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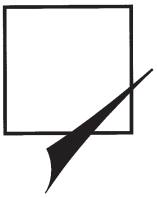

Situated Learning in Communities of Practice

Evaluation of Coercion in Psychiatry as a Case

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A common model for learning from evaluation assumes that learning occurs when evaluators transmit findings and conclusions to programme participants and stakeholders. Learning is then understood as a cognitive act, happening in the mind of an individual and separated from the rest of our activities. In recent years, this common model has been challenged by scholars who argue for 'situated learning' in 'communities of practice'. This alternative conception emphasizes the context-bound nature of learning (versus learning from material abstracted from context) in relationships between people and implies an intimate connection between knowledge and action. Using as an example an evaluation of a coercion project in Dutch psychiatry, this article illustrates and highlights some of the implications of this conception in terms of the learning that occurs and the roles of the evaluator in developing communities of practice.

KEYWORDS: communities of practice; politics; psychiatry; relationships; situated learning

Introduction

It is commonly understood that evaluation contributes to the knowledge of programme participants and other stakeholders, and that they will learn from an evaluation. Yet the topic of learning from evaluation and what we assume about learning and knowing are underdeveloped concerns in evaluation (Schwandt, 2004).

A traditional model for learning from evaluation assumes that learning occurs when evaluators transmit findings and conclusions to programme participants and stakeholders and that they will then process and absorb that information. This transmissional view on information processing understands learning as a cognitive act, something that occurs in the mind of an individual, separate from the rest of our activities. Conducting an evaluation, acquiring knowledge and applying it are

thought of as distinct steps. Schwandt (2004) specifies the underlying assumptions, which can also be found in both behaviourist and cognitive theories of learning, as: (1) the basic psychological processes of learning and cognition are considered the starting point for what it means to know and learn; (2) knowledge is thought of in terms of generalized propositions (statements) and symbolic representations that one 'possesses' or 'has' as a kind of knowledge capital; (3) learning is an 'internal' operation – it takes place in the mind of individual knowers.

This conceptualization of learning has been criticized by a number of scholars who argue that this model is based on questionable assumptions (Abma, 2003; Brown and Duguid, 1996; Lave and Wenger, 1991; Nicolini et al., 2003; Niessen et al., 2004; Schwandt, 2004). First of all, practitioners do not have a static relationship to knowledge. Ideas and knowledge change over time and in relation to context. Second, this model does not acknowledge the fact that people will have to interpret knowledge, and that the interpretation and application of knowledge is normative and thus always influenced by interests and values. These criticisms suggest that a new way of studying what it means to learn from an evaluation entails attending carefully to the actual and unfolding learning process amidst a community of practice.

The idea of 'situated learning' in 'communities of practice' emphasizes the context-bound nature of learning (versus learning from material abstracted from context) in relationships between people. In this conception, there is an intimate connection between knowledge and action. Knowing and learning are dynamic and collective processes unfolding in a social context where people act and interact with each other. Hence, evaluation is situated within a social context that requires participation and deliberation (versus a technical activity that requires knowledge of methods and principles) (Schwandt, 2001, 2004). Evaluation is in this conceptualization 'intimately concerned with the timely, the local, the particular and the contingent (e.g. what should I do *now*, in *this* situation, given *these* circumstances, facing *this* particular person, at *this* time)' (Schwandt, 2001: 229).

This article explores some of the implications of situated learning in communities of practice in terms of the learning that takes place and the roles of the evaluator in developing communities of practice. This will be illustrated with a case concerning an evaluation of a coercion project within the mental health sector in the Netherlands.

'Communities of Practice' as a Concept

'Communities of Practice' (CoP) is a concept introduced by Jean Lave and Etienne Wenger (1991) to highlight that practitioners learn with and from each other in practice. The concept links to two old terms – 'community' and 'practice' (Bood and Coenders, 2004) – both of which have many meanings. Crucial in the concept of CoP is that both terms are inevitably linked: communities emerge out of interactions among people engaged regularly in similar practices. A group of people starts to share their knowledge of and experiences with a practice, and this

fosters a collective and situated learning process. Box 1 provides an example of a community of practice, based on Julian Orr's (1996) anthropological study of the work done by technicians of photocopy machines. Rather than focusing on what the technicians said about their work, Orr focused on what they actually did.

