney, Australia: Macquarie University - Australian Institute of Health Innovation.

Eoyang, G., & Holladay, R. (2013). *Adaptive action. Leveraging uncertainty in your organization*. Stanford, California: Stanford Business Books.

Plsek, P. (2003). Complexity and the adoption of innovation in health care. Paper presented to the conference: *Accelerating Quality Improvement in Health Care – Strategies to Speed the Diffusion of Evidence-Based Innovations*, Washington, CD, 27-28 January.

Preskill, H., Gopal, S., Mack, K., & Cook, J., n.d. *Evaluating complexity. Propositions for improving practice*. FSG.

Sterman, J. (2006). Learning from evidence in a complex world. *American Journal of Public Health*, 96(3), 505-514;

Stroh, D. (2015). *Systems thinking for social change. A practical guide to solving complex problems, avoiding unintended consequences and achieving lasting results*. White River Junction, Vermont: Chelsea Green Publishing.

World Health Organization (WHO). (2009). *Systems thinking for health systems strengthening*. Author.

[122] Kania, J., & Kramer, M. (2013). *Embracing emergence: How collective impact addresses complexity.* Stanford Social Innovation Review; pg. 2.

[123] Preskill, H., Gopal, S., Mack, K., & Cook, J., n.d. *Evaluating complexity. Propositions for improving practice*. FSG.

[124] Preskill, H., Gopal, S., Mack, K., & Cook, J., n.d. *Evaluating complexity. Propositions for improving practice*. FSG.

[125] Boulton, G., Allen, P., & Bowman, C. (2015). *Embracing complexity. Strategic perspectives for an age of turbulence.* London: Oxford University Press; pg. 130.

Appendix B: Why we focus on evidence-informed practice

There is debate in the research world about terms and definitions related to the use of evidence in practice. The notion of "evidence-based practice", or "best practices" grew out of medicine in the 1990s and has since spread to many other fields. In general, "evidence-*based* practice" refers to evidence prioritized according to a specific hierarchy of types of research studies, with randomized controlled clinical trials (RCTs) being favoured over all other kinds of research.

Evidence generated from RCTs is crucially important especially in clinical care. We all appreciate knowing that the drugs we take and treatments we receive have proven effectiveness, for example, or that the practice of using preoperative checklists saves lives. And we all hope that our physicians and clinical practitioners are on top of this kind of evidence.

The challenge with privileging these kinds of studies, however, is that people come believe this kind of "scientific rigour" can and should be applied in all situations – including complex social ones. Unfortunately, this is often not the case.

The community-based addiction and mental health sector faces a much broader and different range of issues than clinical medicine and that cannot be studied or tested in the same way as a new drug might be, for example. In community-based mental health and addiction services, many issues, if not most, are complex and have no single or clearly defined "solution"; there simply is no "one best way" of proceeding. What might work for some people in a particular setting might not work so well with other people in other places. And success often depends on the actions of multiple actors – individuals and organizations – each of which have their own agendas and ways of operating.

For example, consider the system integration goals and actions outlined in the Community Mental Health Action Plan: a common agenda and cross-sector leadership; caregivers' ability to navigate the system; accessing the full continuum of care from promoting positive mental health to intervening with support for addiction and mental illness. Examples of actions under these goals include incorporating the social determinants of health and expanding interdisciplinary teams and integrated pathways. We are unlikely to find RCT evidence, nor prepackaged solutions for these kinds of issues.

Finally, the evidence that does exist in the literature may not always fit with our particular needs in a given situation. The evidence might have been developed under a controlled situation but might not produce the same results "in the wild". Further, current research evidence might exclude many innovations or promising practices that have not yet been evaluated. Or, there might be conflicting evidence with no clear answer as to what is best. Finally, the published evidence might not make sense for the people you're serving or the context in which you're working.

In these cases, it is necessary to draw from many sources of knowledge and to focus on learning and adaptation along the way. This is where evidence-*informed* practice comes into play, alongside a complexity perspective of the world.

"When implementing evidence-informed practices into the real-world setting, it can be difficult to match scientific research findings to the specific needs of an organization and the people it serves. Where evidence exists, it may have been developed in a research environment but does not produce the same results in a less controlled environment. Research findings may also exclude many promising practices that have not yet had a chance to be systematically evaluated. Finally, the practice may not make sense for a given population[126]."

