Benefits of a Recovery-Oriented Knowledge Translation Program for Mental Health Community Support Teams: A Qualitative Study

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ABSTRACT

In most developed countries, health systems are attempting to compensate for underuse scientific evidence and its integration into healthcare services and practices. This qualitative study aimed to identify perceived benefits of a knowledge translation program implemented within mental health community services ((At your fingertips, Quebec, 2016-2018)). Results suggests that the production of a collaborative platform composed of a variety of activities and techno-educational tools, derived from integrated knowledge, facilitates the uptake by professionals in a context of reflective practices. Dissemination of these tools through technology of information and communication provides access to best recovery-oriented practices at your fingertips.

Keywords: knowledge application, information and communication technologies, reflective practice, practice improvement, mental health

RÉSUMÉ

Dans la plupart des pays développés, les systèmes de santé tentent de palier la sous-utilisation des évidences scientifiques et leur intégration dans les services et pratiques de santé. Cette étude qualitative vise à identifier les retombées perçues d'un programme d'application des connaissances implanté au sein des services de soutien dans la communauté en santé mentale (À portée de main, Québec, 2016-2018). Les résultats suggèrent que la plateforme collaborative du programme, composée d'une trousse d'outils techno-éducatifs issus de connaissances intégrées, facilite l'appropriation des connaissances dans un contexte de pratiques réflexives. L'utilisation des technologies de l'information et de la communication donne accès aux meilleures pratiques axées vers le rétablissement.

Mots clés : application des connaissances, technologie de l'information et des communications, pratique réflexive, amélioration des pratiques, santé mentale

In most developed countries, health systems are attempting to address the challenge of utilizing scientific evidence and its integration into healthcare services and practices (Straus et al., 2013). The implementation of various knowledge translation and transfer mechanisms concerns several countries that wish to move from evidence to practice (World Health Organization, 2018; Canadian Institutes of Health Research, 2015; Grimshaw et al.; 2012). The specific field of mental health is no exception. There is well-documented literature on mental health best practices. However, services do not yet fully reflect the available evidence in this area, particularly the subfields concerned with recovery and social participation of individuals with mental health disorders (Rössler & Drake, 2017; Torrey et al., 2012; Vita & Barlati, 2019).

Academics, expert groups, stakeholders' committees and more recently, public policies support the need to implement, for mental health care and services, a recovery-oriented model of care (Davidson et al., 2008; Mental Health Commission of Canada [MHCC], 2012, 2015; Shepherd et al., 2008, 2014; Slade et al., 2012; Torrey et al., 2012). The recovery model promotes hope and the possibility of living a satisfying life on the path to full citizenship, despite mental health problems experienced in the present or in the past (Anthony, 1993; Deegan, 1997; Shepherd et al., 2008). This model does not perceive recovery as the remission or suppression of disease or symptoms, but as a path to well-being and full social participation. To adopt recovery-oriented practices, professionals must recognize experiential knowledge, foster peer

support, establish shared decision-making processes, use recovery-oriented intervention plans, highlight people's strengths and resources, fight stigma, and support opportunities for success—including the pursuit of regular work and education (Davidson et al., 2008; MHCC, 2015; Shepherd et al., 2008, 2010, 2014).

In Québec and Canada, these concerns are reflected in various government policies and action plans, but not always with the expected results (MSSS, 2017; MHCC, 2012). In order to move not only from evidence to practice, but also from policy to implementation, there is a need to develop appropriate support mechanisms to ensure the deployment of best clinical practices across the continuum of mental health service delivery (Gold et al., 2006; Isett et al., 2008; Torrey et al., 2012). In 2008, the Québec ministry of health and social services has created a national body to support the application of best practices in mental health settings: the Centre national d'excellence en santé mentale (CNESM). CNESM counsellors certify and provide their support to mental health public and community-based organizations across the province. Their key challenges is to expand the use of the recovery model, support mental health professionals in this adoption and devote more space to service users in this process of improving practices.

