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**Article (Accepted version)
(Refereed)**

Original citation:

Cornes, Michelle, Manthorpe, Jill, Hennessy, Catherine, Anderson, Sarah E., Clark, Michael and Scanlon, Christopher (2014) *Not just a talking shop: practitioner perspectives on how communities of practice work to improve outcomes for people experiencing multiple exclusion homelessness*. [Journal of Interprofessional Care](#), 28 (6). pp. 541-546. ISSN 1356-1820
DOI: [10.3109/13561820.2014.917406](https://doi.org/10.3109/13561820.2014.917406)

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Available in LSE Research Online: December 2014

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Not Just a Talking Shop: Practitioner Perspectives on How Communities of Practice Work to Improve Outcomes for People Experiencing Multiple Exclusion Homelessness

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Acknowledgements and disclaimer (to be inserted in full after peer review)

We are grateful to the Economic and Social Research Council for funding this work and to Hassan Soubhi for inspiration and guidance. The views expressed are those of the authors and not necessarily reflect those of the funders. An early version of this Paper was presented at the Social Policy Association 2013 Conference as part of a symposium on 'Doing More for Less, Supporting Workers in Challenging Roles in Challenging Times'. The authors report no conflict of interest.

ABSTRACT

Within homelessness services recent policy developments have highlighted the need for integration and improved collaborative working and also, the need for 'Psychologically Informed Environments' (PIEs) in which workers are better equipped to manage the 'complex trauma' associated with homelessness. Drawing on the findings of an evaluation of a multi-site development programme, this paper demonstrates how both these policy aspirations might be implemented through a single delivery vehicle (a community of practice). The paper describes how organisational, educational and psychosocial theory was used to inform programme design and reflects on the utility of these approaches in the light of the evaluation findings. It is reported that communities of practice can deliver significant performance gains in terms of building collaborative relationships and opening-up opportunities for interdisciplinary education and learning. Filling an important knowledge gap, it also suggested how (professional) participation in a community of practice might work to improve outcomes for service users. Most likely we see those outcomes as being linked to tackling exclusion by sustaining the workforce itself, that is in motivating workers to remain engaged and thinking positively in what is an emotionally challenging and stressful job role.

KEY WORDS: multiple exclusion homelessness, communities of practice, integration, collaboration, 'Psychologically Informed Environments' (PIEs), complex trauma, outcomes

INTRODUCTION

This paper describes the findings of an evaluation that tested the use of communities of practice as a means of improving front line collaborative responses to ‘multiple exclusion homelessness’ (MEH). MEH is a term used in UK social policy to refer to the complex web of problems such as drug and alcohol dependencies and mental health issues that can underpin experiences of homelessness (McDonagh, 2011). MEH draws attention to the need to move beyond housing focussed solutions and to tackle and prevent homelessness through improved collaborative working between a range of health, social care and criminal justice agencies. It is a key aspiration of the UK Coalition government that people will receive the holistic support they need as soon as they come onto the streets and that improved integrated services will support them to remain off the streets (Department for Communities and Local Government [DCLG] 2012a). There is also concern that workers should be equipped to manage the ‘complex trauma’ known to underpin experiences of MEH and also the potential impact of this on their own emotional wellbeing and wider team functioning. This is reflected in calls for the development of ‘Psychologically Informed Environments’ (PIES) (DCLG 2012b).

The ‘MEH Community of Practice Development Programme’ was funded by the Economic and Social Research Council (ESRC) to enhance the impact of an earlier research study that highlighted a number of barriers to achieving the policy goals of integrated service delivery and workforce development (Cornes et al., 2011a). This research highlighted how current practice to support people experiencing MEH was often fragmented and uncoordinated and how individual workers could feel ‘out of their depth’ due to isolated (uniprofessional)

patterns of working. The objectives of this 'follow-on' programme were to explore if communities of practice might overcome these barriers by:

- Providing a vehicle for building more collaborative networks and improving and sustaining relationships between different agencies and professions
- Lead to improvements in front line service responses through knowledge brokerage and opportunities for interdisciplinary education and learning
- Provide shelter and space for reflective practice and interdisciplinary group supervision with opportunities for mutual (collegiate) support.