Box 1. Example: A Community of Technicians

> Julian Orr (1996) studied the work of photocopying technicians and noticed that they regularly met in a restaurant instead of visiting customers. This was not just a matter of entertainment or a waste of time, as one might think. On the contrary, Orr shows that the technicians were engaged in one of the most important activities: they exchanged knowledge and experiences by telling each other anecdotes and stories, and they helped each other with the problems encountered at work. If one of them shared a problem with unknown causes, within no time a whole set of stories about former, comparable problems would be discussed. The stories contained hints where one might look for solutions, excluded certain causes and passed on warnings for certain pathways. In the conversations the technicians did not limit themselves to technical details; they also talked about customers (e.g. how to deal with impatient managers), the location of the machines ('You need a pass for that building'), and users (e.g. how to make sure that users you don't see will use the machines in the right way). The technicians found the existing technical handbooks were not very useful and only selectively used these as one source of information. The stories with practical guidelines regarding how to act in certain situations were as important to them as the protocols and checklists in handbooks. Orr concludes that the technicians formed a community and that their conversations, the available information, their work and practice are intimately connected.

Practice

There are various reasons why practitioners, like the technicians of the copy machines, participate in CoP, but almost always they want to improve their practice. The practice on which CoP is focused is not just 'a' practice or 'the' practice in general, but the *shared* practice of the members of CoP. 'Shared' refers to a way of doing things that is common in a certain field and therefore recognizable as a practice. The practice has meaning only for the practitioners in that particular practice. For example, only photocopier technicians know where their practice begins and ends, and what entails good action in that practice. They develop stories to solve problems with the machines and the stories inform them about actions that need to be taken in case of problems. The technicians' stories acknowledge that their practice is far more complex than the technical handbooks assume; technicians also have to deal with the social complexity of their practice (impatient managers, invisible users, etc.). Members of CoP are willing to meet if there is a real concern, an intriguing question or urgent issue that deserves attention. The technicians meet because their work with the copy machines is challenging and they need a supportive community to be able to deal with these challenges. In their case the failing machines form the departure point and legitimacy for the community they develop. Issues of CoP

are often recognized by the broader society and CoP members share a 'sense of urgency' in handling this particular issue.

Community

A Community of Practice is more then just a group of individuals: the CoP members form a community. CoP members like each other's company, and experience their companionship as inspiring and stimulating. It brings them new ideas and challenges them to develop different perspectives. The technicians, for example, shared solutions for failing machines that could not be found in the handbooks. CoP members acknowledge and appreciate each other's input. But there is more. CoP emerge when people make appointments to meet regularly to work and learn in order to improve their practice, like the technicians at lunch hours. The establishment of mutual, personal relationships forms the basis for mutual respect and understanding and creates possibilities for others to join the community. The community becomes a living community. So, besides knowledge, CoP develop into tight communities with particular features, such as a relatively stable membership, clarity over the aims and rules and attentiveness towards each other.

Members

Members of CoP have a dream, goal or ambition. They want to realize something and the community helps them to realize it. The community adds something they cannot find in the formal structures of their organization. The technicians discuss, for example, technical and social problems that are not acknowledged by the protocols and handbooks in their organizations. Often members recall the freedom to go beyond taken-for-granted ideas, to experiment and to realize something without knowing in advance precisely what that is. Members who join CoP will do so on a voluntary basis and because they feel intrinsically motivated to participate. CoP are not formed by others, but are a product of self-organization. Consider the technicians; they do not gather because their managers expect them to do so, but they themselves took the initiative to organize. Relationships are characterized by equality. There are no hierarchical positions and formal authority does not play a role. The egalitarian relationships foster an atmosphere in the community that proves to be a rich environment for learning (Kessels, 2001). There is mutual respect, trust, appreciation and integrity; this creates a safe space and openness for its members.

Learning

Learning has a special meaning in the context of CoP: it is inevitably linked to the participation in the community forming the community of practice. CoP and their members learn when they develop new meanings in order to enhance the effectiveness and/or quality of their practice. Learning is thus an integral part of the practice and of the sociocultural communities around the practice (Dixon, 1994). CoP learn first and foremost by deepening social relationships and by creating openness and trust, which foster new solutions. Members in CoP do not only share and transfer explicit knowledge, but create (transform versus transfer) new

knowledge by sharing tacit, personal-bounded knowledge (Cook and Brown, 1999). It is the process that matters here. Members will engage in constructive dialogues: acknowledge others, question fundamental certainties, tell stories and explore new territories and solutions (Abma et al., 2001; Schwandt, 2001). Complex learning experiences can be documented in 'learning (hi)stories' (see www.learninghistories.com; Basten, 2000). A learning (hi)story describes a critical episode of an organization. The process (retrospective or real-time) itself can be very productive, because it stimulates reflexivity among participants.

Facilitators

CoP may spontaneously emerge, as in the case of the machine technicians. The development of CoP can also by facilitated by an actor. Facilitators of CoP do not focus on the behaviour of the individual members like trainers and coaches, but on the community and the learning environment of the community. In the beginning it is important to introduce new, creative working forms. Later on the facilitator will concentrate on skills to enhance the competence of self-organization. The facilitator requires terrain knowledge in order to gain respect and to be able to communicate meaningfully with members of the community (Wenger et al., 2002).