"Even when you know what research and published advice has to say, you will not know exactly how to apply it to your particular situation with its unique problems and opportunities. Your own organization has its own special combination of personalities and prehistories and "firm-specific" realities. You can get ideas, insights and lines of thought and action, but you can never know exactly how to proceed[127]."

Endnotes

[126] Ontario Centre of Excellence for Child and Youth Mental Health. n.d. *Implementing evidence-informed practice.* Author; pg. 7.

[127] Fullan, M. (1999). *Change forces. The sequel*. London: Falmer Press; pg. 28

Appendix C: Levels of service user participation and power

There are varying degrees or levels of stakeholder engagement and participation. These are often described as being three categories – "doing to" (which includes coercing and educating), "doing for" (which includes engaging and consulting) and "doing with" (which includes co-designing and co-producing). These are depicted in the figure below. The arrow on top of the figure indicates that the further one moves toward the right, the depth of participation increases.

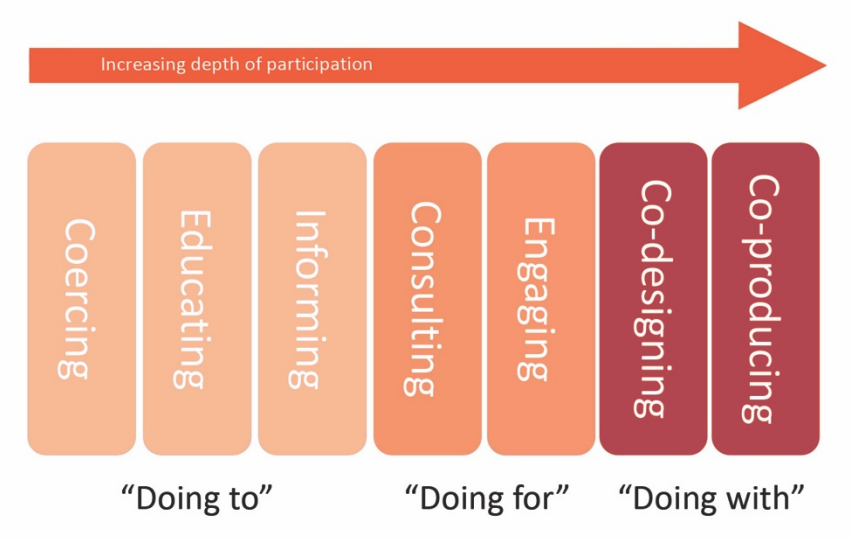


Figure. Levels of service user and stakeholder participation[128]

DOING TO: The first categories (coercing, educating, informing) of participation represent traditional services that are essentially coercive in that services are designed by professionals to educate and cure – to "fix". Recipients of services are not invited to participate in the design or delivery of service; they are simply expected to agree that it will do them good and let the service happen *to* them.

DOING FOR: Moving along the pathway, participation moves from "doing to" to "doing for" by consulting and engaging stakeholders. There is greater participation, albeit shallow and still within clear parameters that are set by professionals. Here, services are often designed by professions with the recipients' best interests in mind, but the peoples' involvement in the design and delivery of the services is constrained. People might be informed that a change will be made, or they might be engaged to see what they think about these changes. But they are only invited to be heard; they are not given the power to make sure that their ideas or opinions shape decision-making.

DOING WITH: Doing with (co-designing, co-producing) is a deeper level of service user involvement that shifts power toward service users. This requires a fundamental change in how professionals work with service users, recognizing that positive outcomes cannot be delivered effectively to or for people but rather than they are best achieved through equal and reciprocal relationships.

Co-designing a service involves sharing decision making power with people – peoples voices are heard, valued, debated and then acted upon. Co-production goes one step further by enabling people to play roles in delivering the services that they have designed – for example, peer support, mentoring, and running their own services including deciding how the organization is operated. Here, peoples' assets and capabilities are recognized and nurtured. They share roles and responsibilities to run the service, working in equal ways with professionals, valuing each other's unique contributions; and, beyond that, organizing their own services and supports.

Regardless of our aspirations to engage service users as fully as possible, it may not always be possible to engage them on the far right of the participation spectrum. In these cases, it is important to be honest about the level of engagement that is possible in each situation, and what peoples' involvement will mean (see the quote below).

"I am realistic enough to understand that many of our aspirations about the degree of involvement and decision-making we would want for service users may be unrealistic in the near future. Nevertheless, we can expect honesty as a baseline about where involvement in service planning begins and ends.

Service users need to know from the outset exactly what their involvement will mean, and it should not be clouded by frilly wrappings of meaningless words and processes of involvement that contain very little within them. Involvement requires recognition and ownership of the many agendas it serves and openness about whose agendas are the most overriding.

