TONE LARSEN FACULTY OF HEALTH SCIENCES

From increased user participation to co-creation leadership

An action research case study in public specialised mental health and substance abuse services

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From increased user participation to co-creation leadership

An action research case study in public specialised mental health and substance abuse services

by

Tone Larsen

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To Vilje

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Summary

The main aim in this thesis has been to develop a 'user participation method' that ensures both service user and service provider impact on service development. An action research single case study was conducted in a Norwegian mental health and substance abuse unit. Increased user participation in public service development and dialogue between stakeholders about service development were facilitated by the researcher through participative observation and in collaboration with stakeholders. Stakeholders engaged as co-researchers and participants in planning meetings and working groups and in co-researcher led multistage focus group interviews, semi-structured individual interviews and dialogue seminars. The overall research question related to the main aim was *How can participation and real influence from patients and staff in service development be ensured*? Three articles were produced to inform the research question and the main aim.

The contribution to theory in article one is to create awareness about concurrent diagnostic culture that keeps patient voices from being heard. The findings suggest that facilitating self-empowerment among service users and providers through training, supervision and explorative dialogue may enable reciprocal empowerment between these stakeholders. In turn, this may make it possible for them to have a united voice when it comes to developing and transforming services.

Article two reveals how organisational defence mechanisms hinder double-loop learning among staff. It proposes elements necessary to unlock the potential of genuine co-production relationships between service users and providers including a mutual agreement, a fixed co-production meeting, joint training/roleplay, and spaces for group and individual reflexivity.

In article three, the contribution has been identifying leadership behaviours that enable co-created organisational adaptability in PSOs.

The following definition of co-creation leadership is proposed: *the ability to recognise service users, providers, and formal leaders as colleagues who co-create services and value in a reciprocally empowering working alliance.* Further, some specific requirements of co-creation leadership are presented: 1) enabling dialogue and adaptive spaces, 2) acknowledging that power is negotiated and relational, 3) co-constructing and connecting leadership to core tasks and functions (not just formal position), 4) recognising consultation, facilitation and delegation as key to decision commitment and collective mobilisation, and 5) ambidextrously maneuvering between participation and decisiveness, care and autonomy, and production and innovation.

To explore how knowledge about a) the relationship between the articles; b) the preliminary main result, namely a *co-production* method; and c) conceptualisation of co-creation leadership can contribute to existing and future PSO challenges, the following synopsis research question was posed:

The role of leadership. How can systematic involvement of leaders, users and providers enable organizational adaptation in public services?

The three articles and experiences with the research design have informed the main result: a renamed and updated *co-creation method*. This method is described as both a practice and an action research method that enables a shift in organisational culture and practice towards a co-creation orientation. In this orientation, facilitating participative co-production of existing services is just as pertinent as facilitating co-innovation of new services. Such facilitation is accomplished through the creation of communicative and adaptive spaces for stakeholders' exploratory dialogue. Systematic integration of a *co-creation practice*, which is defined as the way stakeholders actually collaborate to evaluate, improve, plan, initiate and innovate services, is central. Furthermore, an understanding of co-creation leadership has been included in the co-

creation method design. Multiple choices of leadership behaviours and role-migration between stakeholders are essential.

The implication for practice and research is that the co-creation method has several paths to choose from and can therefore be adapted to various contexts. The co-creation method may be introduced as both a practice and a research method, and it can be utilised as a tool for service improvement, innovation and service/environmental sustainability within and outside of PSOs. Furthermore, leader presence is encouraged to root and legitimise co-creation. Conceptualisation of co-creation leadership may strengthen the co-creation of services and value potential.

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PART I

1 Introduction

1.1 What is it all about?

Citizens in modern welfare states like Norway are used to 'consuming' public services conceived of and provided by governments. However, it has been argued that as service users, citizens are not consumers but rather co-producers in implementing public services in partnership with service providers. Nevertheless, a *co-creation mode* in which citizens are engaged in implementation, planning and initiation of public services is far less frequent than a traditional *provision mode*. Why is such co-creation rarely seen, and how is it possible to make co-production and co-creation of public services within the reach of everybody? This PhD thesis deals with some of the theoretical and practical conundrums embedded in this question.

In public service organisations (PSOs), power dynamics and organisational defence mechanisms and constraints can interfere with a) how service users' argumentation and propositions for service improvement are received and b) how service providers respond. This thesis explores how developing a systematic practice method, while considering the role of PSO leadership, can increase service user participation in public service development and optimise co-production and co-creation of services.

1.1.1 Structure of the thesis

This thesis consists of two parts. Part I is a synopsis containing seven chapters and is organized as follows: The rest of the introductory chapter is devoted to presenting some knowledge gaps this thesis aims to fill, the aim of the thesis, the research question and key concepts. Chapter two presents a social scientific and theoretical framework. The participatory social scientific paradigm is introduced along with theory on empowerment, organisational culture change and leadership behaviours.

In chapter three, the inquiry's action research orientation and single case study design are described, and four philosophical questions are answered related to ontology, epistemology, methodology and axiology. This chapter also includes considerations of research quality and ethical issues. The three articles included in this thesis are summarised in chapter four, followed by a discussion of how they relate to each other and the research aim in chapter five. Chapter six comprises the discussion of the synopsis research question; implications for practice, possible directions for future research and methodological considerations are also presented. Chapter seven concludes the thesis. Part II includes the three articles and appendices.

1.2 Increased user participation

In its Comprehensive Mental Health Action Plan 2013–2020 (WHO, 2013), the World Health Organisation (WHO) urges governments to facilitate active service user involvement and provide opportunities to influence decision-making processes. Such involvement is thought to make mental health and social services more responsive to service users' needs. Service users 'should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation' (WHO, 2013, p. 10). In Norway, increased user participation has been a political aim since 1988 (Ministry of Social and Health Services, 1997). At that time, the service user perspective was regarded as necessary for quality assuring public services, and it was believed that service user views should be collected in a systematic manner (Ministry of Social and Health Services, 1997). Increased and strengthened user participation were also aims of the Norwegian escalation plan for the field of drugs and addiction 2007–2010 (Ministry of Health and Care Services, 2007) and 2016–2020 (Ministry of Health and Care Services, 2015). Close collaboration with service users and carers was regarded a prerequisite for service user-oriented and responsive services.

Even though it has been shown that service user involvement in service development is necessary, there is limited research on the service user stakeholder role in such activity (Armstrong, Aveling, & Martin, 2013; Boote, Wong, & Booth, 2012; Crawford et al., 2002; Souliotis, 2015; Tambuyzer, Pieters, & Van Aidenhove, 2011; Tse, Tang, & Cert, 2012). While service users' participation in decision-making and needs when involved in mental health care have been studied (Dahlqvist, Schön, Rosenberg, Sandlund, & Svedberg, 2015; Guadagnoli & Ward, 1998; Stringer, Van Meijel, De Vree, & Van der Bijl, 2008; Tee et al., 2007), hindrances to service user participation in the development of mental health and substance abuse services are underexplored.

It has been emphasized 'that there is a need to consider measures that ensure user participation locally, both at individual and system level' (Ministry of Health and Care Services, 2015, p. 29). Participation on an *individual* level refers to the right service users have to choosing services and how their individual services are implemented (Larsen, Aasheim, & Nordal, 2006; Patient and user rights Act, 2020, § 3-1). Participation on a *system* level, on the other hand, entails service users providing systematic feedback to ensure public services development and quality assurance. (Larsen et al., 2006). Evaluations have showed that user participation has not been sufficiently ensured in Norwegian mental health and substance abuse services (Directorate of Health, 2012; Larsen et al., 2006; Ministry of Health and Care Services, 2007; Ministry of Social and Health Services, 1998; NOU 2019: 26). They point to a need to develop and test user participation models, and 'there is a need for further development of user participation routines in municipality and special health services' (Directorate of Health, 2012, p. 50-51). The need for effective methods to involve service users in decision-making processes has been emphasised (Ministry of Health and Care Services, 2007). 'Methods' in this context are interpreted as relating to planned procedures that strengthen user involvement in practice and will be from now on referred to as practice methods. In this thesis, I examine the

process of developing a knowledge-based practice method that ensures both service user and service provider impact on service development within Norwegian public mental health and substance abuse services (SMHS).

1.3 User participation practice methods

In Storm's (2010) study of service user involvement in Norwegian community mental health inpatient centres, little 'organisational' (system level) user involvement was reported. Organisational user involvement was measured with regard to the extent to which service users were solicited on the department level and in planning local services, service users' involvement in training/teaching and in hiring decisions, and routine user satisfaction surveys (Storm, Knudsen, Davidson, Hausken, & Johannessen, 2011). Storm (2010) argues that such user involvement has not been well developed and therefore seeks to explore 'the extent to which is it possible to develop or strengthen user involvement practices in inpatient mental health departments' (Storm, 2010, p. 56). Storm et al. (2011) implemented an intervention programme in several Norwegian mental health centres that aimed to positively influence service providers' reports on individual and system user participation (Storm et al., 2011). The interventions significantly changed the providers reports on user participation on a system level. Storm concluded that to increase attention to service user involvement in mental health services, 'an intervention program can be useful' (Storm, 2011, p. 47).

Service user participation has been associated with service development, quality improvement and evaluation. It can 'inform patient and provider education and policies, as well as enhance service delivery and governance' (Bombard et al., 2018, p. 1). To improve service quality with the help of service users, there appears to be a need for practice methods that translate policy aspirations for increased user participation to organisational learning and clinical practice in PSOs. Service

providers have become increasingly 'better at utilising user and experiential competence' (Ministry of Health and Care Services, 2015, p. 19). However, challenging dynamics emerge as 'traditional power relationships are being unsettled' (Carr, 2007, p. 266). Resistance to service user involvement is not uncommon, so change in organisational culture is required (Storm, 2010).

Practice methods for user participation on a system level are presented in the recent Norwegian escalation plan for the field of drugs and addiction (Ministry of Health and Care Services, 2015) and the newest draft of the Norwegian drugs and addiction reform bill (NOU 2019: 26). However, these methods are limited to strengthening collaboration with service user organisations, employing service user consultants, implementing multiple feedback systems, and strengthening user-led centres and local/regional user-boards (Hansen, Tofteng, Holst, Flatval, & Bråthen, 2018; Ministry of Health and Care Services, 2015; NOU 2019: 26). In line with the WHO Action Plan, these efforts appear focussed on valuing service user competence and feedback and strengthening opportunities for co-governance, 'an arrangement in which the third sector, along with public agencies and for-profit actors, participates in decision-making and the planning of public services' (Pestoff, 2012, p. 18; WHO, 2013). However, these practice methods do not appear sufficient to systematically change organisational cultures through organisational learning in unique local services. WHO nevertheless points to the need for new knowledge and skills among professionals, to redefine health workers' roles and to change 'the existing service culture and attitudes of' professionals when moving towards more integrated and responsive services (WHO, 2013, p. 15).

1.4 Involvement culture

When attempting to challenge and transform organisational cultures that appear resistant to service user involvement, the employment of service user consultants seems promising. Also, Stomsky and Morrison (2017,

p. 9) advise that 'placing service users as leaders in key positions throughout mental health services' may help translate policy to practice. Leadership models where service users take on leader roles in mental health services have also been proposed (Gordon, 2004; O'Hagan, 2009). While the most reported barrier to user participation is negative attitudes from health professionals (Gordon, 2004), service providers' low expectations, excluding attitudes and paternalism are also pointed to as hindrances to user involvement (Bee, Brooks, Fraser, & Lovell, 2015; Stomski & Morrison, 2017). It has been suggested that to promote 'more inclusive approaches to service user involvement', service providers need additional training, which 'needs to be embedded in clinical contexts where authentic partnership is standard practice' (Stomski & Morrison, 2017, p. 8). WHO also suggests that service users be included in training health workers as a means to strengthen, empower and ensure a formal role and authority among service users so they can influence mental health services (WHO, 2013).