CoP are not new and can be recognized in several historical partnerships in which people exchanged ideas and experiences. One may think of the medieval guilds, and groups of artists who found each other in their ambition for radical changes, such Der Blaue Reiter and the Cobra group. In our modern world, where the *Gesellschaft* [functional system] has replaced the *Gemeinschaft* [community], room for reflection and innovation is scarce. With the focus on cost reduction and further growth, sources for revitalization have dried up and people and organizations rely on routines. CoP can be a relief and an excellent possibility to foster the emergence of new ideas. There is a widespread call to create room for the human dimension of learning and knowing in the context of informal networks or communities. The next section describes the emergence of CoP in the context of Dutch mental health.

A Case Example

> In the first hospital the reason for isolation [seclusion] was that I interfered too much with other patients on the closed ward where I was hospitalized. I was only told this after I asked for an explanation about the isolation. I hadn't received warnings and I had not realized my behaviour was troublesome. I was full of fear and in pain when I was brought away, meanwhile yelling and screaming. I felt like a criminal who did not know what her crime was. My thumbs and wrists hurt for several days. It was also painful because this was a very humiliating event. It still evokes feelings of powerlessness and anger. (Klaske Bosch, psychiatric patient, in Bosch, 2005)

Several years ago a project was started to develop and implement quality criteria for using restraint in Dutch psychiatry. The overall aim of the project was to improve coercive practice in the mental health sector in the Netherlands.

Coercion occurs when a patient is compelled to do something and has no freedom to choose an alternative option (Berghmans et al., 2001). Examples are seclusion (forced isolation of the patient in a bare, locked room, built for these situations), enforced medication and fixation (mechanical restraint, often with special bandages, in a seclusion room or in a personal bedroom). In the Netherlands most patients in these situations will be secluded (70–80%). Forced interventions limit the freedom of a patient and have a great impact on the well-being of the patient (Dekker, 1989; Hoekstra et al., 2004), especially when the intervention is not conducted in a careful and humane way; the quotation from Klaske Bosch, a psychiatric patient, illustrates this. Klaske's experiences are not an exception. Many other patients have witnessed feelings of powerlessness, fear and anger when undergoing forced interventions (Dekker, 1989; Hoekstra et al., 2004). Health professionals also experience intense feelings and emotions in the case of coercion. They have various, conflicting duties – respecting the autonomy of the patient as well as protecting the safety of the group of patients and general order – and a forced intervention almost always implies that one of these duties cannot be fulfilled. Decisions therefore tend to be 'tragic'; none of the options is fully satisfying (Nussbaum, 1986). This creates mixed feelings among health professionals, but they tend not to talk about these ambivalences in public.

Forced interventions are only legally acceptable in situations of violence or uncontrolled behaviour, but have become a structural part of day-to-day care in Dutch mental health. Klaske notes, for example, that in her case seclusion was used as an intervention to control the ward and to sanction her. She was not dangerous and the reasons for seclusion were thus questionable. She was sanctioned because she did not behave according to the rules of the ward and felt punished like a criminal.

Recently in the Netherlands, health professionals are beginning to acknowledge that there should be more reflection on the extent to which coercion might harm the well-being of patients and the relationships of professionals with them (Van der Werf, 2001). This professional indignation has been stimulated by recent, comparative studies of the use of seclusion in Europe (Vorselman, 2003). These studies demonstrate that in Dutch psychiatric hospitals more patients are secluded than in other European countries. This has led to the development of a set of eight quality criteria in which principles from the ethics of care – responsibility, respect, openness and dialogue – are made relevant to coercion in psychiatry (Berghmans et al., 2001). Coercion is not rejected. The assumption is that coercion is sometimes needed to protect the individual patient or public order. The quality criteria, however, do not focus on the legal question of *when* coercion is required, but on the ethical concern of *how* to treat patients in a more humane way if coercion is necessary.

The quality criteria were developed in collaboration with patients, family members and health professionals. The next step was to implement these quality criteria in a countrywide project involving 12 psychiatric hospitals that varied in size, location, patient population and staff. A national steering committee and project group were formed. The steering committee was composed of

representatives of the board of directors from the participating institutions and representatives of patient and family interest groups. The project group consisted of the project leaders in the 12 institutions and the local evaluators who monitored the implementation. A countrywide evaluation was conducted in order to monitor the implementation processes in the hospitals and to facilitate a learning process between the stakeholders (project leaders, health professionals, patients and family) in the participating hospitals. The overall aim of the evaluation was to foster dialogues between stakeholders in the participating hospitals as a vehicle for practice improvement. As the evaluator of this countrywide project I conducted in-depth interviews with stakeholders in the participating hospitals, participated in the meetings of the project leaders and organized collegial meetings for project leaders and focus groups with patients (see Box 2 for an overview of the research activities).

