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Gateway to FamilySmart™ Evidence

Communities of Practice (CoP) as a Vehicle for Systemic Change in Child and Youth Mental Health Care

QUICK FACTS

Factors that contribute to successful CoPs include (taken and adapted from Ranmuthgala et al., 2011, Table 2):

- Committed facilitators
- Shared purpose
- Commitment and enthusiasm from members
- Endorsement of the CoP from senior management within organizations
- Alignment of the CoP objective with organizational goals
- Self-selected membership
- Regular communication and interaction between members
- Development of relationships through face-to-face interactions (even if at the start)
- Easy access to knowledge or evidence
- Infrastructure to support the work of the CoP

When it comes to changing clinical practice, the dissemination and integration of local and academic knowledge often falls short of actual change (Barwick, 2009, 2012; Novins, 2013). Principles, such as collaboration, can be vague and thus challenging to develop into practical strategies. To address these gaps, knowledge translation efforts - that is the bridging of knowledge into the domain of practice to improve health and mental health services (CIHR, 2012) - have been developed and utilized. The purpose of this article is to highlight an emerging knowledge translation approach, known as **Community of Practice (CoP).**

CoPs are one of the most influential concepts within social sciences in recent years (Hughes et al., 2013, p. 1). CoPs are "*groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis*" (Wenger, 2002, p. 4). It can be considered as a way to structure collaboration and collective learning in response to complex systemic challenges, as well as foster conditions for innovative problem solving (McKellar et al., 2014; Chu & Khosla, 2009).

The Conceptual Development of Communities of Practice

CoPs originated in education, has been applied business practices, and more recently to health care systems as a strategy to improve services (Barwick et al., 2009). The original conceptualization of CoPs comes from Lave and Wenger in 1991, with later seminal works by Wenger in 1998 and in 2002. Initially it was formalized as a theory for understanding learning within workplace settings through interactions between novices and experts (Li, 2009). It later developed into a way for understanding situated learning and, in its most current iteration, can be used as management tool to invoke practice change in systems (Li, 2009). Despite its different formulations, at the core of CoPs is a social theory about embedded learning through purposeful relationships and social participation (Kilbride, 2011). It is a learning community focused on improving professional knowledge and skills through collective learning (Li et al., 2009).

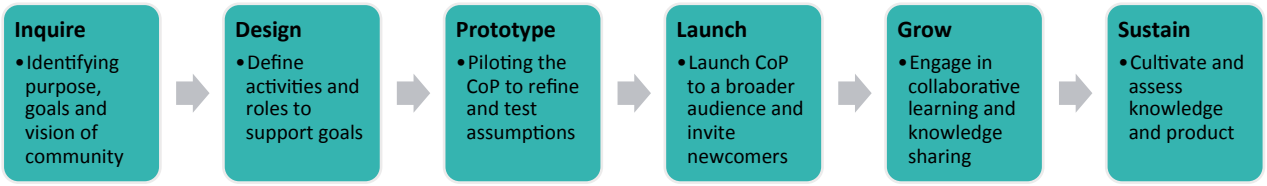
CoP is a type of collaboration that intersects with other collaborative efforts, such as alliances, community of interests, and knowledge networks (see Creech et al., 2012; McKellar et al., 2014; **Ranmuthgala 2012**). Many of these efforts share common features, with some subtle differences in purpose, membership, and formality (Creech et al., 2012). What differentiates CoPs is that it is a voluntary and purposeful individual collaboration that is centered on joint learning (Wenger, Trayner, & De Laat, 2011).

Key Components of a Community Practice (Wenger, 2004)

CoPs can take on many different forms and are meant to be dynamic in nature as it adapts to the system and community that it is implemented in (Ranmuthugala et al., 2011). It can be informal or formal, large or small, homogeneous or heterogeneous, short-term or long-term, and can consist of pre-defined (i.e., facilitators and subject matter experts) or undefined roles (Ranmuthugala et al., 2011; Wenger et al., 2002). Factors that contribute to helping one CoP may be a hindrance to another (Ranmuthugala et al., 2011). Nonetheless, all CoPs share the following (Barwick, 2009, p. 17):

1. *Domain of knowledge* – the common grounds for the community to gather, fosters a sense of common identity, and inspires members to contribute and participate.
2. *Community* – people who care about the domain and voluntarily come together to build relationships, exchange knowledge, inquire and learn from one another.
3. *Practice* – the body of knowledge, which includes frameworks, tools, language, documents, and stories shared by the community and its members.

A review of the literature on CoPs found that groups demonstrated, to varying degrees, and had processes that addressed the following: (a) *social interaction*, in formal or informal settings and in-person and/or online; (b) *knowledge-sharing*, a process for sharing information; (c) *knowledge-creation*, development of new strategies and knowledge to address problems; and (d) *identity building*, the formation of a group identity (Li et al., 2009). When it comes to forming a CoP, its life cycle typically consists of the following (taken from Cambridge, Kaplan & Suter, 2005):



The structure of a CoP is fluid and is dependent on its goals, purpose, and membership. Though early research and development of CoP was based on face-to-face or collocated communities, an emerging trend is the Virtual CoP or Internet-Mediated CoP (Apostolos, 2010; Gunawardena, 2010). The Virtual CoP differs from traditional forms of CoPs in that it is not place-based, membership do not necessarily have to follow certain norms, there are no distinct border between membership, identification is based on ideas and tasks as opposed to place, there are more fluid boundaries and greater flexibility, and less predictability on how products of the CoP are used (Apostolos, 2010). Regardless of how internet technologies are utilized, it is important to recognize that these technologies are meant to complement CoPs and not replace them (Apostolos, 2010).