If this honesty is present, involvement can produce good results even when coming from less democratic principles and practices – when serving compliance agendas for powerful groups, for instance, involvement can still be empowering."[129]

Different kinds of power

These levels of participation are tied to different expressions of power, particularly: power over, power with, power to, and power within.[130]

POWER OVER: Is the most commonly recognized form of power and the foundation of oppression. Here, power is a win-lose relationship wherein having power means taking it from someone else and then using it to prevent others from gaining it. This kind of power has many negative associations for people including repression, force, coercion, discrimination and abuse. When people are denied access to important resources such as housing and employment, power over perpetuates inequality, justice and poverty. In the absence of alternative models and relationships, people repeat the power over pattern in their personal relationships, communities and institutions. This is also true of people who come from marginalized or powerless positions. When they gain power in leadership, they sometimes adopt the "power over" mindset and practices of those who had oppressed them. For this reason, advocates cannot expect that the experience of being excluded prepares people to become democratic leaders. New forms of leadership and decision making must be explicitly defined, taught and rewarded in order to promote more democratic forms of power.

THE CYCLE OF POWERLESSNESS[131]

"The process by which people may perceive themselves as being powerless can begin when individuals and groups living in risk conditions or who experience inequalities in health (poor housing, unemployment, unsanitary conditions) feel distress with the unfairness of their situation (their low status on some hierarchy of power or authority, indicated in part by wealth). These people then internalise this feeling of unfairness as aspects of their own 'badness' or 'failure'.

This internalisation adds to their distress, if not also to their loss of meaning and purpose, with measurable effects on their bodies such as hypertension… The powerless often experience little leverage on the events and conditions that impinge on their existence, either directly or through access to resources, information and facilities.

This situation is made worse when the dominant social discourse on success is competitiveness, individualism and meritocracy, where people are presumed to succeed or fail purely on the basis of their own initiative or ability …This internalization of 'badness' leads to what is described as both false consciousness, failing to utilize the power one has, and failing to acquire powers that one can acquire … and learned helplessness."

Practitioners and academics have searched for more collaborative ways of exercising and using power. Three alternatives – power with, power to, and power within – offer positive ways of expressing power that create the possibility of forming more equitable relationships. By affirming peoples' capacity to act creatively, they provide some basic principles for constructing empowering strategies.

POWER WITH: is about finding common ground among different interests in order to build collective strength. It is based on mutual support, solidarity, collaboration, recognition and respect for differences. It multiplies talents, knowledge and resources for a broader impact, and it can help build bridges across differences by openly acknowledging conflicts and seeking to address them for a larger aim. It can also provide a grounding sense of community.

POWER TO: refers to the unique potential of every person to shape his or her life and world. When based on mutual support, it opens up with possibilities of joint action, or power with.

POWER WITHIN: has to do with a person's sense of self-worth and self-knowledge; it includes an ability to recognize individual differences while respecting others. It is the capacity to imagine and have hope; it affirms the common human search for dignity and fulfillment.

What is empowerment?

Empowerment is, *"a process by which people, organizations and communities gain mastery over issues of concern to them"*[132]. It is integrally related to "power-with", "power-to", and "power within". Psychological empowerment refers to empowerment of individuals and includes perceptions of personal control, a proactive approach to life and a critical understanding of the sociopolitical environment[133]. Community empowerment refers to individuals working together in an organized fashion to improve their collective lives and linkages among community organizations and agencies that help maintain that quality of life[134].

Importantly, we often hear the phrase, "we can *empower* them to…". But as Laverack[135] asserts, **"what must be remembered is that power cannot be given to people but must be gained and seized by themselves."** It is this act of seizing one's own power from within that constitutes empowerment.

Empowering processes are "*those where people create or are given opportunities to control their own destiny and influence the decisions that affect their lives. They are a series of experiences in which individuals learn to see a closer correspondence between their goals and how to achieve them, gain greater access to and control over resources and where people, organizations and communities gain mastery over their lives*[136]." Examples of empowering processes are community development and participatory action research.

Endnotes

[128] Adapted from:
Slay, J., & Stephens, L. (2013). *Co-production in mental health: A literature review.* London: new economics foundation; pg. 4.

[129] Gosling, J. (2010). The ethos of involvement as the route to recovery. In J. Weinstein (Ed.) *Mental health service user involvement and recovery.* Philadelphia: Jessica Kingsley, pg. 30-44.