In 2015, in an effort to meet these challenges, the CNESM partnered with a knowledge translation research laboratory focused on rehabilitation, recovery and social inclusion: the Centre d'études sur la réadaptation, le rétablissement et l'insertion sociale (CÉRRIS). Created in 2010, the CÉRRIS aims to provide a showcase of tools (as an open access virtual library) based on best practices in the field of mental health as well as spaces for reflection, exchange, and creation of integrated knowledge (i.e., knowledge that brings together research data, clinical experience, and lived experience). The work is carried out in French (the province's main language), using information and communication technologies (ICTs). This partnership led to a joint research project named À portée de main, les meilleures pratiques axées vers le rétablissement, (At your fingertips, best recovery-oriented practices). The purpose of this initiative is to facilitate access to best recovery-oriented practices and to support its uptake within mental health services.

This article presents the perceived benefits of the knowledge translation program implemented with a first group of knowledge users: community support teams in Québec. This study aims to address the following gaps in the literature: (1) to evaluate a knowledge translation program dedicated specifically to the implementation of recovery-oriented practices in mental health teams; (2) to gain a better understanding, based on a detailed analytical framework for knowledge translation, of how professionals and clinical supervisors achieve practice change through reflective practice activities; and (3) to better understand the context of knowledge translation within mental health teams in Québec.

Description of the Intervention

The CÉRRIS and the CNESM implemented in Québec (2016–2018) a knowledge translation program aimed at the appropriation of best recovery-oriented practices in mental health.

The themes addressed are

- personal recovery and recovery-oriented services
- recovery plan and intervention plan
- peer support: peer workers and other peer support

- involvement of family or key individuals
- autonomous housing
- supported employment
- strength model
- confidentiality issues

For each theme, a variety of activities and techno-educational tools are proposed: video capsules, animation guides for reflective practices, best practices web files, reminder tools, webcast conferences, blog debate and discussion forum, etc. Every two months, a new theme was available to support reflective practice. All tools were available in the open access virtual library: cerrisweb.com.

In the course of this first stage of evaluation (MESRST funds, 2015–2018), 23 mental health community support teams were involved: 10 Assertive Community Treatment—ACT (*Suivi intensif dans le milieu—SIM*) and 13 Intensive Case Management—ICM (*Soutien d'intensité variable—SIV*)[1], located in five regions of Québec (urban, semi-urban, and rural). The second stage of evaluation is planned across the continuum of mental health service delivery, with a focus on primary care services (MEDTEQ funds, 2019–2022). During a 14 month-period (January 2016 to February 2018), clinical supervisors supported their team's participation by scheduling clinical meetings dedicated to reflective practice. In total, including personal and team time, it is estimated that each professional invested 30–90 minutes per two months (per theme). The clinical supervisors were themselves supported by the research team (knowledge broker coordinator) through a community of practice, one hour per month.

Although this project-specific evaluation is intended for community support teams, the toolkits produced are designed for a broad audience: mental health service users, their family, community members and all mental health professionals, including primary mental healthcare teams; hence our interest in expanding the program more widely within these services in the future. Indeed, during the evaluation project, several mental health professionals used the tools on their own initiative, well beyond the evaluation project. As part of their supporting role to mental health teams across the province, CNESM counsellors referred to these tools and encouraged their use for reflective practice and continuous practice improvement. In total, 524 people registered on the virtual library platform of which 200 were outside the evaluation project.