However, employing service user consultants, leaders and trainers without systematic interventions supporting these developments may not be sufficient to fundamentally change practice. Research focusing on an organisational and professional 'cultural journey' related to increased opportunities for user participation has been called for (Boström, Hillborg, & Lilja, 2017). In their literature review about attitudes, values and assumptions (defined as culture) among service providers and users in healthcare, Bostrøm et al. (2017, p. 163) highlight a cultural change that they described as 'a journey from resistance to appreciated insights'. They acknowledge Schein's definition of culture as 'a pattern of shared basic assumptions learned by a group as it solves its problems of external adaption and internal integration', which are considered valid, and 'the correct way to perceive, think, and feel in relation to' problems (Schein, 2004, p. 17). Before user involvement, service providers appeared to assume that they knew best, resisting and fearing user involvement and lacking trust in service users (Boström et al., 2017) while during and after

involvement these attitudes changed to appreciation of the service users' experiential knowledge and respect for service users. Boström et al. (2017) argue that service user involvement in service quality improvement appears to drive cultural change for both service providers and users. They conclude that 'in many cases the desirable culture appear to actually follow as a result of starting to apply tools and methodologies of user involvement' (Boström et al., 2017, p. 169).

Learning to involve service users is challenging but not impossible for service providers. To develop shared basic assumption about the benefits of involvement, it is necessary to involve service users. Furthermore, 'solving' the involvement 'problem' means changing what are regarded as valid perceptions, thoughts, and feelings related to service user involvement (Schein, 2004). For a PSO to externally adapt to policy and internally integrate a new practice, it seems that it is necessary to enable service providers' professional development and psychosocial change while they collaborate with service users. Such changes in the organisational culture require efficient leadership (Schein, 2010).

1.5 Leadership and organisational culture

Organisational culture can be developed over time by institutional processes and members of the organisation. An organisation's leadership contributes substantially to organisational culture, as their deliberate actions may develop and change that culture (Tsui, Zhang, Wang, Xin, & Wu, 2006). In fact, leadership has been defined as the creation, management, maintenance and consolidation of culture (Schein, 2010). Transformational leadership has been positively related to innovation cultures, among others (Xenikou, fourthcoming). High quality leader-member exchange relationships have been positively associated with organisational learning cultures where leaders model and support learning and where participation, dialogue and team learning are encouraged. Leaders may engage with several mechanisms while attempting to communicate, establish, and reinforce their values and

basic assumptions. To create opportunities for cultural change, leaders may also utilise different tools, such as promoting insiders from selected subcultures or organisational development (Xenikou, fourthcoming).

Culture can be shaped by leaders who understand and take advantage of the context and who introduce 'systems and processes to institutionalize the values that are created within or imported from outside' (Tsui et al., 2006, p. 124). Paying attention to the process whereby leaders shape culture, as opposed to only regarding leadership traits, would benefit further research according to Tsui et al. (2006). While Xenikou (forthcoming) emphasises the need for research that investigates leaders' impact on culture, and vice versa, and mechanisms for managing organisational culture. Therefore, in addition to working to develop procedures, routines and methods that increase/strengthen service user involvement in public service development – it is important to consider how leadership can enable such change. For one, how public leaders master both decisiveness and participation related to their employees seems relevant in a process where service improvement and innovation are encouraged (Aramovich & Blankenship, 2020). Including consideration for service users when manoeuvring participation and decision-making adds to the complexity of public leadership. Uhl-Bien and Arena (2018) call for further research on what kinds of leadership behaviour may enable and/or stifle the organisational adaptability of public services. In particular, public leadership needs to be reconsidered.

1.6 Systematic methods of user participation

There have been some efforts with regard to developing systematic methods of user participation. On the one hand, in a Norwegian example, the service users' competence is regarded as key: 'User Interviews User' (UIU) is a much utilised process-oriented and user-led evaluation approach deriving from a UK research method called user-focussed monitoring (Bjørgen & Westerlund, 2009; Davies, 2009; Hyrve & Johansen, 2008; Steinsbekk, Westerlund, Bjørgen, & Rise, 2013). It

consists of collaboration with services/institutions about which areas need to be addressed, and user-led individual and group interviews with service users about their service experiences. The temporary findings from the interviews are presented in a process report and in a dialogue conference, where service users and providers are invited to validate and discuss them. These results are presented in a final report, consisting of 'an overall description of how the service is perceived' (Plathe, 2017).

On the other hand, the Danish BIKVA model (acronym for User/*Bruker* Involvement/*Involvering* in/*i* Quality development/*KVAlitetsutvikling*) appears to go from facilitating organisational knowledge co-creation to political confrontation without actual dialogue between the stakeholders (Krogstrup, 1997; Krogstrup & Brix, 2019). This model involves group interviews led by a researcher/facilitator with 1) service users, 2) service providers, 3) leaders and, ideally, 4) politicians. The topics are cumulative: in other words, discussions in the first step influence the interview guide and thereby determine what issues are addressed in the next step (Krogstrup & Brix, 2019). Krogstrup and Brix (2019) describe the BIKVA model as one of many collaboration and participation models that are part of the co-creation agenda. They claim that this model, together with other methods, can facilitate co-production.

1.7 Optimising co-production and co-creation

Co-production has been described as a process in which organisations or individuals, such as citizens/service users, who are not responsible for public service production contribute to service production is various ways (Ostrom, 2012; Parks, Baker, Kiser, Oakerson, & Ostrom, 1981). The concept, which originated from research in the public sector, has also been described as service user involvement that is expected 'to go beyond collecting input and should have an impact on the service provided' (Vennik, van de Bovenkamp, Putters, & Grit, 2016, p. 165). Co-creation, a concept rooted in the commercial business and market sector, has become popular in recent years in the public sector as well

(Brandsen, Verschuere, & Steen, 2018). Similar to co-production, co-creation views customers' competence as an asset in value creation and dialogue with informed consumers as vital to the personalisation of the customer's experience with the service a company provides. Thus, the customer becomes a co-creator of the content of their experience (Prahalad & Ramaswamy, 2000). 'Co-creation is a function of interaction' between provider and customer that leads 'to different forms of value creation' (Grönroos & Voima, 2013, p. 133). In the marketing literature, co-creation has been described as both 'improving consumption and usage experiences' and 'stimulating product and service innovation' (Galvagno & Dalli, 2014, p. 644).

Not surprisingly, co-creation and co-production are used interchangeably in a systematic review by Voorberg et al. (2015), which found no striking empirical or conceptual difference between the two concepts. However, based on certain distinctions identified in the review, the authors argue that the term co-creation should be reserved 'for involvement of citizens in the (co-)initiator or co-design level' while co-production should be 'considered as the involvement of citizens in the (co-)implementation of public services' (Voorberg, & Tummers, 2015, p. 1347). Brandsen et al. (2018) agree to an extent with this distinction. They describe how collaboration between service users and providers can take place during service design and implementation, namely co-production, as well as during strategic planning and when services are shaped and initiated, or co-creation (Brandsen et al., 2018). This means that Galvagno and Dalli's (2014) conceptualisation of co-creation covers co-production, co-creation of value and co-innovation of products and services

Many studies, mainly case studies with qualitative data, have been conducted since Elinor Ostrom and colleagues introduced the concept of co-production by describing how police officers and citizens produced neighbourhood safety together (Alford, 2014; Brandsen et al., 2018; Fugini, Bracci, & Sicilia, 2016; Parks et al., 1981; Pestoff, Brandsen, &

Verschuere, 2012). According to Sicilia et al. (2019), since the late 1970s, over 1,100 articles about co-production in public services have been published in academic journals, with most being published since 2015 (Sicilia, Sancino, Nabatchi, & Guarini, 2019). Also, since 2000, research that conceptualises co-creation as the interaction between suppliers and customers has challenged important pillars of capitalism. Co-creation is regarded as 'developing as a new paradigm in the management literature' (Galvagno & Dalli, 2014, p. 643).

Research on the optimisation of co-production of public services in practice has been called for, and further clarification of co-production and related concepts may enable this objective (Brandsen, Verschuere, & Pestoff, 2012). Another productive avenue for research includes exploring the role of professionals in co-production (Osborne, Radnor, & Strockosch, 2016). After all, co-production entails a different kind of relationship between service users and providers (Batalden et al., 2015; Boviard & Löffler, 2012; Pestoff, 2012). A key challenge is to unlock the potential of genuine co-production partnerships between these stakeholders (Osborne & Strokosch, 2013) so they can collaborate efficiently. Co-production can move beyond collaboration on improving existing services to powering a creative potential that may benefit overall public service delivery (Osborne & Strokosch, 2013). Genuine partnerships make it possible to use knowledge that may challenge existing paradigms and transform and co-design new services in *'user-led innovation* of new forms of public service delivery' (Osborne & Strokosch, 2013, p. 39. Emphasis in original). However, naive devotion to user-led transformation may pave the way to the opposite extreme from paternalism: total service user-centeredness. It is not enough to empower service users and expect them to begin total innovation (Freire, 2005; Osborne & Strokosch, 2013). The question is 'how to ensure that service professionals and service users alike have the requisite skills to power' genuine co-production partnerships (Osborne & Strokosch, 2013, p. 40).

Identifying mechanisms that may enable professionals to develop the skills necessary to optimise the potential for co-production seems important (Osborne & Strokosch, 2013). In other words, optimising co-production requires exploring practice methods that may strengthen service providers' engagement in the co-production partnership with service users. Theories of co-production have moved beyond service user participation to a more explicit working alliance that includes potential innovation. However, in their systematic literature review Sicilia et al. (2019) found surprisingly few empirical studies that 'discuss the design of the co-production process under investigation in any depth' (Sicilia et al., 2019, p. 237). Although some elements of the co-production process that facilitate/hinder outcomes were revealed, the selection of co-production or co-creation practice methods related to public services remains limited (Bell & Pahl, 2018; Burns, Hyde, Killett, Poland, & Gray, 2014; Gudowsky & Sotoudeh, 2017). One promising example is the co-production methodology developed by IMPROVE, a UK public participation charity (IMPROVE, 2014). Furthermore, Ind et al. (2017) suggest looking at co-creation's potential in terms of a continuum. At one extreme co-creation is a 'tactical market research tool' while at the other it is a 'strategic collaborative innovation method' (Ind, Iglesias, & Markovi, 2017, p. 15). They do not describe concrete co-creation methods but suggest that future research focus on how to overcome two key obstacles: organisational culture and structure (Ind et al., 2017).

1.8 Summary of knowledge gaps

Government documents point to the need for a practice method that ensures user participation in decision-making and in public service development and quality assurance. The literature suggests that increasing service user involvement on a system level requires organisational cultural change. Thus, further research on organisational and professional cultural change is necessary. It has been suggested that an intervention programme may be beneficial to change service

providers' views on service user involvement. Research on how to optimise the co-production partnership, co-production and co-creation and research that helps clarify and distinguish co-production and co-creation have been called for. Co-production or co-creation practice methods are limited, and surprisingly few empirical studies discuss or investigate co-production process design in depth. It is therefore necessary to explore how to overcome culture and structural challenges in co-production and co-creation. Research on how leaders can shape and impact on organisational culture is also important, and it is necessary to look more closely at which leadership styles enable organisational adaptability. In this context, it seems that leadership behaviours that enable and/or stifle co-production and co-creation merit further exploration.

In summary, increasing and strengthening user involvement requires a systematic practice method that optimises a) co-production and co-creation, and b) organisational culture change while c) taking the complexity of public leadership into consideration.

1.9 Aims and research questions

The main action research aim and purpose of this thesis is *to develop a 'user participation method' that ensures both service user and service provider impact on service development.*

The research questions posed in the three articles that comprise the thesis are the following:

1. What may keep patients' voices from being heard in their collaboration with staff and leaders to improve mental health and substance abuse services?
2. In constrained organisational settings, what may facilitate service providers' engagement in genuine co-production partnerships with service users?

3. What leadership behaviours/styles may enable and/or stifle co-created organisational adaptability in PSOs?

Six important questions concerning qualitative research have been presented by Mason (2018). Philosophical questions related to ontology, epistemology, methodology and axiology (Guba & Lincoln, 1994; Heron & Reason, 1997) will be answered in chapter 3. However, questions illuminating the aims and research questions of the thesis and the three articles will be considered here. This includes three of Mason's questions (Mason, 2018):

1. What is the aims and purpose of my research? (Mason, 2018, p. 16)
2. What is the intellectual puzzle; what is fascinating or intriguing? (Mason, 2018, p. 10)
3. What questions can I ask with my research, and how will they help me in addressing my intellectual puzzle? (Mason, 2018, p. 13)

In line with international and Norwegian political aims presented in the introduction, the aims of this action research have been to facilitate a) *increased user participation in public service development,* and b) *dialogue between service users and providers about service development*. Another aim that was agreed upon in dialogue among staff and patient co-researchers and me as researcher was: *To develop the services offered by this treatment facility for the better.* Importantly, an aspiration was that introducing such collaborative practice to this organisation would result in experiences and co-created knowledge that could inform the main aim of the action research.