Box 2. Overview of the Research Activities

Interviews
In-depth interviews with project leaders, local evaluators, team leaders, nurses and patients were organized in eight participating hospitals to gain more insight into experiences of the implementation process and perceived changes in practice. The interviews were tape-recorded, transcribed and analysed. Interpretations were presented to respondents to ensure credibility.

Participant observation
The two-monthly meetings for project leaders and local evaluators were attended. Discussions, issues at stake and the level of engagement during discussions were monitored. At the end, the meetings were evaluated.

Collegial meetings
A collegial meeting group of project leaders was formed to stimulate reflection on their role in improving coercion practice. Participants were asked to respond to cases raised by members of the group. The group met four times. Conversations were tape-recorded, transcribed and analysed. Afterwards the credibility of the analyses were checked with the participants. The attendance and degree of engagement in conversations were monitored. At the end participants were asked what they learned about (their role in) improving coercion practice.

Focus groups
Three focus groups were organized for patients to stimulate the exchange of experiences with patient participation in the local projects. They were invited to present the project and their involvement in it. Conversations were tape-recorded, transcribed and analysed. The credibility of the analyses was checked. At the end of the series, focus groups participants were asked to indicate what they had learned.

Editorship
A book was edited with 'best practices' to disseminate the created knowledge within the local projects. Local evaluators, project leaders and patients (including Klaske Bosch) were assisted in writing chapters (Abma et al., 2005).

Emergence of a Supportive Community

Over the course of the evaluation the project leaders developed into a supportive community. Most of the project leaders had a background in nursing and a large amount of personal experience with and knowledge of the coercion practice. They had to manage a complex implementation process in their institution. To assist them collegial meetings were organized. During the first year the project leaders came together in the company of the local evaluators. The meetings typically had the character of a formal meeting, with an agenda consisting of issues that were not considered to be very relevant and meaningful by the participants. Time for discussion related to the concerns of the project leaders was short. Project leaders began to express the view that the meeting did not meet their expectations; they wanted to talk about substantial issues. In response to the criticism I proposed meeting in a smaller group composed only of the 12 project leaders to talk about cases relevant to them. Participants were asked to respond to cases introduced at the meeting by attendees (Moen et al., 2000). The group met four times in one year. The attendance was good (at least 10 participants per meeting) and degree of engagement in conversations was high.

The collegial meetings with the project leaders marked a new episode in the project. The engagement of the project leaders was enhanced and as the group was much smaller (12 instead of 20 people or more) there was more room to participate and to develop personal relationships. The following important changes occurred in the group.

(a) Whereas project leaders tended to talk in general phrases and kept feelings and emotions to themselves, in the new formation they were able to relate personally. In the discussions individual differences became visible and a sense of community began to emerge. There was an open and respectful climate. Situations were not always comfortable. The group confronted a painful moment when a team leader unexpectedly joined the meeting of the project leaders and learned from a written document how her ward was discussed as a case among the participants. The project leader and team leader began to argue with each other. This was a painful situation for the group and led to the rule that no staff member from the participating hospitals was allowed to join the group, and that written documents were confidential. In retrospect this critical incident helped the group to grow and develop into a real community. Gradually a stable social fabric evolved composed of strong personal relationships.

(b) Discussions in the group were very lively, constructive feedback was given and creative solutions were brought to the fore. It was also remarkable that during the conversations more aspects and perspectives were encountered than before, such as the relationship between psychiatrists and nurses, 'group think' in teams and the dominant economic discourse. The issues discussed were meaningful for individual members and the collective and had a direct influence on the practice of its members.

(c) The group was open to outsiders and invited them to participate in the process. Outsiders can stimulate reflection on taken-for-granted ideas and contribute new rationalities and perspectives (Gergen, 1992). A team that

had been quite successful in reducing the rates of seclusion of patients but radical in its approach (not offering help, the group is the most important source of learning, patients control the medication) was welcomed to give a presentation. The presentation stimulated creativity and persuaded the participants that there are alternatives to and for forced interventions.

(d) The group reached a degree of self-organization. In an oral evaluation all participants said they wanted to continue the meetings, preferably with professional support, but even without assistance they said they would go on. This illustrates that the group developed a degree of control and self-organization. For example, a group of participants took the initiative to develop a programme for a national conference on coercion in psychiatry. Self-organization is an important feature of CoP (Bood and Coenders, 2004). Self-organization emerges when there is enough room for development (Kessels, 2001).

The group of project leaders turned from a pseudo-community into a real and supportive community. The collegial meetings helped in the development of strong personal relationships and stimulated meaningful discussions. In an oral evaluation the project leaders reported that the collegial meetings kept them informed, inspired and empowered.

