

After the workshop: what then...?

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The Learning Conundrum

- Typical approach
 - Get training
 - Get inspired
 - Go home
 - Good luck! (you are on your own)

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The Learning Challenge



From holistic values

→ To effective skills

→ To integrated practices

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Beyond Workshops

- Knowledge *mobilization* (from knowing about to knowing how to actually do)
 - Attitudes, values, beliefs
 - Better practices
 - Skill development
- Supervision, consultation, “technical support”
- Building affinity groups – local, regional, provincial

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Building A Community of Practice (CoP)



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CoP Definition



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- ***Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly.***

(Wenger, 1998)

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Basic structure of a community of practice:

- **Domain**
 - Creates common ground and a sense of common identity
- **Community**
 - Creates the social fabric of learning; fosters interactions and relationships; encourages willingness to share ideas, ask questions and listen
- **Shared practice**
 - The set of frameworks ideas, tools, information, styles...

Wenger, 2002

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7 Principles of CoP

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The group is dynamic

- Design for evolution
- Shepherd their evolution
- They are dynamic in nature
- New members bring new interests
- Reflection and redesign

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The group is built on the collective experience of community members

- Open dialogue between inside and outside perspectives
- Insiders appreciate what is at the heart of the domain
- Outsiders help members see the possibilities
- With the inside knowledge and outside perspective members can be agents of change

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leadership and participation in the group is shared

- People participate for different reasons
- Levels of participation:
 - Coordinator
 - core group/leaders
 - active group
 - peripheral members
 - intellectual members

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It includes public and private interaction

- Like a local neighborhood
- There is one-on-one networking
- There are public events open to all
- At the heart are the relationships
- Private interaction enriches public events

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It provides value to its members

- Focus on value
- To the organizations, the teams they serve, the members
- Remember participation is voluntary
- It takes time to establish this value
- May not be what you initially expect

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It is familiar and interesting

- Combination of familiar and excitement
- Pattern of meetings, web activity...
- Divergent thinking brings interest
- Invited guests to challenge the group

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It has its own rhythm

- Regular meetings, telecons, web activity creates the rhythm
- Gives community a sense of movement and liveliness
- Its not too fast or too slow
- The rhythm changes and evolves

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Negotiating meaning:
a dance of **reification** and participation

• **Reification**

- Turning something abstract into a "congealed" form, represented for example in documents and symbols.
- Helps prevent fluid and informal group activity from getting in the way of co-ordination and mutual understanding.
- On its own - and insufficiently supported - unable to support the learning process

– Wenger, 1998, p. 61

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Reification

- *"But the power of reification – its succinctness, its portability, its potential physical presence, its focusing effect – is also its danger ... Procedures can hide broader meanings in blind sequences of operations. And the knowledge of a formula can lead to the illusion that one fully understands the processes it describes."*

• Wenger, 1998

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Negotiating meaning:
a dance of reification and **participation**

- **Participation**

- active involvement in social processes.
- not just translation of reified method into embodied experience, but recontextualizing its meaning.
- Participation as essential for getting around the stiffness and the ambiguity of reification.

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Participation

- ***“... If we believe that people in organisations contribute to organisational goals by participating inventively in practices that can never be fully captured by institutionalised processes we will have to value the work of community building and make sure that participants have access to the resources necessary to learn what they need to learn in order to take actions and make decisions that fully engage their own knowledgeability.”***

Wenger, 1998

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Better practitioners...

- *The central issue in learning is becoming a better practitioner, not learning about practice. This approach draws attention away from abstract knowledge and cranial processes and situates it in the practices and communities in which knowledge takes on significance."*

(John Seely Brown)

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Functions

- Legitimizing participation
- Negotiating strategic context
- Being attuned to real practices
- Fine-tuning the field
- Providing support

Wenger, 1998

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Concurrent Disorder Communities
of Practice (CoP)
Our experience



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Getting people on board

- Organizational commitment and buy-in
- Contracting between CDON/CAMH and agencies
- Explicit understanding of roles, deliverables, resources, supports
- Policy validation and rewards for collaboration and formal partnership agreements

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Why CoPs in CD

- To support people working with family members and those who have a CD
- To provide a setting where information and experiences can be shared
- To encourage the increase of skill and confidence when working with concurrent disorders

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Building a Motivational Interviewing CoP for CD

- A group of 25 practitioners were selected and trained in MI for CD in Toronto in February of 2008:

Their expectations:

- Attend the training
- participate in the hub, teleconference and the exchange of information
- They would deliver a minimum of 2 MI trainings in their area in the next year.