Analytical Framework and Study Objectives

To support evaluation, the analytical framework used was adapted from the Institut national de santé publique du Québec's model (Lemire et al., 2013). It presents the expected benefits of a knowledge translation program for healthcare and services providers (Figure I). The adapted framework categorizes expected benefits over a short-term period (increased use of new knowledge, conceptual, reflective and strategic use), a mid-term period (adoption and implementation in decisions and practices) and a long-term period (improved

1. Both services offer psychosocial rehabilitation services within the community. They provide or coordinate the full range of services that meet the individual's specific needs (medical and psychosocial rehabilitation, including criminal justice, addiction and employment; MSSS, 2017). However, the level of service intensity is different, since the ACT teams offer a higher level of service intensity (ratio professional vs. service user, ACT: from 1/8 to 1/15; ICM: from 1/12 to 1/25; MSSS, 2005).

quality of services; Lemire et al., 2013; Rocher, 1988; Skinner, 2007). Table I provides brief definitions of concepts from the analytical framework.

Based on Strauss' definition (2013), we considered knowledge translation as a dynamic and iterative process that includes the synthesis, dissemination, exchange, and ethically sound application of knowledge to improve mental health. From a knowledge integration perspective, all knowledge translation program activities and tools were developed in partnership with stakeholders, including mental health service users (Wallcraft et al., 2009). The co-construction model includes scientific, clinical, and experiential knowledge (Shepherd et al., 2008, 2014; Lemire et al., 2013; Rocher, 1988).

Figure I

Analytical Framework for the Evaluation of the Knowledge Translation Program

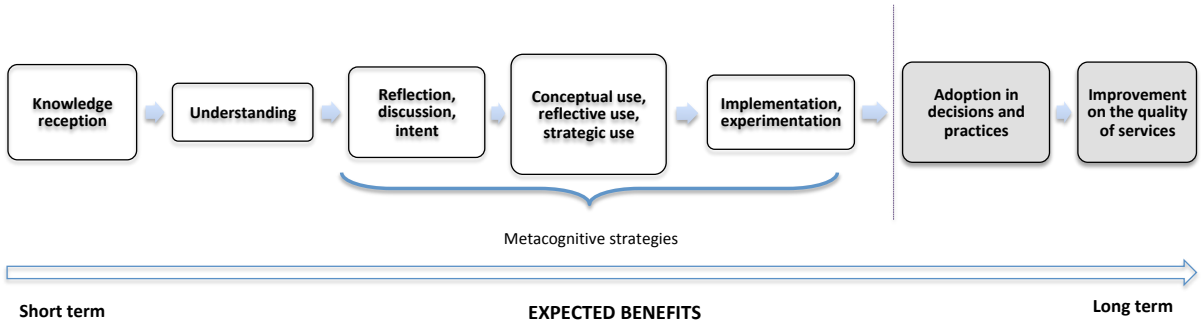

Table I

Brief Definitions of Key Concepts of the Analytical Framework

Key Concepts	Brief Definitions
Conceptual use	Enlighten differently: use of knowledge to deepen understanding.
Reflective use	Reflect about my practice, my choices: use of knowledge as an aid to reflection.
Strategic use	Argue better: use of knowledge helps to justify and legitimize positions.
Adoption in decisions and practices	Help my decisions and influence my practices: Benefits of these decisions are already tangible and concrete with regard to the professional practices or, if they are not yet strongly tangible, they may lead to more concrete changes over a short period of time.
Improvement in the quality of services	Improvement in the ACT and ICM's capacity (Parson's Social System; Rocher, 1988) to: • better consider the expressed needs of mental health services users and best rehabilitation practices (adapt to one's environment), • help restore and improve the living conditions of service users (achieve their goals), • work in a coordinated manner with their partners within and outside the mental health system (operate in an integrated manner), • support the values and principles of recovery-oriented model of care and defend the rights and interests of individuals (create a system of shared values and representations).

In accordance with this analytical framework, the objectives of the study are twofold:

- to evaluate the perceived benefits of participating in the knowledge translation program on conceptual, reflective, strategic use and on decisions and practices; and
- to explore the perceived benefits of participating in the knowledge translation program on improved quality of services.