BACKGROUND

Communities of practice were originally proposed by Wenger (1998) to describe groups of people who share a concern, a set of problems, or a passion about a topic and who want to deepen their knowledge and expertise by interacting on an ongoing basis. The concept of communities of practice is still evolving. In the healthcare sector, they have mostly been developed as unprofessional entities. Here, there is evidence that can play a role in the generation of social, human, organisational, professional and patient capital thus being useful for enhancing care, providing learning opportunities, analysing practice, problem solving, sharing knowledge and generating ideas (Kislov et al. 2011). Much less is known about the development of interdisciplinary communities of practice (Kilbride et al., 2011). Although recent research suggests that they may be an effective vehicle for delivering interprofessional education (Lees and Meyer, 2011). Few studies have explored the impact of (professional) participation in communities of practice on service user outcomes. This is a critical distinction and is the central focus of this exploratory paper. Greig and Poxton

(2001) pose the question of integrative and collaborative working, *'Nice process, but did it change anyone's life?'*

Theoretical underpinnings

It has been suggested that theory is not sufficiently utilised in the context of implementation research (Kislov et al, 2011). With regard to communities of practice, the literature surfaces two distinct theoretical propositions about the instrumental use of communities of practice and how their cultivation might improve collaborative responses in such a way as to impact on service user outcomes. We briefly consider these here to shed light on the underpinning design of the 'MEH Community of Practice Development Programme'.

Theory of collective capability

The first proposition is rooted in organisational management and educational theory and is concerned with enhancing the performance and 'collective capability' of the workforce. The programme logic is that *'quality improvements'* manufactured through participation in communities of practice will necessarily translate as improved outcomes for service users.

Drawing heavily on the theory of 'collective capability', the community of practice model aspired to in this programme comes closest to that described by Soubhi et al., (2010) in the context of improving care for patients with multimorbidity in Canadian primary care. The key features of this model are the use of specialist librarians or 'knowledge brokers' to ensure the integration of interdisciplinary learning and education alongside day-to-day case management activities. In terms of cultivation, these communities rely on organisational support to facilitate: a shared work priority; frequent and timely communication; trust and

mutual respect among members (the flattening of hierarchical structures); co-ordination and ‘task integration’. Soubhi et al. (2010) hypothesise that practitioners engaged in these communities will improve service user outcomes (‘patient care’) by building relationships, reflecting on practice, selecting alternative care strategies, and accomplishing tasks by iterative exploration. Such a process combines structure with renewed improvisations in the face of uncertainty, uniqueness and conflicting values – ‘a learning process akin to what happens in a jazz ensemble’ (Soubhi et al., 2009, p53):

‘High performance in our model is tied to interdisciplinary learning and practice which results from [practitioners’] ability to establish a dynamic balance between organising what they know and do. We call this ability Collective Capability that helps professionals adjust their responses to the complexities of patients needs over time’ (Soubhi 2010, p1)

Psychologically Informed Environments (PIES)

The second proposition about the potential use of communities of practices in the field of MEH is grounded in psychosocial theory and the need for more ‘Psychologically Informed Environments’ (PIES). Scanlon and Adlam (2012) point to the substantial literature describing the ways in which practitioners who work with the ‘complex trauma’ (personality disorder) associated with MEH frequently become distressed and ‘burnt out’ themselves. They describe how workers can feel ‘stuck’ between espoused notions of client centeredness and the social reality that all such help is rationed, conditional and socially controlled. As a consequence workers experience dilemmas and conflicts especially around how to exercise a proper duty of care:

‘Staff come to feel a sense of helplessness that is both a real and imagined threat to their effectiveness and their demand that their anxiety be housed within their teams and organisations becomes ever more urgent’ (Scanlon and Adlam, 2012, p76)

According to Scanlon (2012), where an organisation fails to contain workers’ anxiety this typically increases individualism and patterns of relating that negatively affect a team’s capacity to collaborate and organise effectively. This can lead to a lack of professional accountability, poor practice and poorer outcomes for service users. They suggest that this risk might be reduced through reflective practice and team development consultancy such as that found within in a community of practice:

‘To make the team the focus of attention is to pay due respect to pervasive (dis)organising social defences and potentially traumatising group dynamics that are at the heart of all work with difficult people in difficult places’ (Scanlon, 2012, p214).

The MEH Community of Practice Development Programme

The ‘MEH Community of Practice Development Programme’ ran between March 2012 and February 2013 and was led by researchers from the Social Care Workforce Research Unit at King’s College London and Revolving Doors Agency (an experienced third sector organisation). Space limitations preclude a full discussion of how the programme was established. We would refer readers to the programme report (Cornes et al., 2013a) and an associated ‘tool kit’ that resulted from the learning generated through the programme (Hennessey et al. 2013).

Following a competitive tender exercise, six communities of practice were established in different locations across England (CP1/CP2/CP3/CP4/CP5/CP6). Each host organisation was

awarded a small budget (£6,950) for housekeeping (room hire and refreshments) and to pay a facilitator to undertake the initial brokerage work.

In setting-up the community of practice, the facilitators were expected to recruit a group of between 6-12 front line practitioners from health, housing, criminal justice and social care services whom they considered to be representative of the various 'disciplines' involved in working with people experiencing MEH. One of the six communities of practice failed to gain sufficient members to progress beyond meeting three. It was suggested by the facilitator that this might be down to a recent retendering exercise in which some agencies had lost staff and services to the host agency leading to some bad feeling in the locality.

The remaining five communities of practice established a sustainable interdisciplinary membership base and held six meetings of the course of the programme (most meetings were held monthly). At each meeting a member was asked to present an anonymised case study for discussion. Two of the researchers from the programme team took on the role of 'knowledge brokers' attending all the community of practice meetings to source any research evidence or policy documentation thought to be potentially valuable to the unfolding case study discussion. An online forum and repository for case studies, research information and so on, was hosted by Revolving Doors.

PROGRAMME EVALUATION METHODOLOGY

Because most of the funding for this project was earmarked for the development of the communities of practice, the evaluation was small scale and limited to capturing the views of the facilitators and practitioners taking part in the programme. The evaluation does not therefore constitute an empirically based or objective assessment of service user outcomes.

Rather our aim was exploratory, that is to use the learning and rich insights generated through structured conversations with facilitators and practitioners to shed light on the value of community of practice participation and how this might impact on service user outcomes. Ethical permissions were secured for the initial research of which this extension forms a part.

Data collection and analysis

The evaluation was carried out during December 2012 and was designed to assess to what extent the programme had met its intended objectives. It comprised a focus group discussion with each community of practice (n=5) and a survey of all community of practice members. The focus group discussion (evaluation) was scheduled as part of the agenda for the sixth community of practice meeting and was facilitated by a member of the research team who had least previous contact with that particular group. Members were notified in advance that the evaluation would be taking place and that they were under no obligation to take part. At the end of the focus group participants were asked to complete a short survey questionnaire. Asking participants to complete the questionnaire at the end of the focus group was intended to maximise the response rate. In total 54 practitioners joined the community of practice programme. Of these, 34 participants took part in the focus group discussions. The survey response rate was 61 per cent (n=33/54 members).

The focus groups employed a 'topic guide' that encouraged participants to reflect on their overall impressions and experiences of being part of a community of practice including perceptions of the outcomes that were being achieved both for themselves and the service users with whom they were working. So as not to bias information on the value and outcome of participation, only once this initial discussion was exhausted did the researcher

introduce prompts designed to ascertain more detailed information on the programme's specific objectives. The focus groups were digitally recorded and transcribed and lasted around one and half hours.