Dialogue and collaboration between service providers and users, and a need for 'real' user participation/influence/co-determination opportunities for service users, have been emphasised in governmental documents (Larsen et al., 2006; Ministry of Health and Care Services, 2007, 2015). Ensuring that service users 'are given a formal role and authority to influence the process of designing, planning and implementing policy, law and services' (WHO, 2013, p. 24) is

considered an empowering action in the WHO action plan, which also proposes facilitating dialogue. Accordingly, the overall research question related to the main aim and purpose of the thesis is the following:

How can participation and real influence from patients and staff in service development be ensured?

Furthermore, trying to understand the multiple facets of patient mobilisation, staff resistance and engagement, and leader manoeuvring became increasingly interesting intellectual puzzles over the course of the research process. Indeed, exploring stakeholders' testimonies and actions as they adapted to a new power dynamic that challenged the original treatment hierarchy was also fascinating. To investigate these matters, the analyses in the articles were divided into 1) patient, 2) staff and 3) leader concerns and perspectives. This allowed me to explore each stakeholder's role individually while considering relationships and context. The table below presents the aims and purposes, intellectual puzzles and research questions relating to each article.

Table 1 The three articles – aims/ purposes, puzzles and research questions

	Article 1	**Article 2**	**Article 3**
Aims & purposes	To explore what may keep patients' voices from being heard when collaborating with staff and leaders to improve services. To raise awareness about obstacles to patient involvement.	To explore critical conditions for co-production interaction in a public SMHS. To suggest measures to strengthen staff engagement in co-production.	To explore how involvement in leader decision-making in a PSO may affect an adaptive process. To suggest leadership behaviours that promote conditions for co-created organisational adaptability.
Intellectual puzzle	How are patients perceived and how does this affect their impact on service development?	Why do staff avoid patient contributions to service development?	How do leaders contribute to co-innovation of services?
Research questions	What may keep patients' voices from being heard in their collaboration with staff and leaders to improve mental health and substance abuse services? Helps deepen exploration of issues within the organisational culture that limit patient involvement.	In constrained organisational settings, what may facilitate service providers' engagement in genuine co-production partnerships with service users? Helps turn attention from staff insufficiency to potential for learning to dialogue.	What leadership behaviours/styles may enable and/or stifle co- created organisational adaptability in PSOs? Helps explore how leadership behaviours may enable dialogue among stakeholders and influence decision-making, and focussing on the processes of co-created organisational adaptation.

To achieve an overview of the findings of this action research project and propose steps forward, a new research question has been articulated for the synopsis, namely:

The role of leadership. How can the systematic involvement of leaders, users and providers enable organisational adaptation in public services?

Investigating the role of leadership allows me to explore how a) the relationship between the articles in this thesis, b) the main finding of a co-production method, and c) the conceptualisation of co-creation leadership can help us understand existing and future challenges for PSOs.

1.10 Key concepts

1.10.1 Patient, user and citizen

The Norwegian Patient and User Rights Act distinguishes ‘patients’ and ‘users’: The former term refers to people using health care services while the latter refers to those who ‘request or receive services covered by the Health and Care Services Act’ (Patient and user rights Act, 2020, §1-3, f) that are not health services. Because the research for this thesis was conducted in specialised mental health and substance abuse services (SMHS), and not in welfare services for instance, the appropriate term would be ‘patients’. However, the term ‘service user’ is used in more general discussions of user involvement/participation. In the international literature, the concept appears to include users/patients within the field of mental health care (Millar, Chambers, & Giles, 2015; Wallcraft, Schrank, & Amering, 2009; WHO, 2013).

Furthermore, we use the term ‘citizen’ to describe a former patient who engaged in inquiry activity after discharge from treatment to distinguish

this participant from those patients actively in treatment. This is just to emphasise a change in the relationship between this participant and the PSO under study.

1.10.2 System service user involvement

I use the terms service user participation and service user involvement interchangeably in this thesis. Others, however, have differentiated them: *involvement* means being involved in the design/delivery of research while *participation* means participating as interviewees in interviews or trials (INVOLVE, 2020). Millar et al. (2015, p. 216) define service user involvement as

> an active partnership between service users and mental health professionals in decision making regarding the planning, implementation and evaluation of mental health policy, services, education, training and research.

For patients in Norwegian SMHSs, this right to participate on a system level is regulated by the Health Trust Act, which demands that 'systems for obtaining patients' and other users' experiences and views' be established in the Regional Health Thrusts (Health Trusts Act, 2013, § 35, 2). Moreover,

> the municipality and the regional health authority should facilitate patient and user representatives' participation in the planning, development and evaluation of the rehabilitation/habilitation activities. (Regulation on habilitation and rehabilitation, 2018, § 4, 2).

Although the active participation of patients in this SMHS in service development may have influenced the individual services they received, the focus in this thesis is on user involvement on the service/system/meso level (Abayneh et al., 2017; Millar et al., 2015). More concretely, increasing user participation made it possible to focus on service

development on an organizational level by looking at dialogue between patients, staff and leaders in this local SMHS.

1.10.3 Stakeholders, participants and more

A stakeholder is understood as ‘someone involved with the mental health service system by virtue of employment by a mental health authority, agency, or program, or via receiving mental health services.’ (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009, p. 2087). When referring to ‘stakeholders’ or the three ‘parties’, I include patients, staff (nurses, social workers, social pedagogues, health workers, sports pedagogues, drug specialists, psychologists, psychiatric nurses, and untrained staff) and leaders (medical, assistant unit, unit, clinic, and department leaders) unless specified.

In this thesis, the term participants in principle covers all persons (patients, staff, leaders, trainers, students) who signed the inquiry consent. This includes co-researchers and facilitators. However, it is usually used to refer to persons participating in interviews, dialogue seminars, meetings and so on; co-researchers and facilitators are distinguished when necessary.

2 Social scientific and theoretical frameworks

This chapter presents various theoretical frameworks, including the participatory paradigm, reciprocal empowerment, organisational culture change, communicative and adaptive spaces and leadership, to supplement discussions about orientation and design, as well as the three articles included in the thesis. These theories also contribute to further exploration of leadership and practical methodological concerns related to the systematic involvement of leaders, users and providers in service development

2.1 The participatory social scientific paradigm

To properly address the aim and research questions in this thesis it is necessary to present the theoretical and philosophical frameworks that will be used. The participatory social scientific paradigm has been regarded as an appropriate ground for increasing user participation and co-creating a knowledge-based practice method.

In addition to positivism, post-positivism, critical theory and constructivism (Guba & Lincoln, 1994), Lincoln and Guba (2005) include the participatory/collaborative paradigm in their categorisation (Heron & Reason, 1997; Lincoln & Guba, 2005).

Table 2 The five paradigms

Positivism	Post-positivism	Critical Theory	Constructivism	Participatory
The positivistic paradigms		The interpretivist paradigms		

By including the participatory paradigm, Lincoln and Guba (2005) also include critique of the limitations of constructivism. Heron and Reason

(1997) argue that the constructivist paradigm is only concerned with propositional knowledge, the making of theory. It has not articulated or sufficiently acknowledged *experiential knowing* 'that is, knowing by acquaintance, by meeting, by felt participation in the presence of what is there' and *practical knowing,* which is more useful at the point of action (Heron & Reason's 1997, p. 276). To illustrate Heron and Reason's (1997) arguments, I introduce Searle's (1995, 2006) accounts of reality and knowledge.

2.1.1 Ontology and social facts

Ontology is the branch of philosophy that concerns *what can be said to exist* (Seale, 2006). Unlike objective ontology, subjective ontology is dependent on human conscience. Searle (1995, 2006) differentiates between physical and mental facts: 'Raw physical facts' in the external world – 'mountains, molecules and tectonic plates for example' – exist independent of any human or animal experience and are ontologically objective (Searle, 1995; 2006, p. 55). 'Mental facts' (experience, thoughts and feelings) including 'social facts' (produced by collective intentionality) that are constructed by humans or animals, such as 'pains, tickles and itches', exist only when experienced and are ontologically subjective (Searle, 1995; 2006, p. 55).

2.1.1.1 Subjective-objective ontology

Unlike Searle (2006), Heron and Reason (1997) do not divide reality into things that are dependent on and things that are independent from experience and consciousness. Rather, in the participatory paradigm, reality is participative and co-created by mind and matter; this ontology is termed subjective-objective (Heron & Reason, 1997). Heron and Reason (1997) claim that what can be known about the form and nature of reality is always both subjective, in terms of an individual mind's perception of reality when participating in it, and objective because 'the mind interpenetrates the given cosmos which it shapes' (Heron, 1996, p.

11). The authors argue that the given cosmos can only be known as a 'subjectively articulated world, whose objectivity is relative to how it is shaped by the knower …its objectivity is also relative to how it is intersubjectively shaped' (Heron & Reason, 1997, p. 278).

2.1.2 Epistemology and co-created objective knowledge

Epistemology is the branch of philosophy concerned with *how we may know* what exists (Seale, 2006). Searle (2006) believes that social institutional facts such as money or political elections can be 'epistemologically objective, even though human attitudes are part of their mode of existence' (Searle, 2006, p. 55). For a statement to be considered epistemically objective, it 'presupposes intersubjective communicability' and it should be 'built on available facts or data, and supported by arguments' (Sollie & Barbosa da Silva, 2018 p. 3 and 8). It should be testable in the same or other contexts. Ontologically subjective facts may include both first-person ('I' or 'we') and second-person ('you') viewpoints about experience perceived by conscious humans. Sollie and Barbosa da Silva (2018) claim that the third-person viewpoint is the viewpoint of the scientist. All three viewpoints are necessary to describe epistemological objective knowledge (Solli & Barbosa da Silva, 2018).

2.1.2.1 Extended epistemology and the supremacy of practical knowing

With the notion that reality is both subjective and objective, and that a knower participates in the known, epistemology extends to four interdependent ways of articulating the world: experiential, presentational, propositional and practical knowing (Heron & Reason 1997, 2008). Briefly defined, *experiential knowing* 'is knowing through the immediacy of perceiving, through empathy and resonance' (Heron & Reason, 2008 p. 367). In other words, when we open ourselves to

experiencing the presence of something/someone, we become illuminated by being in a state of interrelatedness and co-presence with it/them (Heron & Reason, 1997). *Presentational knowing* emerges from encounters of experiential knowing. It reveals a preconceptual shared life-world where communion or resonance is explored through 'expressive imagery of movement, dance, sound music, drawing, painting, sculpture, poetry, story and drama' (Heron & Reason, 2008 p. 367). *Propositional knowing* is also rooted in experiential knowing, as it is continually tested in practice. The products of this kind of knowing are spoken or written statements about 'intellectual knowing of ideas and theories' (Heron & Reason, 2008 p. 367). *Practical knowing* completes the former three ways of knowing as its product is skilled action or competence supported by a community of practice (Heron & Reason, 2008): 'This is knowing how to do something… It presupposes a conceptual grasp of principles and standards of practice, presentational elegance and experiential grounding' (Reason, 1998, p. 427).

This extended epistemology is considered radical, particularly as it relates to the primacy of practical knowing (Heron & Reason, 1997). Enhancing personal, social and eco-network fulfilment is an end in itself because knowing how to choose and act hierarchically, co-operatively, and autonomously is regarded as central to human flourishing (Heron & Reason, 1997). The pre-eminence of practical knowing is portrayed at the top of a pyramid resting, and therefore relying, on propositional, presentational and experiential knowing (Reason, 1998). Developing critical subjectivity is thus a necessary challenge for the knower. To provide unclouded descriptions of a world from a disciplined subjectivity that does not contaminate it, it is necessary to be aware of how these four ways of knowing interact (Heron & Reason, 1997). The knower does not supress, but rather accepts, the subjective experiential articulation of participating in the inquiry because it is the ground where she/he stands. Furthermore, as the knower is required to continuously reflect on their

own experience, critical intersubjectivity such as dialogue and feedback from others necessarily enhance critical subjectivity (Reason, 1998).