METHODS

Recruitment

During the 14-month evaluation period, 324 individuals from the 23 study teams registered on the virtual library platform. At the time of the evaluation, which was impacted by staff turnover, 182 professionals (including clinical supervisors) received an electronic invitation to take part in the final evaluation of the program. Sixty-three individuals completed the quantitative end-of-study questionnaire. Among those, 11 professionals and clinical supervisors agreed to participate and were contacted for a telephone interview. They represented all categories of participants involved (managers, clinical supervisors, and professionals). As recommended by authors Pires, (1997) and Fortin and Gagnon (2016), in order to achieve a good understanding of the phenomenon under study, 10 to 20 participants were targeted. No services users or family members were recruited in this study.

To meet the research objectives of this study, only interview data is presented in the paper. That said, a research journal documenting the implementation process was used to understand the context and identify implementation facilitators and challenges. This study received ethical approval from a certified ethics committee and all participants signed an information and consent form.

Data Collection

Semi-structured individual telephone interviews were conducted by two research assistants (under the supervision of the principal investigator). All interviews were recorded, and verbatim transcripts written. The interview guide was derived from the analytical framework. It was designed to describe the newly acquired knowledge by the participants; the reflections and the discussions that occurred; the actions, initiatives, and decisions implemented; and finally, perceived implemented practice changes and improvement in quality of services.

Analysis

A descriptive content analysis approach was used (Miles et al., 1994). The combination of a more structured codification procedure (based on a code lexicon) with an open procedure to create codes from empirical data was performed using the QDA-Miner qualitative data analysis software. Following a first deductive procedure, two research assistants independently performed preliminary coding on four interviews and, subsequently, pooled the results of their work. A research assistant was then assigned to complete the coding on all subsequent interviews. At each step, a second research assistant (under the supervision of the principal investigator) performed a counter-coding to validate the adequacy between the coding and the data and the relevance of the constructed categories. All interviews were counter-coded. The coding guide was adjusted based on this sharing, validation, and counter-coding steps. For more complex coding or counter-coding, the research team was brought together to reach a consensus.

RESULTS

Eleven individual interviews were conducted with managers, clinical supervisors (n = 6) and professionals (n = 5) among the 23 the mental health community support teams (ACT and ICM) that took part in the project (2016–2018).

Conceptual and Reflective Use of Acquired Knowledge

The interviews showed that the professionals of the ACT and ICM teams used the translated knowledge mainly in two different modes: conceptual use and reflective use.

First, the knowledge shared leads to clarifying certain concepts, understandings, and situations in a different mode *(conceptual use)*. The participants were thus able to strengthen their understanding of some concepts and clinical situations, but also to take ownership of the new ideas outlined.

> (…) there are nuances that we appreciated having (...). It brought some insight into the theme of employment and studies, for example (...) I think I could easily bring it out and implement it. (…). Clinical ICM supervisor #11

The second modality *(reflective use)* illustrates that the knowledge translated also allows professionals to question, reflect and step back from their practices and choices.

> I found it interesting that we discussed the practice using precise themes. (…) that we would stop (…) and discuss within the team. Try to look over our practices (…) it highlighted certain things, certain intervention strategies (…). Clinical ACT supervisor #12

In addition, the new knowledge is used in more elaborate reflections within the teams as well as in clinical supervision meetings. This allowed internal discussions (i.e., in a group composed exclusively of team members) and external discussions (i.e., with new partners from the community) to happen.