Situated Learning in a Supportive Community

The project leaders' learning process was intimately connected with and embedded in their practice. The knowledge produced was context-specific, practice- and experience-based and interactively derived. In Box 3, an example is given of the knowledge generated among the project leaders in response to a problematic situation presented and discussed in one of the collegial meetings. It concerns whether the institution should build extra seclusion rooms concentrated in a specialized unit. The problem was raised by a project leader, Larry (pseudonym), who was also the head of the department of closed units in one of the participating hospitals.

The example in Box 3 shows how stories of work experiences were shared not only for entertainment, but in order to foster a sense of egalitarian and supportive community. Participants shared stories about failures (e.g. a specialized unit becoming a policing service, patients experiencing being placed in this unit as a punishment), hard-learned knowledge that, if not shared, might not be learned by others. These stories were used by Larry; he presented the perceived problems and alternative solutions in discussions with his board of directors. He did not, however, find the board to be very receptive to these stories. An external consultancy firm was hired to analyse the problem. The firm came to the conclusion that functional differentiation would not acknowledge the individual development of patients and that a substantive vision of care should underlie the building plans. It was only after receiving the report from the consultancy firm that an open conversation between the board of directors, architects and building companies was possible. Ultimately, the board decided to build four instead of the planned six isolation rooms.

Box 3. Larry's Problem: Building More Seclusion Rooms in a Specialized Unit?

Problem
In one of the institutions, the board of directors wanted to build a specialized seclusion unit as part of a larger reorganization and building plan. The board proposed functional differentiation: all the open units should merge, and all the closed, crisis units should also merge. Larry, project leader of the implementation of quality criteria, had been asked to give advice about the amount of rooms required in the new seclusion unit. The number of young people with aggressive behaviour appears to be growing and seclusion is considered to be the only option for them. As a result, for several years, six seclusion rooms have been continuously used by various clients. Staff from other wards assist the care of patients in seclusion rooms, and this increases pressure on those wards. A specialized seclusion unit is proposed as a solution to these problems.

Informative questions
Questions raised by participants during the collegial meeting related to the power of Larry. He responded that he has at least some influence on the formation of the seclusion unit and the number of seclusion rooms. In response to a question regarding the kind of vision of care that underlies the plans, Larry explained that the board prefers a functional differentiation, but that economic arguments also play a role. The board wants to enlarge the units and enhance organizational efficiency. Larry stated: 'The management questions are: How should these bricks be piled and what is the most logical and cheap way to do that? There is not much discussion of our vision of quality of care.'

Problem definition and solutions
Participants recognized the case and brought several negative experiences with specialized seclusion units to the fore, such as that patients may experience going to another unit as a punishment, the seclusion unit easily becomes a sort of internal police service within the organization and the availability of seclusion rooms will create a need. One of the participants called it a 'logistic story' and argued that it misses the underlying ideas about what quality of care means. Participants also questioned the necessity of the reorganization: 'For whom is this? It is certainly not in the interest of staff and patients!' The group advised Larry to pay more attention to the means to prevent seclusion, such as creating 'healing environments' and enhancing communication and interaction between patients.

Inclusion of Patients in the Community?

One of the challenges presented by the project was the inclusion of patients. They were only represented on the steering committee. The former president of the largest patients association felt they had been struggling and 'fighting' to be included in the process of implementing the quality criteria, even though they have a great deal of experience with forced interventions, and isolation in particular (Dekker, 1989). Members of the project group had little interest in the perspectives and participation of patients and family. They considered it difficult to find the 'right' people and they had worries regarding the drop-out of patients from the implementation process. As a result, the project tended to reflect the wider

situation within Dutch mental hospitals, where patients have little influence at policy level (Boevink, 2003; Inspection for Mental Health, 2001; Kwekkeboom, 1999).

In collaboration with the president of the patients organization, the evaluator organized three meetings with and for clients of local coercion projects. Although it was not easy to interest patients in becoming involved, a core group of eight clients attended all the meetings. The aim of their involvement was to gain insight into the experiences of clients regarding participation in the implementation process. However, room was also created for clients to share their experiences of coercion and the agenda was not predefined. From the onset the meetings were meaningful and respectful. People listened carefully, complimented each other and felt safe to share their personal experiences. An important issue was confidentiality and anonymity; participants did not want to be recognized. Experiences with patient participation showed that in most of the institutions patient involvement was a matter for individuals. Having 'a say' was often no more than being given the opportunity to respond to plans. These individuals felt that they were not informed or supported by other patients. Individual experiences were not related to the stories of others and this created problems with representation. Another issue was related to financial compensation: individuals received nothing or a very small amount of money for their participation. These issues were reported to the project leaders and in the institutions where the situation was far from optimal the levels of support for patients and reimbursement improved.

Reflections on the Case

In the case under consideration, project leaders from 12 mental hospitals developed a sense of community characterized by mutual trust, respect and openness. The group also developed a degree of self-organization. As a community the project leaders developed knowledge and shared experiences of coercion. Later protocols to evaluate seclusion, crisis intervention plans and training programmes have been implemented (Abma et al., 2005). The awareness that forced interventions can be prevented has grown, alternatives have been identified and there is greater attention to the well-being of patients.