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Building a Motivational Interviewing CoP for CD

- Since that time...
 - 61 training events have taken place
 - Over 1178 people have been trained in MI all over the province of Ontario

Evaluation process

- Various participants were asked to participate in a survey to verify the usefulness of the COP. Here are some of the responses
 - a) **What were your expectations going into the project?**
 1. share work and purpose
 2. to access resources, including provincial resources
 3. have people to go to as resources
 4. have a community of people to talk/meet with
 5. bring training to staff; do training; give presentations
 6. learn more about MI from experts
 7. learn unique ways to work with people

Evaluation...(con't)

Have those expectations been met? YES

1. I have the resources that I can access
2. Learned more through the hub
3. Learned more about MI Telecons
4. Communicate with colleagues and networking opportunity
5. Mostly liked meeting everyone, the supportive and enthusiastic group was good
6. The collective positive energy was good
7. Liked the website for information

Evaluations...(con't)

- **Was the commitment met? (delivery of 2 MI trainings in their area)**
 - Most trainings were met.
 - The audiences included nurses, social workers, psychologists, psychiatrists, occupational therapists, dieticians, students, case managers, supervisors, counselor.
 - They ranged from short introductory sessions to full two day sessions but most were ½ to 1 day sessions.

Evaluations...(con't)

- **Did the CD MI CoP build your capacity for training in MI?**
 - Increased my skill and confidence as a trainer
 - I knew I had the resources behind me.
 - It enhanced my capacity as a trainer and with MI
 - Made me more interested in the topic, it's a good way to address MI and CD
 - The training in Toronto was helpful, the role play was helpful

Building a CD Family CoP

Background:

Community Forums held in 2005-2008 in Ottawa, London, North Bay, Kingston, Hamilton, Whitby, Thunder Bay and Toronto

Evaluation question

Which of the following would be useful to you to deliver a concurrent disorder family intervention?

Response:

Networking Opportunities with other family intervention facilitators outranked consultation and other methods

Building a CD Family CoP

COP built on providing:

12 week Concurrent Disorder Family Education and Support Group

Based on the format developed and researched by Dr. Caroline O'Grady (CAMH).

Materials includes Family Guide to Concurrent Disorder (for the family) and the accompanying Facilitator's Guide (O'Grady & Skinner, 2007)

Evaluation component led by Caroline O'Grady

Building a CD Family CoP

Obligations:

Receive training in Toronto (2 trainings were done)

Recruit and implement 2 full sessions within a 2 year period

Agree to participate in ongoing sharing and discussions ie, teleconferences, camh hub, and inter agency communication

Building a CD Family CoP

- LHIN 1 - Chatham
- LHIN 2 - Owen Sound, Stratford
- LHIN 4 - Hamilton, St.Catherines
- LHIN 9 - Toronto (CMHA) + CAMH site
- LHIN 10 - Kingston
- LHIN 11 - Ottawa (French), Hawkesbury (French)
Cornwall
- LHIN 12 - Bracebridge, B'saanibamaadsiwin
- LHIN 13 - Kaspuskasing, Sudbury

Building a CD Family CoP

PRINCIPLES

- ❖ That all the COP members have an equal access to the COP
- ❖ That all the members are 'experts or experts in training'
- ❖ That all feedback is appreciated and valuable
- ❖ Each community has its own challenges and capacities to help families (some more than others)

Family Community of Practice EVALUATION DATA

- Mixed methodological framework
- Processes + outcomes (qualitative + quantitative data collection / analysis)
- Demographic Data
- Combining Groups (issues of equivalence & fidelity)
- Results of paired samples t-tests
- Additional evaluative data
- Qualitative feedback

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Demographic Data

- All groups (to date) were combined
- Mean group **participant age** = 51.4 years (32.5 female; 11.1 male)
- Mean **consumer age** = 31.9 years
- '**Marital**' status of group participant (family member): 27.2% married; 5.3% single; 2.9% divorced; 2.9% common-law; 2.1% separated; 1.2% widowed