> Otherwise, I might end with confidentiality. The fact that we discussed this topic has led to further internal discussions here at home, which have led us to perhaps go a little further with regard to some legal content. (...) We brought in a community mental health advocacy organization (...) to talk about that very theme (...) it opened up on "what we have the right to disclose," "to whom we have the right to disclose." (…). Clinical ICM Supervisor #11

> The main impact (…) it's had (…) on the families, relatives… we brought in the APAMM [editor's note: Association des parents et amis de la personne atteinte de maladie mentale—association of parents and friends of a person with mental illness] in our region, who came to meet us as a team to explain what they do for families. We involved more people around us, then, I really saw a big difference. Clinical ICM Supervisor #13

> (…) the themes "recovery" and "recovery intervention plan"… it led us to create a clinical committee (…) to improve our clinical processes. (…) supervised by the Centre national d'excellence en santé mentale. Clinical ICM Supervisor #14

Adoption in Decisions and Practices: Benefits on Recovery Practices

Despite the fact that the animation guides for reflective practices available often allowed teams to take time to reflect on a specific theme, the discussions did not stop there, and the workshops served as a

catalyzer for further discussions and led to changes in practices. The most significant changes were observed at the practice level. They led to some individual or collective decisions. They also either showed immediate beneficial effects or they guided future actions and changes over a short-term period. These changes in practices are classified into five different categories of recovery-oriented practices.

Practice 1: Promoting Self-Management and Taking the Person's Choices into Consideration

This practice involves helping mental health service users to increase their self-management capacity and empowerment, i.e., taking more responsibility for the management of their medication or other issues related to their mental health, as well as actively engaging in making decisions for themselves.

> I believe that … (…) really, the active role of the person in his intervention plan. In the sense that it is his plan, the decisions are his. (…) "Start looking at what you want, what do you want to change, what do you want to modify. (…) lately, we've begun leaving medication at the person's home." ICM professional #9

Participation in the knowledge translation program helped professionals gain greater confidence and capitalize on people's strengths. The intervention is voluntarily reduced in favour of support, adjustment, and taking into account personal choices and interests. Rather than convincing service users to go in a direction favoured by the team, it is a matter of supporting them and adapting to their own path.

> (…) let's say, someone who lost their driver's license. The doctor doesn't want him to have his driver's license, but he still wants his driver's license. Before, I would have been inclined to look for strategies to make him understand (…). Now, I'm more likely to say: "What do you think is the next step in getting your driver's license"? and I'm going in there with him. Basically, I don't have to give him any answers (…) I find that it makes me do things differently. ICM professional #5

> (…) Me, I tended, in my practice, (…) to go in a more directive manner (…) Today, what I see that has changed in my practice … I'm going to leave more room before I go. (…) to lead (…) I'm going to let the persons see, for herself, from where she wants to start. Now, I'm gonna adjust. What I wasn't doing. Usually, I did the opposite. (…) I was very proactive (…) I let the person come to me. Finally, it can go in a completely different direction than I planned. In the end, it's much more successful (…). ICM professional #10

Practice 2: Involvement and Engagement of Family and Key Individuals

This practice refers to the willingness to involve families and key individuals throughout the person's care and recovery journey, from the very beginning of the process, not just when things go wrong. The data showed that most teams did not work closely enough with the person's family or key individuals. This reflection led several teams to improve the ways in which they consider and understand the role of families and to initiate significant practice changes to improve their involvement and engagement of family and achieve better intervention outcomes.

> (…) family, what I get out of it, is (…) that we don't work enough with the family. It made us aware, we saw, after that, a team effort to engage others. (…) [There's] a case that comes back to me (…) It's been many years since the status quo; there's nothing moving and… we started working with the father. Basically, it wasn't much, but it was to let him know what we were working on with his son and where we were headed. (…) it's just been helpful (…) I'll tell you that even… we didn't believe it that much, but it

> worked. We managed to get the person into therapy… into rehab for… a few months. Therapy that he has successfully completed. ICM professional #7

> (…) our main impact… (…) I come back with the families (…) to involve them more (…) less in conflict resolution or… (…) but when it goes well (…) The idea was to see: "Okay, well such a person is significant, is very much in her life. Can we all brainstorm together about what would keep things going well or take you a little further in your goals?" ACT clinical supervisor #12

Practice 3: Using a Recovery Plan

This practice implies using a recovery plan more consistently and regularly during follow-ups. The recovery plan is a tool for personal support, self-management of one's mental illness and is used to guide one's recovery and wellness process. It is for the person him/herself, and may or may not involve professionals. Rather than restricting itself to a parsimonious or confined use at the end of a care episode or simply using it as a "safety net," the project demonstrated the benefits of it throughout the interventions.