The CoP of project leaders emerged during the course of the evaluation. The evaluation aimed to evaluate the implementation of quality criteria in 12 mental hospitals in order to further improve practice in the hospitals. The evaluation started from the issues raised by various stakeholder groups, among them the project leaders. The CoP formed a platform for a learning process among the project leaders and as such it contributed to the overall aim of the evaluation. The CoP also produced data that were valuable for the evaluation and that could not easily have been gathered by the evaluator through other data collection methods. The richness of the ideas and experiences developed in the group were not available within the separate institutions, for example, the set of stories about the concentration of seclusion rooms in one specialized unit. As such, the members of the CoP had something valuable to offer to each other and to the evaluation. In the context of a safe environment they responded to each other, asked questions, redefined problems,

deliberated, revealed 'blind spots' and explored new dimensions and perspectives. Their analyses often proved to be valuable for the evaluation, since the project leaders were able to interpret data in the context of their practice. They knew more about the complexity of their practice than the evaluator and were in a position to unravel many factors that explained the problems encountered. Their discussions addressed evaluative questions, such as the quality of the implementation process and more specifically the inclusion and participation of patients in this process.

The evaluator acted as a facilitator of the CoP. The facilitator took care of all kinds of activities and practical matters, such as arranging meetings and disseminating new insights, in order to facilitate a dialogue among the members of the CoP (see Box 4 for an overview). Individual interviews with the project leaders, time and social and interpersonal skills enabled the facilitator to bring people together and to develop personal relationships with and between members of the CoP. Especially in the beginning, the facilitator acted as a 'linking pin' between the members of the CoP. The facilitator also functioned as a 'linking pin' between the group and the steering committee and with members of the board of directors of the institutions. In this intermediary role the facilitator ensured that the ideas of the CoP were acknowledged by policy-makers and managers. Although the group had developed a degree of self-organization, it appeared that the members were not able to define their future without the assistance of the facilitator. Besides the facilitator role, the evaluator also acted as social scientist, gathering and analysing data. This was sometimes confusing for the various audience groups. For example, it was expected that the evaluator as scientist would produce an end product in the form of an evaluation report. As facilitator the evaluator focused, however, on the quality of the process (level of engagement, dialogues between stakeholder groups) and initially paid less attention to the product. This issue was therefore renegotiated at the end stage of the evaluation.

Box 4. Activities Undertaken by the Facilitator in Collaboration with the CoP

- Define a clear domain that is meaningful to potential members and external, sponsoring organizations (e.g. coercion practice in psychiatry).
- Define urgent issues and questions (e.g. rates of seclusion are too high; are there alternatives?; how to enhance carefulness and liveability).
- Attract knowledgeable, creative people; use existing networks.
- Develop personal relationships and explore individual differences (small group of people).
- Develop rules for interaction (e.g. confidential meetings).
- Quality of conversation/dialogue (e.g. respect, appreciation, mutual trust, constructive feedback, safe space).
- Creative working methods (e.g. collegial meeting instead of regular meeting, work with cases that appeal to the imagination).
- Invite outsiders with a vision.
- Stimulate self-organization.

A great challenge was the inclusion of patients. Project leaders did not show a great interest in the perspective and participation of patients. It was considered to be difficult to engage them in the project on a local level. The project leaders wanted to learn with and from each other, and they did not expect to learn much from the experiential knowledge of patients. Of course, they tolerated the fact that the evaluator organized meetings with patients, listened politely to the findings and undertook some actions, but the following issues were never discussed: what patients and patient involvement meant to them; and whether or not patients should have a voice in decisions concerning the project and quality of care. 'Learning from patients' was simply not an issue.

Discussion

This article deals with the intersection of evaluation with current interest in the 'communities of practice' concept. More specifically it tries to document and recount the origins of and experiences in one community of practice, situated within an evaluation study, as a particular kind of learning in and from evaluation. This kind of learning is less instrumental, abstract and cognitive, and more concrete, interactive, relational and action-oriented. The CoP described in the case under consideration emerged during the course of an evaluation, and the evaluator was the facilitator of this CoP. The community contributed to the learning process among a group of stakeholders (the project leaders of the implementation of quality criteria for coercion in psychiatry) and generated data and analyses that were valuable for the evaluation.