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Demographic Data

- **Relationship of family member participant to ill relative (consumer)**
- 31.7% parent
- 5.3% sibling
- 3.7% spouse
- 1.2% adult child of ill person
- 1.2% close friend
- 1.2% other blood relative (e.g. Grandparent, uncle, aunt, etc.)
- 0.8 % partner

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Demographic Data

- **How many people living at home?**
- 1 person = 4.2%
- 2 people = 14.0%
- 3 people = 11.5%
- 4 people = 9.5%
- 5 people = 3.7%
- > 5 people = 0.8%

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Demographic Data

- **Ill family member (consumer) working?**
 - Yes = 30.5%
 - No = 12.8%
- **Where does ill family member (consumer) live?**
 - 21.8% living at home
 - 7.8% own apartment
 - 3.7% another city
 - 2.5% currently in hospital or addiction treatment
 - 1.2% homeless
 - 0.8% university / college
 - 0.8% shelter / mission

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Demographic Data

- **Consumer - Type of Mental Health Problem:**
 - 14.4 % multiple psychiatric diagnoses
 - 11.5% mood Disorder (depression or bipolar)
 - 7.4% uncertain / not yet diagnosed
 - 3.7% schizophrenia
 - 2.5% other (e.g. ADHD)
 - 1.6% currently no mental health symptoms
 - 0.4% schizoaffective disorder
 - 0.4% anxiety disorder alone
 - 0.4% dementia

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Demographic Data

- **Consumer - Drug of Abuse:**
 - 28.4% polysubstance abuse / dependence (more than 1 drug of choice)
 - 7.8% only alcohol
 - 4.5% hallucinogens (primarily marijuana)
 - 1.6% no drug use at present time
 - 0.8% prescription drugs (primarily oxycontin and heroin)
 - 0.4% only stimulants (e.g. crystal meth)
 - 0.4% other depressants (e.g. anxiolytics)

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Primary and Secondary Quantitative Outcome variables

- **Two primary outcome measures:**
 - **(a) Social Support**
 - Education (learning personal mastery skills and self-efficacy skills) =
 - **(b) Empowerment**
- **One Secondary Outcome Measure:**
 - **Caregiver Burden**

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Results of Dependent Samples T-Tests

- Primary outcomes – **TOTAL SCORES**
- N = 89
- **Self-efficacy scale:** (seven items)
- Pre-group total mean X = 20.33
- Post-Group total mean: X = 22.37

- T=-5.324; df = 88; **P = .000 *****

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Examples of statistically significant individual items

- **Self-Efficacy Scale:**
 - **"There is really no way I can solve the problems I have"**
 - Pre-group: X = 2.80
 - Post-group: x = 3.37
 - T=-4.24; df = 88; **P = .000 *****

 - **"There is little I can do to change many of the important things in my life"**
 - Pre-group: X = 3.10
 - Post-group: x = 3.47
 - T=-4.70; df = 88; **P = .000 *****

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Results of Dependent Samples T-Tests

- Primary outcomes – **TOTAL SCORES**
- N = 89
- **Mastery Scale:** (47 items)
- Pre-group total mean: X = 132.52
- Post-Group total mean: X = 145.24

- T=- -8.42; df = 88; **P = .000 *****

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Examples of statistically significant individual items

- **Mastery Scale:**
 - **"When unexpected problems occur, I don't handle them well"**
 - Pre-group: X = 2.69
 - Post-group: x = 3.19
 - T=-5.01; df = 88; **P = .000 *****

 - **"I understand psychiatric medications and their use"**
 - Pre-group: X = 2.89
 - Post-group: x = 3.26
 - T=-3.71; df = 88; **P = .000 *****

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Results of Dependent Samples T-Tests

- Primary outcomes – **TOTAL SCORES**
- N = 89
- **Empowerment Scale (self-efficacy + mastery):** (54 items)
- Pre-group total mean: X = 152.82
- Post-Group total mean: X = 167.57

- T=- -8.95; df = 88; **P = .000 *****

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Results of Dependent Samples T-Tests

- Primary outcomes – **TOTAL SCORES**
- N = 89
- **Social Support Scale** (12 items)
- Pre-group total mean: X =61.38
- Post-Group total mean: X = 65.67

- T=- 2.21; df = 88; **P = .030 ***

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Examples of statistically significant individual items

- **Social Support Scale:**
- *“There is a special person with whom I can share my joys and sorrows”*
- Pre-group: X = 5.41
- Post-group: x = 6.10
- T=-3.25; df = 88; **P = .002 ****