> The recovery plans (…) just when they were closing files so there'd be some kind of safety net. So, now, the recovery plan is more present throughout the intervention… (…) it's still not far behind in the follow-up. ICM clinical supervisor #13

Practice 4: Providing Solutions in the Person's Living Environments

This practice concerns the increased use of resources and solutions in the person's living environment. In particular, contacts with landlords and the search for solutions with them were given a greater consideration. For example, the establishment of a lease with specific clauses to defuse sensitive situations. In many contexts, the teams realized the importance of the living environment and the involvement of a significant individual in a recovery process. Teams then facilitated contacts within the community.

> (…) I'm proud of myself on this. (…) There were some landlords who were uncomfortable renting to our clients … In consultation with those with whom we already had (…) good links, we began to draw up leases with specific clauses. That is, we keep the head lease, but there's a cover letter next to it, specifying that instead of kicking him out after a warning, [there will be] an intervention by the owner [who] will contact the ACT team member. Second [time], [there] will be an intervention by the owner and the ACT together to come up with solutions to help the client stay at home. (…) The third [time], it's really going to be a months' notice, on both sides, to give time to the person to find an apartment, to relocate. ACT professional #10

Practice 5: Valuing a Worker's Role

This practice reports quotes from professionals and clinical supervisors who emphasize the increased energy devoted to employment support. While a traditional intervention often swept away the return to the regular workplace for "clinical reasons," the project reinforced the importance of maintaining a worker's role in a process of recovery and improvement of the person's living conditions.

> (…) I would say that in terms of employability. (…) the ideas or strategies that we exchange (…) are not always limited to approaches or referrals to protected or adapted resources. We're trying to think about getting people to do more… that they can have experiences in environments… let's say "natural" [regular employment settings] (…) I would say that, for me, it's part of (…) the things that have changed in my

> approach to group supervision and that are transferred (…) I see receptive professionals in there. ICM clinical supervisor #8

> (…) before, I was perhaps a little less interested, [about] "Emploi Québec"'s websites… (…) I made a little handout for clients "preparing for an interview." (…) All "Pass Action" programs [a social assistance and support program offered by "Emploi Québec" whose objective is to develop social and professional skills related to an employability process], they don't necessarily have to practice for an interview. (…) it's really changed… ACT professional #3

Perceived Benefits on Quality of Services

The perceived benefits on the quality of services reported by ACT and ICM teams covers the four dimensions identified in the analytical framework (Parson's Social System in Rocher, 1988). They refer to services that (1) meet the expressed needs of mental health community support service users; (2) promote the recovery of individuals; (3) allow coordinated work between the various stakeholders; and (4) support shared, recovery-oriented values, attitudes, and behaviours.

> (…) she [professional] went to play cards with this person for several weeks to try to work on objectives (…) this man had always been opposed to follow-up (…) by involving him more (…) he feels less that we are against him (…) it even led us to give him some support, that support had a positive ripple effect (…) We feel much less like we had failed. It's a lot less frustrating for us. ACT clinical supervisor #12

> (…) the downside was that (…) by involving the father (…) it just made it so that we were able to mobilize the [service] user. ACT professional #7

> (…) it did, in fact, break some deadlocks. It allowed the psychiatrist to be involved and follow what the person named, what he really wanted. (…) to accompany him in the expression of his will in front of the psychiatrist (…) it [led] the psychiatrist to become more involved and to want to accompany him in this. Rather than having closure. ICM clinical supervisor #8

> (…) by having an, attitude, precisely, more respectful or more of a companion and not a decision-maker, I think that the relationship with the client [has] strengthened (…) there's a sense of mutual respect and non-judgment (…) it just validated that it was the right attitude to have to build lasting relationships (…). ACT professional #9

DISCUSSION

The main objective of the CÉRRIS and CNESM partnership was to facilitate access to best recovery-oriented practices and to support its uptake within mental health community support teams in Québec. Partners also aimed to innovate in clinical support and supervision mechanisms using ICTs. The study suggests that the knowledge translation program implemented met the objectives and shows positive results.