The questionnaire was designed to ascertain background information on each community of practice member (for example, on professional qualifications) and members' employer organisations. Further questions were then designed to generate some simple metrics on the extent to which the programme was meeting its objectives (see Table I).

<Insert Table I about here>

In addition to participating in the focus group discussions, the community of practice facilitators were also interviewed separately on a one to one basis (n=6) to capture the learning around setting-up and running a community of practice. Finally, each community of practice was asked to submit a report of its activity and a 'case study' in order to give an insight into the working practices that were emerging.

The data were analysed thematically (by all four members of the research team) against the stated objectives of the programme. For triangulation purposes, the preliminary findings were then 'fed back' to the programme's Advisory Group comprising service users, professional experts and the community of practice facilitators.

FINDINGS

In this section we consider the evaluation evidence in relation to each of the programme objectives. We then consider members' views on how their participation in a community of practice was perceived to impact on service user outcomes.

Building collaborative networks and improving and sustaining relationships

There was good evidence from both the focus group discussions and survey that the communities of practice were effective in building collaborative networks. 94% of those completing the survey 'agreed' or 'strongly agreed' that they had increased their networks and contacts through membership. In terms of improving and sustaining relationships between different agencies and professionals, members appreciated the structured approach to community of practice meetings with clear ground rules for confidentiality and information sharing. The use of anonymised case studies worked well in that it seemed to afford respite from the 'turf wars' that can damage day-to-day joint working relationships.

'[A community of practice is] like a very informal MAPPA (multi-agency public protection arrangements) type process, a multi-agency thing but obviously less protocol in it... A bit more relaxed in a sort of friendly environment and probably a bit more constructive in some ways' (Member CP4)

A key advantage of the temporary 'co-location' afforded by the community of practice meeting was increased opportunities for face to face communication which led on some occasions to care co-ordination and 'task integration'. For example, in one meeting it became apparent that Mrs A was particularly isolated and vulnerable to crises at weekends so she attended the Hospital Accident and Emergency Department. In light of understanding that the agency providing the mainstay of support was unable to provide a worker at weekends, the community of practice police representative asked a Police Community Support Officer to call on Mrs A over the weekend in order to try to break this cycle.

While there was a strong sense that more collegiate working was emerging 'inside' the community of practice, there was some concern that this did not extend further as regards broader interagency working in the locality. In particular, it was notable that each community of practice was left with 'gaps' in terms of its membership. For example, mental health professionals and social workers from adult social care were thought to be particularly hard to engage and as a result relationships with these workers and agencies remained unchanged.

Improvements in front line service responses through knowledge brokerage and opportunities for interdisciplinary education and learning

The communities of practice were all thought to have provided good opportunities for interprofessional education and learning. With little time for reading research articles, the contributions of the 'knowledge brokers' were particularly appreciated. Overall, 94% of survey participants 'agreed' or 'strongly agreed' that their knowledge of working practices with people facing MEH had improved through membership of the community of practice. 91% felt that their skills and competencies had also improved.

'[On first hearing about the community of practice] I thought "Oh God no, it's another meeting"... but I've been pleasantly surprised just how well everyone's related and we do have a vast variety of skills and expertise here... and you're hearing about how different people deal with different problems and it's "Oh yeah I never thought about that" and now I'm sort of seeing things in a different perspective...' (Member CP5)

Shelter and space for reflective practice

The concept of 'shelter' was a pervasive theme in many of the community of practice meetings. Many members were anticipating or undergoing service re-structures or cutbacks to staffing. They reported feeling beleaguered by targets that did not reflect the intricacy of their holistic work with clients. Some were weary at the realities of doing more for less and of what it meant for those whom they are seeking to support. Mitigating this anxiety and sense of frustration was seen to be one of the main advantages of community of practice participation. 97% of members agreed or strongly agreed that the community of practice was a supportive environment in which to discuss these kinds of challenges.