- *“I have a special person who is a real source of comfort to me”*
- Pre-group: X = 5.35
- Post-group: x = 5.92
- T= -2.630; df = 88; **P = .010 ****

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Results of Dependent Samples T-Tests

- Secondary outcome – **TOTAL SCORE**
- N = 89
- **Caregiver Burden Scale** (24 items)
- Pre-group total mean: X =64.01
- Post-Group total mean: X = 53.56

- T=- 6.21; df = 88; **P = .000 *****

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Examples of statistically significant individual items

- **Caregiver Burden Scale:**
- *“My social life has suffered”*
- Pre-group: X = 3.22
- Post-group: x = 2.76
- T= 3.18; df = 88; **P = .002 ****

- *“I feel angry about my interactions with my ill relative”*
- Pre-group: X = 2.72
- Post-group: x = 2.18
- T= 4.14; df = 88; **P = .000 *****

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Was the family CD group beneficial / helpful to you?

- N = 70

- **Very Helpful:** 91.4%
- **Somewhat Helpful:** 5.7%
- **Neutral:** 1.4%
- **Not Very Helpful:** 1.4%

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Additional Evaluative Items

- **Do you think that the family CD support / educational group is a valuable service?**
- Yes = 98.6%
- Missing Data: 1.4%

- **Would you recommend the family CD support / educational group to others?**
- Yes = 98.6%
- Missing Data: 1.4%

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What was the most beneficial component of the family CD support / educational group?

- *All components beneficial:* 57.1%
- Information from peers and facilitators and support from facilitators: 10.0%
- Information from peers and information from facilitators: 7.1%
- Support from peers and information from facilitators: 5.7%
- Information from peers: 5.7%

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Favourite Chapter

- **Recovery** (*session eleven*) – 15.7%
- **Intro to Concurrent Disorders** (*session one*) – 14.3%
- **Family Member (Caregiver) Self Care** (*session five*) – 12.9%

Second Favourite Chapter

- **Impact of Concurrent Disorders on the Family** (*session four*) – 20.0%
- **Relapse Prevention** (*session nine*) – 15.7%
- **Recovery** (*session eleven*) – 11.4%

Third Favourite Chapter

- **Relapse Prevention** (*session nine*) – 15.7%
- **Stigma** (*session six*) – 14.3%
- **Recovery** (*session eleven*) – 14.3%
- **Family Member (Caregiver) Self Care** (*session five*) – 10.0%

Building a CD Family CoP

QUALITATIVE DATA

IS THE FAMILY CONCURRENT DISORDERS GROUP A VALUABLE SERVICE?

The group provided space to reflect, think, breathe – and reminded us that we are not alone. It honours the unique journey of substance use and mental health for families and creates a place of support and respect, where we can learn, vent and speak about our loved one without judgment

(Downtown Toronto, Group 1)

Building a CD Family CoP

I learned so much valuable information. I used this information wisely and it made me understand what living with a loved one with a concurrent disorder is all about. It changed a lot of my beliefs and changed my life in a positive way. (*Owen Sound, Group 2*)

Would you recommend this family concurrent disorders group to others?

Yes – this group was so helpful and hopeful. Caregivers and family members are usually not helped to understand or deal with their loved ones in the present system. (*St. Catharine's, Haldimand Brandt Niagara*).

Building a CD Family CoP

EVALUATING THE PROCESS SO FAR:

- ❖ Excellent participation
- ❖ In some areas recruitment is a challenge but most have completed or are in the process of completing a group (13 out of 15)
- ❖ Participants have been very collaborative in doing pre and post evaluations
- ❖ More process evaluation to come

Beyond the event – CoP as a continuing process

- The training
- Follow-up – what's different
- Hub – portal
- Listserv
- Telemeetings
- Face to face



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Planning

- Building team identity and cohesion
- Planning for local training
 - Finalizing content
 - Developing training strategies
- Target goals for year 1
- Going beyond the concrete deliverables to building CoP
- Finding the balance: reification & participation
- Participation styles – having choices

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Resources

- Michael Beitler, Ph.D., *Communities of Practice* (www.michaelbeitler.com)
- Etienne Wenger, Richard McDermott, and William M. Snyder, (2002) *Cultivating Communities of Practice*
- (www.wenger.com)

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Thank You