[130] Definitions of power over, power with, power to, and power within are adapted from:
Miller, V., VeneKlasen, L., Reilly, M., & Clark, C. (2006). *Making change happen: Power.* Just Associates; pg. 5.

[131] Laverack, G. (2005). *Public health. Power, empowerment and professional practice.* New York: Palgrave Macmillan; pg. 33.

[132] Zimmerman, M. (1995). Psychological empowerment: Issues and illustrations. *American Journal of Community Psychology,* 23(5), 581-599; pg. 581.

[133] Zimmerman, M. (1995). Psychological empowerment: Issues and illustrations. *American Journal of Community Psychology,* 23(5), 581-599; pg. 581.

[134] Zimmerman, M. (1995). Psychological empowerment: Issues and illustrations. *American Journal of Community Psychology,* 23(5), 581-599; pg. 582.

[135] Laverack, G. (2005). *Public health. Power, empowerment and professional practice.* New York: Palgrave Macmillan; pg. 3.

[136] Zimmerman, M. (1995). Psychological empowerment: Issues and illustrations. *American Journal of Community Psychology,* 23(5), 581-599; pg. 583.

Appendix D: Additional information about evaluating complex initiatives

Preskill and colleagues[137] developed a set of propositions for evaluation that match the characteristics of complex systems. These propositions point to the kinds of things you might want to look for and the questions you might want to ask if you are working on something complex. We have found this to be one of the clearest and simplest descriptions of evaluation can address complexity. See the table below for an overview of their propositions.

Preskill et al.'s propositions for evaluating complexity [138]		
Characteristics of complex systems	**Propositions for evaluation**	**Description**
Continual change, often in unpredictable ways	Design and implement evaluations to be adaptive, flexible and iterative.	Evaluation needs to be nimble and open to periodic "refreshes" as stakeholders constantly learn from feedback.
Interconnectedness (everything is connected; events in one part of the system affect all other parts)	Seek to understand and describe the whole system, including components and connections.	Evaluators need to know how and why different parts of the system interact. This is an ongoing, "dynamic" activity, not just a "one-off" exercise.
Information drives learning and helps systems thrive	Support the learning capacity of the system by strengthening feedback loops and improving access to information.	Evaluation can improve the system's capacity to learn through the collection, analysis and co-interpretation of data. As data are collected and analyzed, learning conversations with stakeholders and insights into how and where the system is responding to the initiative's activities can be very useful.
Context matters; it can make or break an initiative	Pay particular attention to context and be responsive to changes as they occur.	Context must be explicitly studied as part of the evaluation. Evaluation should measure ways in which the initiative affects context. Evaluating findings should be interpreted and grounded in context.
Each situation is unique; best principles are more likely to be seen than best practices	Look for effective principles of practice in action, rather than assessing adherence to a predetermined set of activities.	Evaluation should identify and explain how effective principles of practice are alive in the work.

Different sources of energy and convergence can be observed at different times.	Identify points of energy and influence, as well as ways in which momentum and power flow within the system.	Evaluation needs to look for times and places where energy, influence, power and momentum show up within the system. This may include examples of how individuals and organizations are building new or different connections, power dynamics and patterns of engagement.
Relationships between entities are equally if not more important than the entities themselves	Focus on the nature of relationships and interdependencies within the system.	Evaluation should capture and describe relationships and interdependencies between various parts of the system. With each key relationship it is important to understand its nature, its strength and its longevity.
Cause and effect is not a linear, predictable or one-way process	Explain the non-linear and multi-directional relationships between the initiative and its intended and unintended outcomes.	Evaluation should capture complex relationships between cause and effect. This involves tracking the pathway between an initiative and its outcomes and understanding how it varies under different conditions and circumstances.
Patterns emerge from several semi-independent and diverse agents who are free to act in autonomous ways (self-organization and emergence)	Watch for patterns, both one-off and repeating, at different levels of the system.	Evaluation needs to pay close attention to patterns as a way to gauge coherence in the system. Attention should also be paid to the ways certain patterns (both productive and non-productive) repeat themselves at multiple levels of a system.

Endnotes

[137] Preskill, H., Gopal, S., Mack, K., & Cook, J. n.d. *Evaluating complexity Propositions for improving practice*. FSG; pg. 5.

[138] Source: Adapted from Preskill, H., Gopal, S. , Mack, K., & Cook, J. n.d. *Evaluating complexity Propositions for improving practice*. FSG.