'There's a lot of agencies have clinical supervision and I still do... [The community of practice] feels outside of that. It's very reviving to sit round with lots of people who are coming from different perspectives...' (Member CPI)

Impact on service user outcomes

Despite acknowledging the wide range of benefits accrued through community of practice participation, members were unclear as to how these performance gains might translate as improved outcomes for their service users. There was a sense that in the current economic and political climate of austerity it was becoming increasingly difficult to achieve positive outcomes for people. With the advent of 'payment by results' schemes for example, certain kinds of 'recovery' or 'change' outcomes such as finding employment or becoming abstinent from drink and drugs were being prioritised over those for longer-term maintenance and prevention work. As a result,

‘Having [service users] stabilised for a period of time is an outcome but it’s not one because they’ve not progressed but they’ve not got any worse and actually that’s a bloody big achievement for some of the customers that we’ve been discussing...’

(Member CP4)

Indeed, what often emerged in the community of practice meetings was a sense of mutual frustration about the intractability of many the issues that were being discussed. Particular issues noted across all the communities of practice were, for example, the shortage of accommodation for a homeless young people and the shortage of psychological support services for people with a diagnosis of personality disorder. There was a sense that these ‘wicked issues’ were rooted in longstanding political and structural factors and that communities of practice would therefore be largely powerless to address them. Nevertheless, it is significant that 100% of survey respondents agreed that communities of practice were not just a ‘talking shop’,

‘The value of this [community of practice] is not necessarily moving the customer (client) on, it’s keeping the staff engaged and motivated to continue to do what they’re doing on a daily basis for the customer that’s presenting with the same problem day in day out for three years. That can be quite draining on the staff but actually to sit and talk about it and get that collective support that we’re all going through the same thing gives you a bit more energy and motivation to **carry on** doing whatever it is, for a longer period of time’ (Member CP4, own italics)

DISCUSSION

In a review of the research evidence, Cameron and Lart (2012) note that while many studies explore the process of 'joint working' few have asked either the prior question of why 'joint working' should be seen as a good thing and therefore why it should be done or at the consequent question of what difference it made. In this paper we have sought to address this gap, using theory to inform programme design ('why it should be done') and drawing on the findings of a programme evaluation to explore outcomes ('what difference it made'). In this discussion section we reflect on the utility of the theories we applied in light of the evaluation findings outlined above.

Overall, there was strong evidence that the programme achieved its objectives and that communities of practice could generate a wide range of benefits for members including extended collaborative networks, new knowledge and skills and, on occasions, more coordinated and integrated ways of working. However, the anticipated gains for service users to flow from this 'collective capability' or 'high performance' did not seem to materialise in the evaluation quite as directly as Soubhi's theory might imply. We would suggest that this points to an underdeveloped component in the 'collective capability' theory chain. While Soubhi et al. (2010) suggest that support from senior leaders is important in continually generating value and renewed excitement in communities of practice, we would argue that this does not adequately capture the extent to which the wider economic, cultural and political context can **impact upon** the translation and spread of any performance improvement. For example, the flexibility and blurring of agency boundaries evidenced in Mrs A's case above is something that is often aspired to in descriptions of integrated systems. However, practitioners in that site reported that they would get into

trouble if their managers found out about these practices because service delivery specifications and contracts were now so tight as to prohibit this.

On a practical note the learning that stemmed from this for the programme was the need to explore ways of connecting the communities of practice to their local commissioning structures so, for example where problems such as a shortage of accommodation for young people were identified these were brought to the attention of those who could potentially make changes. Unless this connection can be made in a meaningful way there is the danger that communities of practice will quickly become tired if members find themselves repeatedly discussing the same ‘wicked issues’ to which there are no solutions other than referral ‘higher-up’ the policy chain.