2.1.2.2 Axiology and the researcher's practical knowing

Axiology is the branch of philosophy that is concerned with ethics, aesthetics and religion (Lincoln & Guba, 2005), but also with value more generally (Heron & Reason, 1997). In the context of this study, the researcher's values are a 'major point of departure' as they are fed into the inquiry process through choices about the problem, the paradigm guiding the inquiry, the theoretical framework, data-gathering/analytic methods, context, and what journal to publish in (Lincoln & Guba 2005, p. 169).

In the participatory paradigm, axiology is connected to the pre-eminence of practical knowing, of developing an ability to be reflexive *in* action (Heron & Reason, 1997; Argyris, 1995; Freire, 2005). For example, Heron and Reason (1997) call for 'an action inquiry useful to the actor at the point of action, rather than reflective science about action' (Heron & Reason, 1997, p. 279). Axiology also determines the intention of participation in this paradigm: Propositional knowledge may be grounded in researchers' own experiential knowledge; however, according to a participatory worldview 'our action is in the service of human flourishing' and transformation (Heron & Reason, 1997, p. 284). This intention is related to empowerment theory (Freire, 2005).

2.2 Reciprocal Empowerment

Paulo Freire's liberationist philosophy has been considered one of the main contributors to empowerment theory (Freire, 2005). In *The Pedagogy of the Oppressed* Freire defines oppression as being hindered in pursuing self-affirmation, liberation and becoming more fully human (Freire, 2005). Self-initiative, self-inquiry and self-directedness echo through action research literature as benefitting system/societal change

(Brydon-Miller, Greenwood, & Mguire, 2003; Greenwood & Levin, 2007; Heron, 1971, 1996; Kasl & Yorks, 2002; Newton & Goodman, 2009; Reason & Bradbury, 2008; Torbert, 1981; Torbert & Taylor, 2008). Like Freire, action researchers have argued that empowerment is not something that is granted by those with the most privilege. Rather, it happens when genuine relationship shifts are facilitated through collaboration on equal terms (Yorks et al., 2008).

In *role migration,* for example, a person can step up into a different role claiming power as teacher or leader to influence others. The other person steps back, consciously or not, into the role of learner or follower (Yorks et al., 2008, p. 494). Freire's concept of *dialogical action* similarly connotes reciprocity (Freire, 2005, 2014). According to Freire, dialogue should be a curiosity-driven epistemological relationship between the oppressed and their oppressors (Freire & Macedo, 1995) with the aim of naming and transforming dominant structures together (Freire, 2005). Freire argues that the oppressed must commit to uncovering the world through *praxis*, which he describes as transformational action and reflection, and that dialogue can collectively empower both parties (Freire, 2005; Freire & Macedo, 1995).

To put it another way, facilitating individual growth of self-directed capacity is regarded as valuable to collective empowerment. Self-empowered persons can more fully develop in reciprocal empowering relationships; naturally, both self- and reciprocal empowerment contribute to a collective momentum when fighting for liberation from oppressive dominant societal structures (Freire, 2005; Heron, 1996). In this thesis, the understanding that empowerment is reciprocal is linked with an understanding of professional and experiential perspectives as complementary contributions to strengthening service quality and service responsiveness (Larsen & Sagvaag, 2011).

2.3 The diagnostic culture

Assuming that knowledge is regarded as equal and complementary in the relationship between service users and providers is not necessarily the norm in PSOs. A study conducted in a Norwegian psychiatric hospital revealed a pathologizing diagnostic culture among service providers (Løchen, 1970). This organisational culture was confrontation-avoidant and restraining in relation to social change and an individualised diagnostic logic steered the explanations toward the pathology of the patients. By limiting the causes of behaviour to the individual, the members of this diagnostic culture failed ‘to see behaviour as an expression of a social constellation or conflict’ (Løchen, 1970, p. 212). Patients were encouraged to try out co-determination, although some restrictions and constraints were regarded as necessary: There was always a possibility that patients would self-harm or be in conflict with the system. By adding patients’ protests to already existing pathological assumptions about them, the diagnostic culture hindered patients from promoting their claims and thereby avoided conflict (Løchen, 1970).

Løchen’s (1970) theory is considered a landmark in Norwegian sociology (Næss & Pedersen, 2012). More recent literature has also pointed to the diagnostic culture inside and outside mental health services (Brinkman, 2016; Frances, 2013). Staff and leaders in such organisational cultures appear to over-cautiously manage patients into receiving roles. The assumption that controlling patients’ co-determination (due to pathological concerns) is the way to solve psychiatric problems is not new. In today’s context, where public involvement is regarded as valuable, the question is rather whether the problem-solving mechanisms of diagnostic organisational cultures are getting old (Beredsford & Menzies, 2014; Sweeney, Beredesford, Faulkner, Nettle, & Rose, 2009). To enhance public involvement in PSOs, some organisational cultures may need to change so that collective empowerment is not limited by a failure to recognize social and societal interpretations of behaviours and communication.

2.4 Organisational culture, learning and dialogue

Schein defines organisational culture as 'the pattern of basic assumptions' that have been 'invented, discovered or developed in learning' (Schein, 1984, p. 3). These assumptions lead to problem-solving mechanisms that are considered appropriate for addressing internal and external problems. Organisational culture is rooted in experiences of positive problem-solving behaviour that ensure predictability and harmony. However, an individual's striving for equilibrium may also cause anxiety-avoidant behaviour, which will be repeated if the cause of the anxiety is not tested for its validity. An example of this related to public involvement would be the 'cultural journey' (Boström et al., 2017). Consequently, assumptions that are taken for granted must be uncovered when aiming to achieve organisational development (Schein, 1984). Schein argues that organisational learning requires 'the evolution of shared mental models that cuts across the subcultures of an organization' (Schein, 2002, p. 28). Shared mental models are shared assumptions in the form of 'individually held knowledge structures that help team members function collaboratively in their environments' (McComb & Simpson, 2014, p. 1479).

Schein regards dialogue as a tool for facilitating the formulation of shared problems, solutions and assumptions (Schein, 2002). The central purpose of dialogue is to establish a communication field for vigorous exploration and free flow of meaning (Isaacs, 2000). While inquiring into often incoherent and fragmented interpretations of meaning, 'people gradually learn to suspend their defensive exchanges and further, to probe into the underlying reasoning of why those exchanges exist' (Isaacs, 2000 p. 232-233). In the evolving communication there may be a recognition that the dialogue's purpose is not to hide but to explore tacit differences (Isaacs, 2000). Establishing dialogue requires the refinement of 'collective modes of awareness to promote increasingly more subtle and intelligent modes of interaction', such as suspending

defensive routines and observing patterns of interaction (Isaacs, 2000 p. 246). Groups can fluctuate between suspending and discussing views, but incoherence and fragmentation can cause frustration among their members. Being exposed to unexpressed assumptions previously taken for granted can be difficult. It may be tempting to engage in competitive, persuasive and decision-oriented discussion or debate (Isaacs, 2000; Schein, 2002).

However, the group may develop a capacity to engage in more deliberate inquiry, for instance suspending and examining individual and collective assumptions makes 'listening for the incoherence of the whole' possible (Isaacs, 2000, p. 246). Dialogue can be confrontational, but it also allows group members to build trust and common ground. *Metalogue* is described as collective thinking and communication, in which the members of a group build new shared assumptions together (Isaacs, 2000; Schein, 2002). In this process, assumptions are identified, questioned and evaluated for their usefulness in guiding action (Zaunderer, 2001). Thus, in exploratory dialogue between service providers and users, the former's assumptions about knowing best about the latter's pathology may be tested for their usefulness in guiding action related to service development (Boström et al., 2017; Løchen, 1970). In an organisational hierarchy where patients may be oppressed, creating safe and open communicative space is necessary to facilitate cool inquiry between stakeholders (Gayá Wicks & Reason, 2009; Løchen, 1970).

2.4.1 Communicative space and empowerment

Communicative space is a social arena where stakeholders explore issues of joint concern through constructive dialogue and creative problem-solving (Bodorkós & Pataki, 2009). Such space makes new and different relationships possible. However, it must be both safe – allowing the containment and expression of anxiety, chaos and diffusion – and open – enabling individual and collective life worlds to be communicated (Gayá Wicks & Reason, 2009, p. 249). Opening a communicative space

in a setting where 'some people bring experiences of being disempowered' can be challenging (Gayá Wicks & Reason, 2009, p. 249). Awareness of power relationships and process facilitation are necessary (Arieli, Friedman, & Agbaria, 2009; Drake, 2014; Eady, Drew, & Smith, 2015; Freire & Macedo, 1995; Ospina et al., 2004; Reason & Bradbury, 2008). Drake (2014) suggests that we think realistically about and confront the challenges that exist in settings where 'us and them' interactions are the status quo: 'Othering' can be challenged and overcome in quality relationships where understanding, compassion and co-production of knowledge is nurtured (Drake, 2014). Therefore, the emotional quality of interaction must be attended to continuously through dialogue facilitation to uphold a safe environment where participation can flourish (Gayá Wicks & Reason, 2009).

Communication is both cognitive and affective, but the suppression of affect hinders processes of emotional and cognitive transition, learning and maturing (Newton & Goodman, 2009). Underpinning communicative space are the acceptance of affectivity and the acknowledgement and tolerance of the emotional force behind the needs of others. Such emotional receptivity can be difficult, but facilitators can promote this capacity among participants in action research (Newton & Goodman, 2009). Emotional receptiveness can lead to understanding as the feelings of the other resonate within oneself. Newton and Goodman (2009) define this as *learning in the presence of others.* Participants may feel threatened by this process because cognitive and emotional engagement with the other may literally change their minds (Newton & Goodman, 2009; Smith et al., 2015); however, without affective exchanges and acknowledgement of emotional shifts, communication and interpersonal relations often remain shallow (Newton & Goodman, 2009).

In light of Freire (2005), facilitating self-empowerment appears to include strengthening what Newton and Goodman (2009) describe as the development of an individual's capacity to be emotionally receptive and

to make sense of affectivity. Such a capacity for self-empowerment may enable stakeholders to engage in genuinely reciprocal relationships, as opposed to excluding or avoiding the other party to protect oneself against disempowering, overwhelming affective/emotional resonance (Newton & Goodman, 2009). Facilitating the development of this capacity for self-empowerment may also include providing opportunities to learn how to suspend emotions and break away from defensive exchanges/routines and assumptions in a safe environment and explore the usefulness of these factors in guiding one's actions (Isaacs, 2000; Zaunderer, 2001). These individual developments may contribute to mutual growth and collective empowerment, benefitting both service providers and users (Freire, 2005; Newton & Goodman, 2009).

Thus, a facilitator must support the development of a space for learning in the presence of the other. When it is possible to feel and think together across hierarchical boundaries, threatening issues can be worked through and learned from as opposed to avoided by using established personal and organisational defence mechanisms (Argyris & Schön, 1974; Drake, 2014; Newton & Goodman, 2009). In public involvement, it appears that communicative spaces are important for confronting threatening, deep-seated dilemmas, such as power and exclusion, engaging in meaningful collaboration, and building and sustaining relationships (Eady et al., 2015). When considering power, emotional receptivity, affectivity sense-making, and defensive exchanges we are looking closely at the potential for organisational culture change. It is time to look at the role of leadership in relation to public involvement and PSO adaptation.

2.5 Leadership

2.5.1 Enabling adaptive space

It can be argued that adaptive space has some of the potential of communicative space (Uhl-Bien & Arena, 2018). Adaptive space

encompasses how an organisation's ability to adapt to a dynamic environment emerges in interaction between entrepreneurs and operatives and through integration between innovation and production. The 'facilitator' is a leader enabling the adaptive space who also manages entrepreneurial and operational leadership styles (Uhl-Bien & Arena, 2018). Rather than top-down leadership that shows bias towards order and responds to chaos by pulling back to equilibrium, Uhl-Bien and Arena (2018) emphasise leadership as a network-oriented adaptation process where conflict and tension are enabled and addressed/encountered. Adaptive spaces open when pressure to meet the needs of a given situation increases and dissolve when that pressure is reduced.