Community of Practice and Child and Youth Mental Health

CoPs have been used to influence policy, improve health outcomes, and reduce health inequalities (Bertone et al., 2013). The benefit of CoPs is that its structures are iterative and enable members to experience, reflect on actions, and adjust to feedback in social community and environment (Kothari et al., 2015). A review of the research indicates that CoPs within health care systems contribute to factors that may lead to improvements in service provision (Ruthmangualn et al., 2011). Specifically, CoPs have been found to support knowledge sharing (Iaquinto, 2011), improve standards of general practice (Jiwa, 2009), and improve waiting times in health care (Huckson, 2004).

Within Child and Youth Mental Health, researchers in Ontario compared the use of CoP to practice as usual for the integration of evidence-based practice. They found that those who were part of a CoP over the period of a year yielded better content knowledge, greater use of the tools of practice, and increase satisfaction with the implementation of practice supports. Though the study did not demonstrate improved service outcomes, it is still an example of how CoPs can lead to integration of promoted practices within a child and youth mental health system (Barwick et al., 2009). Other examples of CoPs in the Canadian mental health care systems can be found in Table 1.

Table 1. Examples of Community of Practices in Canadian Mental Health Systems

Community of Practice	Domain	Community	Practice
Integrating recovery-orientated practices in Quebec's mental health care system (Piat et al.,2015)	Making recovery a reality in Quebec and to facilitate full participation of civic life of people with mental illness	Face-to-face meetings with 38 members from a variety of community and public organizations (i.e. service users, practitioners, family members, administration, and researchers)	Knowledge translation and sharing of local recovery practices; develop broad strategies such providing recovery training to service providers; and introducing recovery "change agents" in organizations.
ECHO Ontario Mental Health at The Centre for Addiction and Mental Health and the University of Toronto (Portico)	To equip primary care providers with applicable knowledge and collegial support to manage complex mental illness and addictions needs within their practices.	Online community made up of specialists from the fields of mental health and addictions that are primary care providers, such as psychiatrists, family physicians, and social workers.	Based on a 'Hub' and 'Spoke' model of knowledge dissemination and capacity building. Knowledge exchange between academic health science centres and the frontline of community care.
Collaborative Opportunities for Resources (CORe) in Richmond and Vancouver (CORE)	Improve family wellness in communities by improving service navigation, increasing interagency collaboration, and working with families to identify needs and service gaps.	Face-to-face meetings with service providers. Members include professionals from mental health, addictions, school districts, police, child protection, community services.	Sharing of localized knowledge and community needs; development of projects to address service gaps; and fostering partnerships with other organizations to enhance services.

Challenges and Opportunities

Despite the proposed benefits of CoPs, it is important to understand that empirical evidence on its effectiveness is still limited (Li et al., 2009; Ruthmanguan et al., 2011). The reasons for these limitations are due to the changing definitions of CoPs (Li et al., 2009), lack of agreement on how to evaluate CoP effectiveness and influence (McKellar, 2014), and varying CoP structures make it difficult to compare past research (Ranmuthugala et al., 2011). Thus, the fluid and emergent structure of CoPs, though beneficial to changing systems, can be problematic for evaluation (McKellar, 2016).

To continue to support the uptake of CoPs in child and youth mental health, limitations in research and evaluation will need to be addressed. For instance, Participatory Action Research (Kilbride, 2009) can be well-suited for studying CoPs given its emergent quality and focus on community needs. It is also important to understand that it is impossible to isolate the effects of CoPs based on a linear evaluation perspective, thus examining other dimensions such as the value of CoPs within organizations, may be more appropriate (McKeller, 2014). Lastly, a realist approach to evaluating CoPs that is centered on how, why, and when an intervention works can be more beneficial than measuring an unrelated pre-defined outcome (Ranmuthangala, 2011). Integration of these strategies can contribute to enhancing the research and evaluation agenda of the CoP.

- Development of CoPs
  - http://ktdrr.org/resources/rush/copmanual/CoP_Manual.pdf
  - CoPs Design Guide - https://net.educause.edu/ir/library/pdf/nli0531.pdf
  - Tips for CoPs - https://www.icohere.com/Community_Engagement_Tips_and_Tricks.pdf
  - Learning module for CoPs - http://www.excellenceforchildandyouth.ca/building-and-sustaining-effective-communities-practice-cop#
  - Ontario Centre of Excellence - http://www.excellenceforchildandyouth.ca/sites/default/files/eib_attach/CommunitiesofPracticeandInterest_FINALREPORT.pdf
  - Wenger, E. (2002). Cultivating communities of practice: a quick start up guide. Accessed November 2013 from http://ec.europa.eu/employment_social/equal_consolidated/data/document/0709-copguide_en.pdf
- CoPs as an online entity (Rolls et al., 2016)
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4933801/
  - Jevack (2014) - http://search.proquest.com/openview/52617e0b244e618833417b71f0d86f95/1?pq-origsite=gscholar for nursing practices
  - Gunawardena, C. N., Hermans, M. B., Sanchez, D., Richmond, C., Bohley, M., & Tuttle, R. (2009). A theoretical framework for building online communities of practice with social networking tools. *Educational Media International*, *46*(1), 3–16. https://doi.org/10.1080/09523980802588626

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Portico. Project Echo- see https://www.porticonetwork.ca/web/echo-on-mh

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