Taking into account the specific characteristics of the multimorbidity linked to MEH and the known impact this can have on the workforce, psychosocial theory did seem to have particular utility. In the evaluation, there was some evidence that coming together as a community of practice supported workers to remain motivated and engaged especially as regard their most ‘difficult’ or ‘troublesome’ cases. It may be that the outcomes potentially achieved for service users as a result of this are linked to more ‘elastic tolerance’ and the prevention of the so called ‘inverse care law’ where people with the most complex needs are excluded from services. In the MEH literature, it is known that repeated exclusions from services are commonplace (a phenomenon known as the ‘revolving door’) and that this is associated with very poor outcomes such as ‘rough sleeping’ and premature death (DCLG 2012b). Here, the community of practice might be seen as a preventative mechanism that supports continuity of care and the delivery of so called ‘maintenance outcomes’ geared toward promoting and general health and wellbeing (Cornes et al., 2013b).

Reflecting on the difficulty of achieving large scale system change which would see all excluded people being 'socially included', Scanlon and Adlam (2011) draw attention to what they see as a societal refusal to face-up to the reality of the problems facing people at the margins of society: *'a denial of their essentially complexity and the role society itself plays in perpetuating the very problems they seek to alleviate'* (p131). The failure to recognise the value of longer term case work and the achievement of 'maintenance outcomes' within the context of some 'payment by results' schemes is arguably one expression of this and further example of how the wider economic, cultural and political environment can 'disrupt' programme logic.

Conclusion

This exploratory paper has considered the dual theoretical underpinnings of community of practice methodology in relation to an applied case study. The evaluation is limited in that it was small scale and carried by those who were responsible for programme delivery. This may have led to some bias towards more positive reporting of the findings and some participants may have been reluctant to share more negative views in front of the programme organisers. More direct service user engagement would also have given greater confidence in the findings as regards the outcomes that were being achieved for service users. However, the evaluation is one of the few accounts of the process of nurturing communities of practice across agencies and professions and the first to consider their use in the context of MEH and PIES.

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Words 4716 (this document) plus Table 349 = 5065

Table 1: Participant Survey Responses on the Extent to which the ‘MEH Community of Practice Development Programme’ Met its Objectives

<i>Objective 1: Evidence that the community of practice (CP) provided a vehicle for building collaborative networks and improving and sustaining relationships between different agencies and professions</i>	<i>Participant Responses</i>
I have increased my networks and contacts through my membership of the CP	94% strongly agree or agree
My knowledge of the role and function of other agencies has increased through my membership of the CP	100% strongly agree or agree
My skills in working with other agencies has improved through my membership of the CP	79% strongly agree or agree
Interagency co-operation in our area has improved as a result of the CP	51% strongly agree or agree
<i>Objective 2: Evidence of improved responses through knowledge brokerage and opportunities for interdisciplinary education and learning</i>	
The research findings supplied by the knowledge broker were	91% helpful or very helpful
It has been helpful to discuss my practice with staff from a range of different agencies.	97% strongly agree or agree
My Knowledge of working practice with people facing multiple needs and exclusions improved through my membership of the CP	94% strongly agree or agree
My skills and competencies in working with people facing multiple needs and exclusions has improved through my membership of the CP	91% strongly agree or agree
There are other opportunities for interprofessional education and development outside of the CP	61% strongly agree or agree
<i>Objective 3: Evidence that the CP provided shelter and space for reflective practice and interdisciplinary group supervision with opportunities for mutual (collegiate) support.</i>	
The CP is just a ‘talking shop’, it was <i>not</i> a good use of my time	0% strongly agree or agree
The CP is a supportive environment in which to discuss the challenges in my work	97% strongly agree or agree
The CP acted as a ‘critical friend’, constructively challenging my practice	78% strongly agree or agree
There are other opportunities to reflect on my work outside of the CP	58% strongly agree or agree
	Response Rate 61% (33/54 members)