> These spaces can be physical (e.g., work space, adaptive architectural designs), virtual (e.g., social networks, online communities), meetings (e.g., hackathons, design thinking sessions), or head space (e.g., dedicated free time for innovation). (Uhl-Bien & Arena, 2018, p. 99)

Ambidexterity is essential to Uhl-Bien and Arena's (2018) framework for leadership for organisational adaptability. Being able to write with both hands seems an appropriate metaphor for leaders who balance exploration and exploitation in a learning organisation through an adaptive process. Ambidexterity describes how leaders must engage in the tension between innovation and efficiency and create linkage/integration between organisation members so that they can collaborate to adapt the organisation to the external environment (Uhl-Bien & Arena, 2018). Boundary spanning activities such as mediation; aligning actions through organisation and implementation (integration); enabling collaboration through joint training, planning and decision-making; and deploying resources are examples of linking activities.

Finally, integration is also necessary in and across the hierarchical levels of an organisation, and distributed leadership should be supported. Thus,

ambidexterity is also about generating tension between leaders and employees in an organisation. If this tension is followed by 'integration –the process of achieving unity of effort among the various subsystems of an organization' – it is beneficial (Uhl-Bien & Arena, 2018, p. 91). With leadership for organisational adaptability, leaders may potentially enable service users' and providers' joint efforts in service development/organisational adaptation. However, the leadership level is part of the tension in the adaptive process. Although both communicative and adaptive spaces may prove essential to exploring and implementing change/adaptation, effective PSO leadership also seems to include skill in making decisions and involving stakeholders in decision-making processes.

2.5.2 Decision-making

It has been argued that the best supported contingency theory of effective leadership is Vroom and Yetton's normative decision model (Yukl, 2010). Building on cumulative research related to the Vroom-Yetton (and, later, Vroom-Jago) model (Vroom & Jago, 1995), Vroom developed five leadership styles: *decide, consult individually, consult group, facilitate* and *delegate* (Vroom, 2000). This conceptualisation could help social scientists understand how decisions are actually made with regard to whether and when leaders decide to involve others in decision-making. Table 3 underneath has been adapted from Vroom (2003, p. 970)

Table 3 Vroom's Leadership styles

Decide	You make the decision alone and either announce or 'sell' it to the group. You may use your expertise in collecting information from the group or others that you deem relevant to the problem.
Consult (individually)	You present the problem to group members individually, get their suggestions, and then make the decision.
Consult (group)	You present the problem to group members in a meeting, get their suggestions, and then make the decision.
Facilitate	You present the problem to the group in a meeting. You act as facilitator, defining the problem to be solved and the boundaries within which the decision must be made. Your objective is to get concurrence on a decision. Above all, you take care to ensure that your ideas are not given any greater weight than those of others simply because of your position.
Delegate	You permit the group to make the decision within prescribed limits. The group undertakes the identification and diagnosis of the problem, developing alternative procedures for solving it, and deciding on one or more alternative solutions. While you play no direct role in the group's deliberations unless explicitly asked, your role is an important one behind the scenes, providing needed resources and encouragement.

In addition to the enabling, entrepreneurial and operational leadership styles proposed by Uhl-Bien and Arena (2018) and Vroom's (2000) five leadership modes, there are many more leadership behaviours for PSO and other leaders to choose from (Goleman, 2000; Jacobsen, 2018; Ospina, 2016; Uhl-Bien, 2006; Uhl-Bien & Arena, 2018; Van Wart, 2011, 2017; Vroom, 2003; Yukl & Gardner, 2020). The Hierarchical Taxonomy of Leadership Behaviours, described below, presents another 15 leadership behaviours (Yukl, 2012)

2.5.3 Multiple leadership behaviours

To contribute to increased understanding of leadership behaviours and ways to improve effective leadership, Yukl and colleagues have conducted studies to assess support for a multi-dimensional model (Yukl, Gordon, & Taber, 2002; Yukl, Mahsud, Prussia, & Hassan, 2019). In the Hierarchical Taxonomy of Leadership Behaviours, four meta-categories are used to describe how team, work unit and organisation performance can be influenced by leadership behaviour (Yukl, 2012). The categories *task*-, *relations*-, *change-oriented* and *external* leadership behaviours correspond to different performances.

The behaviours associated with task-oriented leadership are planning, clarification, monitoring operations and problem solving. *Planning* means deciding on objectives and priorities, scheduling, organising, allocating resources and assigning tasks to accomplish objectives. Furthermore, because employees need to understand what results are expected, what to do, and how to do it, they need *clarification*: leaders must explain relevant rules, policies, procedures, responsibilities and tasks, communicate objectives, priorities and deadlines, and set performance standards. Task-oriented leaders also *monitor operations* to assess whether the work is progressing according to plan and the assigned tasks are being carried out. *Problem solving* is necessary for dealing with unpredictable situations and illegal, destructive or unsafe behaviour among staff members.

Relations-oriented leadership behaviours include supporting, developing, recognising, and empowering behaviours. Showing positive regard, helping people cope and building cooperative relationships are all *supporting* behaviours. To increase members' skills and confidence and facilitate career advancement, leaders can engage in *developing* behaviours, for instance, providing career advice, opportunities, developmental coaching, and tasks that facilitate experiential learning for individual development. Furthermore, by *recognising* workers'

efforts, leaders show appreciation for team members who are effective and contribute to the team or organisation. Leaders can also be *empowering,* giving subordinates more influence and autonomy in decisions about work. Yukl claims that consultation (asking for advice) and delegation (giving decision-making authority to individuals/groups) are empowering decision-making procedures related to leadership effectiveness (Yukl, 2012).

Behaviours associated with change-oriented leadership include advocating change, envisioning change, encouraging innovation and facilitate collective learning. When *advocating change*, leaders explain why it is necessary by providing information about successful changes and explaining possible undesirable outcomes if problems and opportunities are ignored. A leader may propose a strategy, but 'involving people with relevant expertise usually results in a better strategy and more commitment to implement it' (Yukl, 2012, p. 73). When *envisioning change*, leaders build commitment to new initiatives and strategies by articulating a clear and appealing vision that is relevant to the values, ideas and needs of members. *Encouraging innovation* involves encouraging creative thinking and facilitating creativity and innovation. A leader that explicitly values creativity can create a climate of mutual trust and psychological safety. As champions or sponsors of innovative proposals, leaders may also provide opportunities and resources for developing new products and services. Further, a leader can *facilitate collective learning* of new knowledge. Existing work methods and strategies can be improved, or new ones may be discovered. Also, by supporting internal activities such as research projects or small-scale experiments and learning activities from external sources, leaders may enable members to acquire new knowledge. Moreover, a climate of safety may enhance collective learning from failures and successes.

Finally, external leadership behaviours include networking, external monitoring and representation. *Networking* builds and sustains favourable relationships. *External monitoring* includes identifying

threats and opportunities and analysing information about the external environment that is relevant to the organisation's performance. Also, in transactions with superiors, peers or outsiders, leaders are *representing* their organisation. This includes lobbying, promoting, defending, negotiating agreements and coordinating related activities (Yukl, 2012).

To summarize, leaders in PSOs have many behaviours/styles to choose from when adapting public services to the contemporary context. Although leaders are regarded as key contributors to the organisational cultural change and organisational change required to enhance public involvement, the literature exploring co-creation and co-production leadership is limited (Boström et al., 2017; Schein, 2010; Storm, 2010; Tsui et al., 2006; WHO, 2013; Xenikou, fourthcoming). Leadership of co-production processes has been explored by Schlappa and Imani (2018). They argue that in co-production the power to influence and set the direction does not belong to PSO leaders alone (Schlappa & Imani, 2018).

2.5.4 Partnerships and leadership

Co-production demands more active participation and decision-making from the service user (Needham & Carr, 2009). It therefore moves beyond consultation exercises, where service providers only ask for feedback and have no obligation to change services based on the advice they get from service users. Needham and Carr (2009) argue that even if flexibility with regard to the service users' priorities collides with organizational constraints, service users must be involved in defining problems and developing and implementing solutions (Needham & Carr, 2009). Combining 'co' with 'production' emphasises the shift from subordination to parity and addresses the need for a more active and visible role, function, and status for service users (Cahn, 2004). The co-production partnership 'should mean service users and carers work with frontline staff who are empowered and confident about sharing power' (Needham & Carr, 2009, p. 9). Co-productive approaches emphasise the

outcomes of close and sustained relationships between service providers and users, promoting dialogue and negotiation in service development. Both parties have resources and assets that can be exchanged, and collaboration between them can result in beneficial relationships that enhance individual and community power, influence and activity (Needham & Carr, 2009).

2.5.4.1 Co-production and co-creation of value

In *consumer co-production,* the core of co-production is individual service consumption (Osborne & Strokosch, 2013). Through face-to-face contact, service staff and service users collaborate to achieve consumer satisfaction. This is the 'moment of truth', 'where service users' expectations of a service collide with their experience of the service process' (Osborne & Strokosch, 2013, p. 36). *Participative co-production* takes place at the strategic planning level in the form of participative mechanisms and user consultations with the aim of improving the quality of existing services based on service user experiences. Service users can therefore have a 'direct effect upon the direction of service development' as partners (Osborne & Strokosch, 2013, p. 38). In addition to co-designing their own care plan in consumer co-production, service users may engage in co-designing public services through participative co-production. Co-designing involves cooperating creatively, exploring and expressing needs, and making solutions together (Steen, Manschot, & De Koning, 2011). It concerns improving public service capacity, design, and delivery (Osborne, Zoe, & Strockosch, 2016).

Co-production has been defined as the involvement of public service users and providers 'in any of the design, management, delivery and/or evaluation of public services' (Osborne, Zoe, et al., 2016, p. 640). It 'involves a mixing of the productive efforts of regular and consumer producers' and may occur directly in the production process or indirectly in related efforts (Parks et al., 1981, p. 1002). Co-production

encompasses *co-implementation,* such as citizens filing tax returns (Pestoff, 2012) or calling the police (Ostrom, 2012); *co-design,* such as designing a public service website (Boviard & Löffler, 2012) or a patient's own wellness programme (Etgar, 2008); *co-provision,* such as parental involvement in child care (Vamstad, 2012); and *co-innovation*, such as the non-monetary service transactions in time banking (Cahn & Gray, 2012) and user-led innovation (Osborne & Strokosch, 2013; Osborne, Strokosch, & Radnor, 2018).

As with co-production, many authors have regarded the increase of citizen involvement as one of the main objectives of co-creation (Voorberg et al., 2015). At the same time, co-production can lead to value co-creation (Osborne et al., 2018), which is described as the usage/consumption stage of co-production (Etgar, 2008; Karpen, Bove, & Lukas, 2012; Osborne, Zoe, et al., 2016; Vargo & Lusch, 2008; Voorberg et al., 2015). Some regard co-production as a means and value in itself (Cahn & Gray, 2012; Voorberg et al., 2015) while others claim that co-production precedes and is both subordinate to and nested within co-creation of value (Etgar, 2008; Vargo & Lusch, 2008). In co-creation of value, the service user and the service provider together create the value that the service user experiences when offered a public service (value-in-use). According to Osborne et al. (2018), this value originates from a) welfare that enables individuals to enhance their lives, b) well-being as a result of interacting with service providers and c) an increase in individual problem-solving capacity due to welfare and help from service providers (Osborne et al., 2018).

Although co-production is not a normative good, there is no guarantee that the process will be constructive. It can also lead to co-destruction of value when it is misunderstood as tokenism (Osborne, Zoe, et al., 2016). Scholars have argued for the benefits of a critical relational perspective on leading co-production (Schlappa & Imani, 2018).

2.5.4.2 Leading co-production

Schlappa and Imani (2018) draw on distributed leadership when defining leadership as something other than a property of a few privileged individuals. Leadership itself may be co-produced in social and relational interactions between leaders and followers (Carsten & Uhl-Bien, 2012; Uhl-Bien, Riggio, Lowe, & Carsten, 2013). Schlappa and Imani (2018) claim that co-production is a relational and interdependent process, and that professional and citizen co-producers may have conflicting expectations and motivations. A leadership approach to co-production requires a perspective that acknowledges power dynamics among, and actions of, professionals and citizens in context. The following are three ways regular and citizen co-producers might approach and understand leading service co-production:

- Nurture opportunities for dialogue about content and purpose, and for challenging assumptions and expectations rooted in dissimilar knowledge and expertise.
- Create spaces that are lightly structured, where restrictions and rules that constrain discussion and actions are minimized. Provide opportunities for citizens to shape a context that facilitates involvement.
- Acknowledge that power is negotiated and relational, and that 'leadership and associated expressions of power are negotiated and dynamic' (Schlappa & Imani, 2018, p. 103-4)

In short, if we ask 'Who is in the lead?' in co-production, the response is more likely collaborative practices than normative leadership frameworks (Schlappa & Imani, 2018, p. 103). This implies role-migration (Yorks et al., 2008). Awareness of an interdependent co-production partnership between stakeholders where any party may initiate direction is in line with these authors' understanding of co-production leadership (Needham & Carr, 2009; Osborne & Strokosch, 2013; Schlappa & Imani, 2018). They urge a departure from public

administration leadership research 'rooted in assumptions that control and power resides with independent individuals or groups where one has power and control over the other' to explore more horizontally and vertically distributed leadership where power is a relational dynamic (Schlappa & Imani, 2018, p. 106).