In terms of perceived gains, the ACT and ICM participating teams noted the positive benefits of quick access to scientific evidence and mechanisms for exchange and reflection. This easier access to knowledge triggered new reflections and insights into their practices (conceptual and reflective use). In particular, by enabling professionals to increase their skills in reflective practice and the ability to self-monitor gaps between regular and recovery-oriented practices, it led professionals and clinical supervisors to discuss their practices and change some of their decisions (both in terms of clinical processes and intervention practices).

Practices are more focused on recovery as they promote more clearly self-management and empowerment, enhance family and key individuals' involvement, and move towards solutions in the living environment of the person, etc. As the teams worked differently with family members and key individuals, some benefits were also reported in the quality of services provided. There is also an improved coordination between the various stakeholders in the mental health system and services are more attuned to the person's needs.

Facilitating Factors Observed

During this project's implementation, the conditions for success were to ensure that teams had (1) clear support from directors and decision-makers that legitimized the time spent in reflective practice; (2) up-to-date content and credible support and feedback mechanisms based on integrated knowledge (scientific, clinical, and experiential); (3) time for reflection and discussion to address the issues of their local realities; and (4) concrete support that met participants needs.

- Both partners (CÉRRIS-CNESM) are acknowledged for their expertise within the mental health care and services network. The CNESM, as a governmental body (MSSS), provides legitimacy to the process. Its association with a research centre gives credibility and improves the quality of the content broadcast. The activities and techno-educational tools developed in the program are integrated into the CNESM's certification process, which includes clinical support to teams and recommendations for continuous improvement processes. This support must be complementary with the use of evaluation and feedback mechanisms (e.g., fidelity grid; Bond & Drake, 2017).
- The commitment of managers, allowing monthly communities of practice for clinical supervisors and the involvement of their teams was also a fundamental criterion facilitating the use of the program's toolkit. The value of time for discussion and reflection and the adjustment of expectations (e.g., by accepting and acknowledging time for clinical supervision) was a concrete support from managers. The professionals were thus validated in their efforts to acquire scientific evidence and participate in a reflection on their practice.
- The use of ICTs and the open-access virtual library providing simple and user-friendly tools seems to accelerate the appropriation of scientific knowledge. Considering an average investment of time of 30–90 minutes per two months (including listening to the video capsule, team discussion, and participation in webcast conferences, etc.), the teams had the appropriate support mechanisms to initiate reflection and guide actions and decisions.
- As the program's toolkit is developed in co-construction knowledge (bringing together research results, clinical experience, and lived experience) and based on the identification of needs, it is properly adapted to the people for whom it is intended.

These conditions for success are in line with the literature in the field (Briand & Menear, 2014; Thornicroft et al., 2008). The implementation of best practices is not limited to simply understanding the evidence and the gaps between desired and actual services. It involves all levels of decision-making and concrete support mechanisms. Based on a review of the literature, Briand and Menear (2014) identify six facilitating factors:

1. Clear support from national and regional decision makers who legitimize an ongoing process (Isett et al., 2008).
2. Concrete support of managers and clinical supervisors who are responsible for creating a culture of practice improvement and adapting expectations and performance indicators for new demands (Bond & Drake, 2017; Gold et al., 2006).
3. Support and feedback mechanisms (supervision and coaching, monitoring practices with feedback, fidelity scales) offered by credible and legitimate entities (Bond & Drake, 2017; Gold et al., 2006).
4. Discussion and knowledge-sharing activities to participate in the movement towards improving practices, while respecting one's professional identity and autonomy (exchange activities, learning communities, etc.; Carlson et al., 2012; Dorsey et al., 2017).
5. Time and resources to reflect, experiment, and develop a sense of competence for both professionals and clinical supervisors (Carlson et al., 2012; Dorsey et al., 2017).
6. Access to knowledge and interactive methods of teaching and skills development (e.g., using ICTs; Doebbeling et al., 2006).