Other evaluators might want to take on the role of facilitator of CoP for the same reasons. First, a CoP forms a learning platform for stakeholders and fosters reflection on the practice. The community enables stakeholders to enhance their knowledge of the practice and to learn with and from each other during the evaluation process. Commitment to apply solutions and to improve the practice is therefore high: members recognize the findings of the evaluation as their 'own' products. Second, the CoP produces knowledge that is concrete and contextual. Members of the community often know more about their practice, its social and technical complexity, than the evaluator. The evaluator acknowledges and uses experiential knowledge and expertise optimally when practitioners are enabled to discuss and reflect on meaningful issues by sharing anecdotes and stories. The 'logistic story' about building seclusion rooms provides a good example. Stories are relevant sources of knowledge because they are located within specific contexts. For example, the formal quality criteria and laws on coercion cannot be made relevant to practice without considering the particulars of a situation. This is often referred to as the principle of indexicality (Roth et al., 2000): abstract criteria will only gain meaning in a concrete context. The context of the situation is the index for the use of the criteria. Stories can reveal the ambiguities of practice and contain therefore a large amount of practical wisdom.

Acting as a facilitator of a CoP fits very well with the formative aim of evaluation studies to improve (versus summative judgement) the evaluated practice.

The action-oriented character of these evaluation studies resonates with action research. Yet the evaluation study and approach described in this article are explicitly normative, while action research operates within the value system of practitioners.

The normative framework that was used here is based on the idea that the quality of a practice should be defined in terms of the quality of its relationships and dialogical processes (Abma, 2006; Greene, 2004). Important relational and social values include respect for each other and acknowledgement and appreciation of the input of all members. Values of social justice also matter: a practice should be inclusive and listen to the stories of patients. Furthermore, it is assumed here that the quality of the learning processes unfolding in a CoP are not a matter of the attainment of consensus among stakeholders, but that learning processes are stimulated through confrontation with diversity. Multiplicity is considered to be a source of innovation and dynamics (Bodenrieder, 1998; Hosking et al., 2000). This implies that facilitators of CoP will not focus on the behaviour of the individual members, but on the community and the learning environment of the community. Facilitators may introduce new, creative working forms, bring in knowledge from outside and enhance skills for self-organization (Bood and Coenders, 2004). This normative stance also implies that practitioners are engaged in evaluative activities, but that members of these communities do not fully take over the evaluative function. The evaluator introduces external, process criteria to value the practice.

The CoP concept is based on the idea that the experiential knowledge of practitioners is valuable and often underestimated by managers and policy-makers (Yanow, 2004). Larry's alternative solution for the building of extra seclusion rooms in a specialized unit was, for example, not immediately acknowledged by the management of the hospital. Practitioners know much more about their practice than managers and policy-makers tend to assume. Acknowledging the professional practitioner is therefore a good thing: it balances the power of managers. The case study under consideration and other studies illustrate, however, that professionals tend to neglect the critical voices and perspectives of lay persons (Abma, 1997, 1998, 2003). The professional judgement of practitioners like Larry should thus be welcomed by evaluators, but their expertise should not be privileged but be balanced by the experiential knowledge of less powerful groups. The aim here would be to develop a learning community that is inclusive of different members, among them psychiatric patients such as Klaske and others who are traditionally excluded and under-served.

Note

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References

Abma, T. A. (1997) 'Voices from the Margins: Political and Ethical Dilemmas in Evaluation', *Canadian Review of Social Policy/Revue Canadienne de Politique Sociale* (Spring) 39: 41–54.

Abma, T. A. (1998) 'Storytelling in a Mental Hospital as Inquiry', *Qualitative Health Research* 8(6): 821–38.

Abma, T. A. (2003) 'Learning by Telling, Storytelling Workshops as an Organizational Learning Intervention', *Management Learning* 34(2): 221–40.

Abma, T. A. (2006) 'The Social Relations in Evaluation', in I. F. Shaw, J. C. Greene and M. M. Mark (eds) *The Sage Handbook of Evaluation*. London: Sage.

Abma, T. A., G. A. M. Widdershoven and B. Lendemeijer (2005) *Dwang en drang in psychiatrie: Kwaliteit van vrijheidsbeperkende maatregelen.* Utrecht: Lemma.

Abma, T. A., J. Greene, O. Karlsson, K. Ryan, T. S. Schwandt and G. A. M. Widdershoven (2001) 'Dialogue on Dialogue', *Evaluation* 7(2): 164–80.

Basten (2000) *Metaforen en verhalen over organisatiewetenschap en onderwijsinnovatie: Een leergeschiedenis.* Venlo: Repro Press.

Berghmans, R., D. Elfahmi, M. Goldsteen and G. A. M. Widdershoven (2001) *Kwaliteit van dwang en drang in de psychiatrie.* Utrecht and Maastricht: GGZ Nederland and Universiteit Maastricht.

Bodenrieder, I. (1998) 'Social Architecture: A Prerequisite for Organizational Learning', *Management Report* 38. Rotterdam School of Management, Erasmus University.

Boevink, W. (2003) 'Vernieuwingsgehalte van de Nederlandse psychiatrie', 6e *Deviant lezing*. Amsterdam: De Rode Hoed, April.