In this chapter, I introduced the participatory paradigm as an appropriate scientific foundation for exploring how to increase user participation and co-create knowledge that may inform the development of a practice method that enables both service users and providers to influence service development. Furthermore, I selected theories to look at the potential for reciprocal empowerment in co-production partnerships to optimise public involvement and change from a paternalistic diagnostic organisational culture into a partnership-oriented one. In doing so, I have suggested potential tools for personal/professional development, organisational adaptation and leadership in the form of theories of communicative and adaptive spaces and potentially fluctuating leadership roles, styles and behaviours.

3 Orientation and design

3.1 Participatory paradigm and action research

Lincoln and Guba (2005) claim that the clearest example of the division between the philosophical paradigms of positivism and interpretivism is their take on action in research. Positivism sees researcher action as advocacy that contaminates subjectivity – and therefore a threat to validity and objectivity. While interpretivist paradigms regard ‘action on research results as a meaningful and important outcome of inquiry processes’ (Lincoln & Guba 2005, p. 174). Following Kuhn (1970) and Lincoln and Guba (2005), Heron and Reason (1997) explicitly differentiate the participatory paradigm from what they regard as objectifying and limiting positivism. This paradigm

> allows us as human persons to know that we are part of the whole, rather than separated as mind over and against matter… in relation with the living world—and we note that to be *in relation* means that we live with the rest of creation as *relatives*, with all the rights and obligations that implies (Heron & Reason 1997, p. 275, emphasis in original)

The action research orientation, which lies within the participatory paradigm, has been regarded as appropriate for pursuing both action and research aims and questions of this thesis. Creating ‘change *with* others’ through collaborative and cyclic engagement in action and reflection are considered key in action research (AR) (Reason & Bradbury, 2008, p. 1. Original italisation); improvements and democracy are desired outcomes of AR, and the creation of communicative space as central to an emancipatory endeavour (Hyland, 2009; Newton & Goodman, 2009). There is a wide variety of AR methods and approaches, including co-operative inquiry (described below), the AR methodology which has inspired this research (Chen, Huang, & Zeng, 2018; McNiff, 2017; Reason, 1994). Both qualitative and quantitative research methods may

be utilised in AR, and stakeholders' participative engagement is regarded as essential (Hummelvoll, 2003). This study used qualitative research methods including participative observation (May, 2001; Savage, 2000), co-researcher led semi-structured individual interviews (Silverman, 2006), multistage focus group interviews (Hummelvoll, 2008), and dialogue seminars (Hansen & Bjerke, 2011), as described in Larsen and Sagvaag (2018).

3.2 AR inquiry practices in a single case study

A single case study was determined to be a suitable design (Yin, 2009) for this AR study, which aimed to intervene in a Norwegian SMHS unit to increase user participation, facilitate service development and develop a practice method based on these experiences. The use of single case studies in AR has been promoted by Reason (2003; 2006), who claims that the collection of intense and focussed experiences through *first-* and *second-person inquiry* is necessary to transform attitudes, experiences and practices that in turn may change society (Reason, 2003). To elaborate, AR requires the researcher to foster an inquiring approach, taking into consideration his or her impact on the context and facilitation of participation (Torbert & Taylor, 2008). This is part of first-person inquiry practice, which both researcher and participants may engage with. At the same time, a researcher's self-awareness and mindful action may benefit self-inquiry and self-initiative in others and help them develop experience and skills (Reason & Bradbury, 2008). Such communicative processes qualify as second-person inquiries in face-to-face exploration of issues of mutual concern such as improving personal and professional practice (Reason & Bradbury 2008), for example improving public services. Knowledge produced in first- and second-person inquiry in an action research context may strengthen third-person inquiry conducted by the researcher, referred to as theory- and hypothesis-making (Reason & Bradbury 2008; Torbert & Taylor, 2008).

In line with the participatory worldview (Heron & Reason, 1997), I was 'part of the whole' single case study as an action researcher in relation to stakeholders, some of whom became colleagues, friends or even 'foes'. Therefore, engaging in first- and second-person inquiry with supervisors, participants and research colleagues was vital to ensure a trustworthy researcher/third-person inquiry practice (Solli & Barbosa da Silva, 2018; Torbert & Taylor, 2008). When translating the communications and actions of my participant 'relatives' into theory, I made a concerted effort to avoid contaminating them with undisciplined subjectivity (Heron & Reason, 1997). However, because of my proximate access to and engagement in the inquiry as an action researcher, my preunderstandings impacted the context, the participants and the knowledge that comprises this thesis.

3.3 Preunderstandings

I had been a social consultant in the SMHS for less than a year when I introduced the plans for this project to my leaders. I was a member of the multi-disciplinary treatment team as part of the treatment staff. I had gained insight into the organizational structure, culture, rules and treatment practice and became acquainted with the tasks and roles of professionals and leaders in the organizational hierarchy. In addition to professional and theoretical preconceptions, a preunderstanding from personal experience with addiction provided another perspective on theory and action. In my experience, these preunderstandings were both conflicting and complementary, they also appeared to strengthen my mediation and translation between the involved parties to resolve conflict, develop services and more. I suspect that a more detached researcher would have had difficulty identifying some of the deeply-rooted issues in this context. However, my professional and personal background also both enabled and hindered my moving between outside and inside perspectives. After all, some issues were perhaps too 'close to home' – and psychological defense-mechanisms such as self-stigma,

denial and secrecy could emerge and veil potential knowledge in the data.

3.3.1 Withdrawing from immersion

To produce articles appropriate for publication in scientific journals, it was necessary to withdraw from the experiential immersion I engaged with as a participating researcher in this project. Kuhn's box metaphor about a revolutionary transition from one paradigm to another is apt to describe my move from experiential and practical knowing to propositional knowledge (Heron & Reason, 1997; Kuhn, 1970): In one sense I had to climb out of the box I had been in and studied from the inside to analyse these experiences with the help of theory from a more distant position outside – at my desk. This resembles what Kuhn describes as a revolutionary transition of vision (Kuhn, 1970).

3.4 A critical, unique and revelatory case

Flyvbjerg (2006) claims that describing a unique phenomenon without attempting to generalise can be valuable to the collective process of knowledge accumulation, and it may contribute to scientific innovation (Flyvbjerg, 2006). Although AR does not aspire to distance, objectivity and control, creating theory from a distant as well as a proximate stance is vital (Brydon-Miller et al., 2003). Yin (2009) argues that 1) critical, 2) unique/extreme and 3) revelatory cases, among others, can only be conducted as single-case studies: The first critically tests existing theory, the second studies rare or unique circumstances, and the third includes observation and analysis of a previously inaccessible phenomenon (Yin, 2009). In this thesis, all three rationales applied to the selected case.

Approaching this study as a *critical* case, we wanted to challenge, confirm and perhaps even extend existing theory in the fields of public involvement and leadership while meeting the conditions for theory testing (Yin, 2009, Flyvbjerg, 2006). For instance, continuously asking

the leaders and staff in the SMHS whether patients should be invited to a given meeting/conference/hearing was an effort linked with governmental incentives about increasing user participation. Disseminating the co-created knowledge resulting from this project, on the other hand, may support and inspire subsequent research, theory-building and change on a societal level.

This case may also be regarded as *unique*. At the time of the study, no reports were found of AR conducted within Norwegian public mental health and substance abuse services with service improvement as a shared objective among stakeholders. Yin (2009) explains that a unique case may be so rare that it is fruitful to document and analyse it. Determining the precise nature of an unknown phenomenon and ascertaining whether related phenomena exit can be necessary to develop further knowledge or a hypothesis worth testing with further investigation (Yin, 2009). In particular, concerning the degree of stakeholder involvement, the research design, the practice method and the underlying conceptualisation can all be viewed as new scientific contributions to our understanding of public involvement and leadership. Unique cases are also suited to dramatically getting a point across (Flyvbjerg, 2006), as Løchen's (1970) field study did. Our unique case study suggests that organisational cultures may be deeply rooted but with systematic intervention they may change.

Yin argues that another way to conduct a single-case study is to uncover 'some prevalent phenomenon previously inaccessible to social scientists'; this is what he calls a *revelatory* case (Yin 2009, p. 49). Part of what makes the study in this thesis revelatory is what Lofthus (2018) calls the researcher's four dimensional knowledge: a preunderstanding anchored in experiences as service user and provider, carer and researcher (Lofthus, 2018).

3.5 Differences and similarities between AR and case studies

The term action research was coined by social psychologist Kurt Lewin, who described it as a 'process in a spiral of steps, each of which is composed in a circle of planning, action, and fact-finding about the results of the action' (Lewin, 1946, p. 20). Like many AR projects, this thesis has been inspired by the theories of Argyris, Schön, and Freire – who are among the forefathers of AR in the fields of organisational development and learning and collective empowerment (Argyris & Schön, 1974; Freire, 2005). With the help of qualitative methods and AR knowledge development principles, the stakeholders in the studied SMHS pursued positive social change through democratic practices (Cogland, 2014; Heron & Reason, 2008). This action research process involved diagnosing the situation and defining the problem, planning action-steps, implementing change and evaluating of the results (Hummelvoll, 2009).

Action research and case studies have been described as being distinctive yet having similar qualities (Baskerville, 1997; Dresch, Lacerda, & Miguel, 2014). When combined, they make it possible to pursue both an action outcome 'in the form of beneficial intervention to organizational concerns', and a research outcome 'in the form of contribution to research question and theory' (Halecker, 2015, p. 27). In this thesis, the case under study is related to the research question of how to ensure stakeholder involvement and impact in service development, as well as the research aim of developing a practice method. The action aims are intertwined with the research question and aim, they concern the facilitation of increased involvement, dialogue and service improvement. Naturally, in both case studies and action research, the research aim is concerned with theory building (Dresch et al., 2014).

Gomm et al. (2008) contrast case studies with experimentation and surveys, claiming that the core meaning of case study is studying a

number of cases in depth (Gomm, Hammersley, & Foster, 2008). A case study 'investigates an empirical topic by following a set of prespecified procedures', and it also has its own distinctive scope of inquiry (Yin, 2009, p. 21). Contrary to AR and cyclic knowledge development (Reason, 2001), a case study is a somewhat linear process, the steps of which are 1) defining a theoretical conceptual structure, 2) planning the case, 3) conducting a pilot test (and then adjusting the planning), 4) collecting data, 5) analysing data, and 6) creating a report (Dresch et al., 2014, p. 1120). Data may be collected through 'documentation, archival records, interviews, direct observation, participant observation and physical artefacts' (Yin, 2009, p. 101).

In this case study, 1) mapping literature about user involvement in service development and research (Larsen & Sagvaag, 2011) was done in the first phase (described below). 2) The case was planned in collaboration with the stakeholders, including data collection strategies. 3) Interview methods were tested, and the design was adjusted according to evaluations. 4) Data was collected in collaboration with stakeholders. 5) Stakeholders influenced the analysis of the data through their continuous reflective participation; however, I and my supervisors produced the final theoretical analysis was after the intervention. 6) Report was predominantly created by me, including drawing theoretical implications (Dresch et al., 2014).