Challenges

While numerous positive results were observed, some challenges were encountered during this first step of implementation. The main challenge is access to technological resources (internet service, equipment, technical support, digital literacy training, etc.) within healthcare settings. Public healthcare settings too often experience a digital divide—in contrast to the private or the educational sectors (Hollis et al., 2015). This situation hinders the development of a culture of improved practices and real-time use of knowledge in decision-making, where the use of techno-educational tools and activities are now essential. Another challenge experienced by some teams is staff turnover and the lack of time dedicated to reflective practice. Learning communities, places of exchange and discussion must take part of the daily work of mental health professionals (Bond & Drake, 2017). Time for individual reflection, trial, group discussion, supervision, and adjustment to the local context is a key component in the continuous improvement of practices. In the context of the study, it is important to mention that a major transformation of the Québec healthcare system was carried out and came in conjunction with the implementation of the program. This context limited the time dedicated to the project. At last, another challenge was to ensure the respect for a reflective practice culture that combines improved practices and professional autonomy. Since the Québec's mental health system is based on the decision-making autonomy of qualified professionals, it must support transversal reflective mechanisms (rather than only vertical quality assessment mechanisms) in order to improve practices. This change of culture, which advocates collective reflection, in a spirit of mutual benevolence and integrated into practice, still requires efforts to be actualized. Despite the desire to design tools that combine knowledge (scientific, clinical, and experiential) and allow for discussion with service users, professionals used the tools mainly among themselves, without involving service users very often, for making changes in practice or decision-making. This important step in co-reflection requires a more integrated application of recovery principles in practice and a paradigm shift, which is not yet the situation for the majority of the

teams. However, teams continue to use the program's toolkit, increasingly on their own and as needed. The sustainability of the initiative is thus integrated.

Limits

This study addressed the perceived (rather than observable) quality of services provided by ACT and ICM teams once exposed to a knowledge translation program. Even though participants addressed benefits spontaneously, they couldn't be attributable to single effect of the project. Especially considering that only 11 people were interviewed. These exploratory data suggest a potential benefit on the quality of services, and further impact assessment studies are needed to confirm these effects. Also, it may be possible that only participants who were supportive of the program participated in the interviews, despite our desire to compose a reasoned sample representing a diversity of perspectives. Although we believe that data redundancy allowed us to achieve a good understanding of the perceived impacts of knowledge translation program required in this qualitative research, we cannot confirm this. Finally, as it wasn't the primary focus of this project, no service users, family members, or other mental health teams were interviewed, a higher number of interviews would have been required.

CONCLUSION

The results of this study suggest its potential to increase the appropriation of recovery-oriented best practices within ACT and ICM teams. Indeed, supporting reflective practice in mental health teams appears to lead to increased knowledge uptake. The production of simple tools derived from integrated knowledge (scientific, clinical, and experiential) seems to facilitate the uptake by stakeholders (managers, clinical supervisors, and professionals). In addition, the dissemination of tools through technology provides access to best practices at your fingertips.

This first step of implementation supports the relevance of maximizing the benefits of this innovation. Accordingly, a second step of the program deployment is currently underway within primary care services. As the program is designed to meet the needs of all those involved (managers, clinical supervisors, professionals, service users, and family members), this innovation has the potential to improve practices and the quality of services for the benefit of the persons who use them, members of their families, and the community. Further evaluation results will be published in the future on these topics.

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