Bood, R. and M. Coenders (2004) *Communities of Practice: Bronnen van inspiratie.* Utrecht: Lemma.

Bosch, K. (2005) 'Isoleren werkt angstverhogend', in T. A. Abma, G. A. M. Widdershoven and B. Lendemeijer (eds) *Dwang en drang in de psychiatrie: Kwaliteit van vrijheidsbeperkende interventies*, pp. 31–6. Utrecht: Lemma.

Brown, J. and P. Duguid (1996) 'Organizational Learning and Communities-of-Practice: Toward a Unified View of Working, Learning and Innovation', in M. D. Cohen and L. S. Sproull (eds) *Organizational Learning*, pp. 58–82. Thousand Oaks, CA: SAGE.

Cook, S. D. N. and J. S. Brown (1999) 'Bridging Epistemologies: The Generative Dance between Organizational Knowledge and Organizational Knowing', *Organization Science* 10(4): 381–400.

Dekker, J. (1989) *Stenen voor brood: De isoleercel in de psychiatrie*. Utrecht: Cliëntenbond GGZ.

Dixon, N. M. (1994) *The Organizational Learning Cycle: How we Learn Collectively.* London: McGraw-Hill.

Gergen, K. J. (1992) 'Organization Theory in the Postmodern Era', in M. Reed and M. Hughes (eds) *Rethinking Organization: New Directions in Organization Theory and Analysis*. London: SAGE.

Greene, J. (2004) 'What Kind of Learning? What Kind of Communities?', paper presented at the panel 'Learning Evaluation: The Relevance of Communities of Practice', European Evaluation Society 6th Biennial Conference, Berlin, Oct.

Hoekstra, T., H. H. G. M. Lendemeijer and M. G. M. J. Jansen (2004) 'Seclusion: The Inside Story', *Journal of Psychiatric and Mental Health Nursing* 11: 276–83.

Hosking, D. M. and R. Bouwen (eds) (2000) 'Organizational Learning', *European Journal of Work and Organization Psychology* 9(2): 129–274.

Inspection for Mental Health (2001) *Jaar Rapport 2001* (Annual Report). The Hague: Inspection for Health Care.

Kessels, J. (2001) *Verleiden tot kennisproductiviteit, oratie.* Enschede: University of Twente.
Kwekkeboom, M. H. (1999) *Naar draagkracht: Een verkennend onderzoek naar draagvlak en draagkracht voor de vermaatschappelijking in de ggz.* Enschede: SCP.
Lave, J. and E. Wenger (1991) *Situated Learning: Legitimate Peripheral Participation*. Cambridge: Cambridge University Press.
Moen, J., P. Ansems, J. Hanse and M. Vintges (2000) *Leiden of lijden? Het handelingsrepertoire van de manager.* Assen: Van Gorcum.
Nicolini, D., S. Gherardi and D. Yanow (2003) 'Introduction: Toward a Practice-Based View of Knowing and Learning in Organizations', in D. Nicolini, S. Gherardi and D. Yanow (eds) *Knowing in Organizations: A Practice-Based Approach*, pp. 3–31. Armonk, NY: M.E. Sharpe.
Niessen, T., T. A. Abma, G. A. M. Widdershoven and C. Van der Vleuten (2004) 'Contemporary Epistemological Research: The Need for a Reconceptualization', paper presented at the Third International Conference on Dialogical Self, Warsaw.
Nussbaum, M. C. (1986) *The Fragility of Goodness*. Cambridge: Cambridge University Press.
Orr, J. (1996) *Talking about Machines: An Ethnography of a Modern Job*. Ithaca, NY: ILR Press.
Roth, W.-M., D. Lawless and K. Tobin, (2000) 'Time to Teach: Towards a Praxeology of Teaching', *Canadian Journal of Education* 25: 1–15.
Schwandt, T. A. (2001) 'Understanding Dialogue as Practice', *Evaluation* 7(2): 228–37.
Schwandt, T. A. (2004) 'Some Thoughts on Learning in and from Evaluation', stimulus paper presented at the panel 'Learning Evaluation: The Relevance of Communities of Practice', European Evaluation Society 6th Biennial Conference, Berlin, Oct.
Van der Werf, B. (2001) 'Veiligheidsbeleid en gedwongen separatie in Europees perspectief', *Preacox* (Dec.): 11–15.
Vorselman, A. (2003) 'Seclusion, Fixation and Medication: The Application of Coercive Measures in Adult Psychiatry Internationally Compared', masters thesis, public administration and public policy, European studies, University of Twente.
Wenger, E., R. McDermott and W. M. Snyder (2002) *Cultivating Communities of Practice: A Guide to Managing Knowledge.* Boston, MA: Harvard Business School Press.
Yanow, D. (2004) 'Translating Local Knowledge at Organizational Peripheries', *British Journal of Management* 15: 9–25.

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