3.5.1 Participant or 'fly on the wall'

It appears that the biggest difference between AR and a case study is the researcher's position as a participant versus as a 'fly on the wall' (Baskerville, 1997; Dresch et al., 2014; Halecker, 2015). In AR, it is impossible for the researcher not to participate while traditionally, 'case study research does not permit intervention by the researcher into the events being observed' (Baskerville, 1997, p. 5). However, as noted in more recent case study literature, participant observation is one of many sources of functional evidence (Yin, 2009). A case study is ideal when

relevant behaviours cannot be manipulated. A researcher doing participant observation is not able to manipulate and control as directly, precisely and systematically as a researcher doing experiments in a laboratory. Rather, a research who is participating can create a greater variety of situations in the case, thereby informally manipulating it (Yin, 2009). In my case, as participative observer I could only prepare for a dynamic environment with stakeholders who both accepted and rejected a joint action aim. In a sense then, my facilitation can be regarded as a kind of informal manipulation – as the situations created in the research intervention were new to this context. Again, in my role, first- and second-person inquiry were pivotal to avoid manipulating the situations and stakeholders for my own benefit.

3.6 Four philosophical questions – methodological considerations

Lincoln and Guba (2005) connect ontology, epistemology, methodology and axiology to the five paradigms with four philosophical questions (Guba & Lincoln 1994). In the following section, these four questions are presented along with some amendments made by Reason and Heron (1997). For the purpose of the subsequent analysis, a table presenting the relevant rows from Lincoln and Guba's (2005 p.168 and 172) tables has been composed to illustrate the basic beliefs in the participatory paradigm related to the four questions.

Table 4 Participatory paradigms and basic beliefs

	Participatory paradigm
Ontology	Participative reality – subjective-objective reality, cocreated by mind and given cosmos
Epistemology	Critical subjectivity in participatory transaction with cosmos; extended epistemology of experiential, propositional, and practical knowing; cocreated findings
Methodology	Political participation in collaborative action inquiry; primacy of the practical; use of language grounded in shared experiential context
Axiology	Practical knowing about how to flourish with a balance of autonomy, cooperation, and hierarchy in a culture is an end in itself, is intrinsically valuable

3.6.1 An ontological question

Guba and Lincoln (1994, p. 108) poses the question concerning ontology:

1. What is the form and nature of reality and, therefore, what is there that can be known about it?

To answer this first philosophical question related to pursuing the development of a practice method through user involvement and dialogue, subjective ontology is essential. An example would be how stakeholders experienced service quality or how service improvement was regarded as necessary. In this study, testimonies of stakeholder's shared intentions, beliefs and desires, the social facts, served as records of their experience with service quality and propositions for change.

Furthermore, while pursuing the project's action and research aims, stakeholders changed their surroundings, for instance with material upgrades that impacted the service quality experience. As an action

researcher, I participated in this same reality with the stakeholders, so my perceptions and experiences/subjective reality are also essential to knowledge co-creation. In other words, the form and nature of reality in this study was both subjective and objective in terms of how the services were perceived and changed by the stakeholders and by me. What could be known about reality was this: How services can change or be shaped in co-creation between stakeholders and an action researcher, and how this can inform the development of a practice method. In this sense, reality was participative and co-created by mind and matter, and the practice method resulting from this study would be co-created knowledge-based (Heron & Reason, 1997).

3.6.2 Epistemology and co-created objective knowledge

The epistemological question in Heron and Reason (1997, p. 277) is,

2. What is the relationship between the knower or would-be knower and what can be known?

I propose the following answers to this second question:

In this study, first- and second-person statements were intersubjectively communicated between the stakeholders and me as the action researcher. Recordings of these social facts were member checked by the stakeholders to ensure scientific trustworthiness (Lincoln & Guba, 2007) and tested through abductive analysis (Timmerman & Tavory, 2012) as described below.

To further respond to Heron and Reason’s epistemological question, I will only briefly mention *social constructionism* related to social facts and epistemological objective knowledge (Lincoln & Guba, 2006; Searle, 2006). Gergen (1973) introduced the concept of social constructionism and argued that knowledge is historically and culturally situated and a result of social interactions (Gergen, 1973). Berger and

Luckman (1991) claim that society and humans reciprocally influence each other. Therefore, knowledge continuously changes as individual views are relative and individual perceptions must be regarded in relation to social processes. However, in line with Searle (2006) and Sollie and Barbosa de Silva (2018), Berger and Luckman (1991) also claim that it is also possible to attain scientific understanding of an objective reality when reality is regarded as a social construction. 'Knowledge about society is thus a realisation in the double sense of the word, in the sense of apprehending the objectivated social reality, and in the sense of ongoingly producing this reality' (Berger & Luckman, 1991, p. 84). So while Heron and Reason's (1997) subjective-objective ontology claims that human perception of experience creates reality and vice versa, Berger and Luckman (1991) claim that knowledge and reality are continuously reciprocally produced. Similarly, in this study, knowledge and actions cumulated in continuous cycles of social constructions of reality. Knowledge is therefore not considered relative in relation to isolated subjective perceptions but rather co-created through intersubjective communication.

Thus, in the study, ontological existence was explained in the form of epistemological objective knowledge through a *co-creation of knowledge process*: With the intention of improving the services, stakeholders *co-inquired* into their (ontologically subjective) experiences of *existing service quality* and produced *social facts* about what they believed should remain the same or change. In addition to being integrated into the stakeholders' own competence, this *co-created knowledge* was documented and *fed into processes of service co-production/co-creation*. Furthermore, in a reciprocal manner, epistemologically objective information, such as records of service upgrading/change/innovation, produced *new co-created knowledge* and social facts and vice versa. In this way, the knowledge of the social world I wanted to investigate is represented in this co-created knowledge

and these social facts and co-produced/co-innovated services (Mason, 2018).

3.6.2.1 Extended epistemology and practical knowing

The relationship between the knower or would-be knower and what can be known in participatory inquiry is rooted in the subjective-objective ontology. Therefore, to conclude the answer to the epistemological question we could say that the relationship between me as researcher, the stakeholders and knowledge was one of critical subjectivity, critical intersubjectivity and co-creation. On the one hand, as a researcher I self-reflectively and intersubjectively (with participants, in researcher communities) explored my experiential (subjective perceptions), propositional (minutes, reports and publications) and practical (skills as a facilitator and researcher) knowledge. This means that the practical knowledge I acquired through this study was co-created. On the other hand, in dialogue with co-researchers, facilitators and participants, I continuously inquired into the experiential (experiences with services and in co-researcher roles), propositional and practical (co-researcher or professional know-how) knowledge of the stakeholders. In an intersubjective field, the stakeholders' practical knowledge about how to co-produce and co-create was also co-created.

3.6.3 Methodology

Methodology concerns *how researchers study* a phenomenon. According to Heron and Reason (1997, p. 277) the methodological question is,

3. How can the inquirer… go about finding out whatever he or she believes can be known?

As seen in the articles in this thesis, a participatory and qualitative oriented methodology chosen to study service development with the goal of collective mobilisation for change. The method of this thesis can be

described as qualitative data-collection within an action research framework inspired by co-operative inquiry.

3.6.3.1 The logic behind the co-operative inquiry methodology

Heron and Reason describe co-operative inquiry as cycles of reflection and action including the four ways of knowing, critical subjectivity and intersubjectivity (Heron & Reason, 2008; Reason 2008). The authors provide a short introduction to the logic behind this methodology:

> People work together to define the questions they wish to explore and the methodology for that exploration (propositional knowing); together or separately they apply this methodology in the world of their practice (practical knowing); which leads to new forms of encounter with their world (experiential knowing); and they find ways to represent this experience in significant patterns (presentational knowing) which feeds into a revised propositional understanding of the originating questions. (Reason 1998, p. 429)

Epistemic and *political participation* are central principles in this AR methodology. The former means that the researchers' experiential knowledge is the basis for the propositional knowledge that is produced; the researchers are themselves subjects. The latter stresses the basic human rights of research subjects to 'participate fully in designing the research that intends to gather knowledge about them' (Heron & Reason, 1997, p. 281). In co-operative inquiry, the action researcher and co-researchers collaborate in partnership, consciously and self-critically cycling between experience and reflection. In this way, ideas, practice and experience are constantly honed and improved through four knowledge development phases (Heron & Reason, 2008). Figure 1 shows the phases of this project.

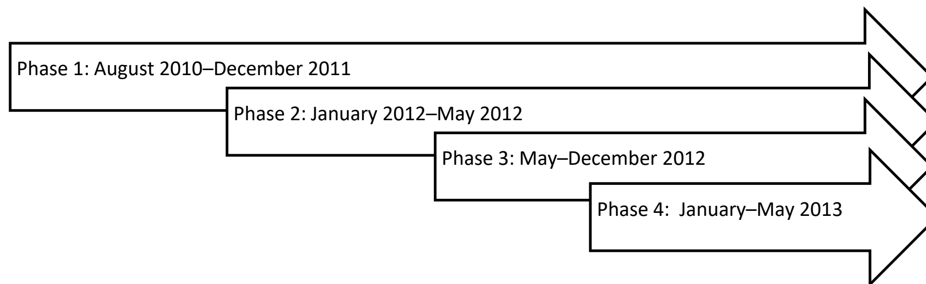


Figure 1: Timeline of the knowledge development phases

3.6.3.1.1 Phase 1: Propositional knowledge

Propositional knowledge, which is expressed as theories and statements, must be obtained from the stakeholders' experiential and practical knowledge. In the first phase, co-researchers from staff and patients '[agreed] on the focus of their inquiry, and [developed] together a set of questions or propositions' (Heron & Reason, 2006 p. 145). In this phase qualitative data selection methods were chosen, and the multi-stage focus group interview method was tested. Along with first draft interview guides, the knowledge was recorded as propositional knowledge in a joint (work) report. The report was the preliminary propositional knowledge baseline documenting co-researchers' statements and propositions. The joint report was used internally in the SMHS to inform plans and follow-up actions.

3.6.3.1.2 Phase 2: Practical knowledge

In Phase 2, patient co-researchers engaged in the action; they '[observed] and [recorded] the process and the outcomes of their own and each other's actions and experiences' (Reason & Heron 2006, p. 145). The co-researchers were involved in the design and management of the inquiry; they initiated and influenced the process, explored, made sense and drew conclusions (Reason & Heron, 2006). In this phase, co-researchers explored both practical and experiential knowledge, although practical

knowledge was their main focus. First, patients explored and refined their own practical knowledge in their role as co-researchers. However, perhaps due to the length of the phase (3 months) and their own motivation, their engagement can in many ways be regarded as experiential immersion (described below). Also, as all parties were regarded as having role-related practical knowledge, their respective practical knowledge was explored. For instance, staff's communication skills, patients' service utilisation, and leaders' decision-making and facilitation skills were all considered know-how. Knowledge acquired through subjective experience in these roles was considered experiential knowledge. For instance, staff and leaders had not yet developed know-how related to responding to patients in co-researcher roles, but some of staff's experiential knowledge from this new dynamic was recorded.

At the end of the phase, patient co-researchers presented their practical and experiential knowledge and explored this knowledge in dialogue with the stakeholders. Finally, the propositional knowledge from this phase was recorded in an experience report, which presented information about the experiences and service developments from each phase. Updated versions of this document continuously informed plans and follow-up actions in the SMHS.

3.6.3.1.3 Phase 3: Experiential knowledge

In this phase, co-researchers challenged their experienced knowledge 'gained through direct encounter face-to-face with persons, places, or things' (Reason, 1994, p. 6). This involved seeing things in new ways, opening up to new experiences, thinking of new ideas, and initiating unpredicted action. Some might have even forgotten that they were taking part in an inquiry (Heron & Reason, 2006). Such *immersion* into action and experience is the strength of this AR orientation: 'this deep experiential engagement, which informs any practical skills or new understandings which grow out of the inquiry' separates co-operative inquiry from conventional research (Reason & Heron, 2006, p. 145).

In this phase, both practical and experiential knowledge among the stakeholders was explored, although the emphasis was on experiential knowledge. Staff co-researchers advanced the patient co-researchers explorations as they moved on to inquire into superficial understandings and propositional knowledge from earlier phases. For instance, participants were invited to elaborate/challenge statements that had been made previously. At the end of this phase, staff co-researchers presented the practical and experiential knowledge uncovered and explored it in dialogue with the stakeholders.

3.6.3.1.4 Phase 4: Critical scrutiny of the propositional knowledge

In the final phase, co-researchers return to consider the original research propositions and hypotheses in the light of their experience in the previous phases (Heron & Reason, 2006). In this sense, the final phase of co-operative inquiry involves a critical return to propositional knowledge and the practice chosen in the propositional phase, and to the practical and experiential data from previous phases (Heron & Reason, 2006).

By the end of the inquiry, patient, staff and leader co-researchers analysed propositional knowledge in the experience report from phases two and three. Presentational knowing was not explored in the inquiry; it has been discussed in the methodological considerations. The co-researchers were supported by a staff co-researcher and a citizen (former patient) facilitator. At the end of the phase, the critical scrutiny of the propositional knowledge was presented by the co-researchers and explored in dialogue with the stakeholders.

In short, both epistemic and political principles were applied in this action research project: I engaged as a participative observer while facilitating co-researcher participation in design, data collection, reflection, action and dissemination of co-created knowledge inside and outside the organisation. However, the study cannot be regarded as a co-

operative inquiry per se because it did not followed the methodology to the letter. Rather, an adjusted knowledge development framework was applied to the organisational level, and the process was regarded as potentially benefitting organisational learning beyond the various inquiry groups. Therefore, a key criterion of co-operative inquiry, namely that the same inquiry group engages throughout the four knowledge development phases, was not followed (Heron, 1996). In this study each knowledge development phase was led by separate inquiry groups.

3.6.4 Axiology

The axiological question Heron and Reason (1997 p. 277) propose is the following:

4. What is intrinsically valuable in human life, in particular what sort of knowledge, if any, is intrinsically valuable?

Heron and Reason (1997) define practical knowing and human flourishing as ends in themselves. In this study, the freedom and opportunity to collectively explore practical knowledge about reciprocal empowerment (how to flourish) was considered intrinsically valuable. Furthermore, co-created knowledge, including knowledge about the transformations resulting from such creativity was highly valued.

3.6.5 The four questions and the three articles

This study's answers to the four philosophical questions have been given above. Table 5, below, summarises these answers in relation to the participatory paradigm and the three articles in the thesis. In addition, it presents the methodology, based on Larsen and Sagvaag (2018), including descriptions of the co-researcher and researcher roles, participation and qualitative data-collection methods.

Table 5 The four philosophical questions related to the three articles

	Article 1	**Article 2**	**Article 3**
Ontology: What is the form and nature of reality and, therefore, what is there that can be known about it?	Subjective-objective co-created reality focused on patient perspectives. Organisational culture related to organisational change with the goal of increasing patient involvement.	Subjective-objective co-created reality focused on staff perspectives. Staff actions, reactions, and communicative behaviours related to expected dialogue with patients.	Subjective-objective co-created reality focused on leader perspectives. Leader actions, reactions, and leadership behaviours related to co-created organisational adaptability.
Epistemology: What is the relationship between the knower or would-be knower and what can be known?	Researcher investigating patients' experiential knowledge in relation to staffs'/leaders' practical knowledge.	Researcher investigating staff reactions to having their practical knowledge challenged by patient co-researchers' practical knowledge.	Researcher investigating leadership behaviours in the co-creation of new practical knowledge.
Methodology: How can the inquirer go about finding out whatever he or she believes can be known?	<u>Political participation</u> *Co-designed research focus:* Patients and staff co-created inquiry aim, and questions for individual interviews. Patients and researcher co-created questions for multistage focus group interviews. *Co-designed research method:* Staff, leaders, patients and researcher co-decided to use multistage focus group interviewing. Patients and researcher co-designed a new T3 – multistage focus group interview procedure and co-decided on the researcher observer/participative observer role in individual and group interviews.		

		Co-designed supplementing communicative spaces: Patients, staff, leaders and the researcher co-designed the Ideasmithy, a fixed meeting where the stakeholders discussed service quality. Patients and the researcher suggested the Ideasmithy mandate and membership, which were approved by staff and leaders. Staff, leaders and the researcher co-created the Ideasmithy coordinator role. Staff, leaders and the researcher co-decided to establish a reference group, as well as its content and membership.	
Qualitative Methods:	The researcher engaged in participative observation in work group and ad hoc group meetings,		
	and in co-researcher-led individual interviews. The researcher observed co-researcher-led multistage focus group interviews.	and in ad hoc individual/group meetings.	and in ad hoc individual/group meetings and email correspondence. The researcher observed co-researcher-led multistage focus group interviews.
Axiology: What is intrinsically valuable in human life, in particular what sort of knowledge, is intrinsically valuable?	Facilitating human flourishing and transformation in the relationship between self-directed stakeholders.	Developing practical knowing among staff about how to flourish in the presence of self-directed patients.	Developing practical knowing about human flourishing in co-creation leadership.
	Co-created knowledge, particularly		
	patient expertise	staff expertise	leader expertise

3.7 Research quality

3.7.1 Documentation and analysis process

The cited documentation was member checked by the relevant participants as described in the section on trustworthiness below (Lincoln & Guba, 2007). I wrote first drafts of minutes and reports and presented them to participants. Some field notes were summarised into descriptions of interactions in situations, meetings and other conversations. After having been approved in member checks, these summaries were considered as (field) minutes. Participants were urged to look for missing elements or misinterpretations in the texts, which were amended according to their recommendations. The relevant participants approved the external dissemination of all published results, except my journal notes. Documentation was written in accordance with the SMHS's documentation tradition to ensure consistency, familiarity and readability (two exceptions are described under member checks below). The minutes were thus predominantly condensed descriptions of conversations, not verbatim transcriptions (Hammersley, 2010; Poland, 1995).

All data were subjected to qualitative conventional and directed content analysis using NVivo 9 (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005). The analysis was abductive, which encouraged inductive and deductive reasoning (Blaikie & Priest, 2019; Timmermans & Tavory, 2012). In abduction, these forms of reasoning may be repeated as new anomalous and surprising findings emerge. Thus, mapping the literature on public involvement, power, leadership, organisational studies and so on while considering experiences and action was a continuous cumulative cycle in this inquiry. Through this inferential creative process, which began with the empirical data from the first planning meeting and work groups and continued throughout the four phases of inquiry, new hypotheses and theorical explanations were produced. However, as opposed to induction, where the researcher is

expected to examine the empirical data without theoretical preconceptions, the abductive process acknowledges the researcher's theoretical position (Timmermans & Tavory, 2012). Therefore, my theoretical preconceptions resulting from social work education and practice (especially concerning the system, empowerment, relations, social integration theories) constituted an acknowledged foundation on which I based my exploration of theories about public involvement, organisational culture and leadership related to my data. However, I did not set out to prove or falsify such theory. Rather, my aim was to discover 'the way social actors typify and understand their way of life' in an analysis that moves 'from lay descriptions and explanations to social scientific descriptions and explanations' (Blaikie, 2018, p. 638). To this end, the data have been *revisited* repeatedly in the articles in this thesis through a process of *de-familiarization,* which involves theoretical cultivation and sharing ideas among communities, and *alternative casing,* which involves creating new cases with the help of theory (Timmermans & Tavory, 2012). These three steps were necessary to ensure saturation of concepts and harness temporality when constructing new theory (Timmermans & Tavory, 2012).

3.7.2 Trustworthiness

Lincoln and Guba (2007) suggest 'trustworthiness' as a more adequate concept in qualitative research than 'rigor'. Trustworthiness criteria are appropriate for evaluating inquiry that recognizes that 'multiple realities are socially constructed' and thus include a more holistic view on the interrelated pieces of these realities (Lincoln & Guba 2007, p. 17). The authors propose the following parallel criteria to replace conceptualization associated with rigor: *credibility* corresponds to internal validity, *transferability* to external validity, *dependability* to reliability and *conformability* to objectivity (Lincoln & Guba 2007).

Elo et al (2014) argue that the trustworthiness of qualitative content analysis is often difficult to evaluate due to defective descriptions of data

collection methods and/or analysis (Elo et al., 2014). The aim with this section is to describe the precise measures implemented to increase the trustworthiness of the thesis. Developing mutual trust among researchers and participants and wanting to provide constructive expertise-specific contributions to reach a common goal were key. I prioritized *credibility* through the following factors (Lincoln & Guba, 2007):

a) *Prolonged engagement*: I was situated in an office within the SMHS unit under study for more than three years.
b) *Persistent observation*: I pursued developments, conflicts, and salient topics and urged the stakeholders to do the same.
c) *Triangulation*: The study combined different qualitative methods (individual and group interviews, dialogue seminars and participative observation), sources (audio recordings, power point presentations, post-it notes and flip-charts, journal, field notes, minutes, reports, emails) and investigators (co-researchers, participants, facilitators and researcher).
d) *Peer debriefs:* I discussed the project with my supervisors outside of the research context and in research communities (e.g. at conferences, writing-seminars, research groups and networks),
e) *Negative case analysis*: I purposefully invited new perspectives and facilitated dialogue between conflicting views.
f) *Member checks:* The documents recording the actions indicating the direction the project would take (e.g., minutes, reports were checked by members to ensure the context-specific authenticity of the findings (Lincoln & Guba, 2007).

3.7.2.1 Member checks

Member checks are defined as

> the process of continuous, informal testing of information by soliciting reactions of respondents to the investigator's reconstruction of what he or she has been told or otherwise found out and to the constructions offered by other respondents or sources, and terminal, formal testing of the final case report with a representative sample of stakeholders. (Lincoln & Guba, 2007, p. 19)

In this study, member checks were conducted in the following manner:

During the initiation of work and inquiry groups, it was co-decided among the co-researchers, participants and myself that as researcher, I would take on an advanced secretary role (Hummelvoll, 2003) with responsibility for writing minutes and reports (see Larsen et al. (2020) for details). After member checks, reports were placed in a folder in the treatment environment to ensure access and transparency for the stakeholders in this context.

Member checks for the multistage focus group minutes were conducted during the interviews, as well as after them. In this method, the function of the participative observer (in this study it was one of the co-researchers) is to ask follow-up questions and write field notes about communication climate and summaries of the discussions. At two points during the interview, in the middle and at the end, summaries were presented to the participants for member checks to assure that everything had been understood correctly (Hummelvoll, 2008). After each interview, the co-researchers and I listened to the interview recordings, and I recorded our first impressions and thoughts in field notes. I wrote the minutes from the multistage focus group interviews while listening to audiotape recordings and comparing my field notes with co-researchers' field notes. The minutes were then approved by the relevant participants for external dissemination.

In the stage two interview, a participant read these minutes out loud for the rest of the group, and a patient co-researcher urged the participants to choose a topic of interest from these readings to discuss further. After stage two, the same documentation and member check procedure was conducted. As reading the minutes from the previous stage in the interview was too time consuming, the participants in stage three were provided with the member checked minutes from stages one and two before stage three. They were urged to read them so they would be informed about the topics raised and could prepare for the next interview. They were also instructed to choose a topic of interest from these readings to discuss further. The minutes from stage three were member checked in the same manner.

Before stage four, I prepared a summary of the minutes from the previous stages minutes for the staff co-researchers and participants in stages four-six. The participants in these stages were instructed to choose a topic of interest from these readings to discuss further. The member checks continued in the same manner as before; in this round, participants had read the minutes from the previous stage before entering another group interview and were urged to initiate discussion about the topics they considered most salient. Again, minutes from these interviews were approved in member checks.

Anonymized individual interview minutes were written while listening to audiotape recordings and comparing the patient/staff co-researchers and the researcher's field notes. Nine sets of interview minutes were approved in member checks. One interview was reformulated because a staff member did not accept the word-for-word transcription of the interview. This participant was not content with the subsequent reformulated condensed version. All records from this interview were therefore deleted. After this transcribing test, I continued writing condensed minutes with a few direct quotes in all instances but one (see below).

The planning meetings with leaders and staff were not audio recorded; the minutes were written immediately after the meeting based on field notes. These minutes were approved by all participants. The dialogue meeting was audiotaped and documented in the same way as the interview minutes. It was approved by all parties without comments. The reference group meeting minutes were based on audio recordings and field notes. The reference group minutes form one meeting was transcribed word-for-word. They were all approved.

Dialogue seminars were recorded in field notes, co-researchers' power-point presentations and flip-charts with post-it notes from the plenary discussion. Summaries were written as chapters in the experience report. In the member checks for dialogue seminars one and two, patient/staff co-researchers considered a first draft of the chapter that documented 'their' phase. The inquiry teams met to discuss accuracy and explore the topics further. patient/staff co-researchers' feedback was recorded in my field notes and the chapter was amended accordingly. Also, two patient co-researchers each wrote a section in the experience report about a topic they considered salient from our inquiry group discussions. Participants approved the amended chapters; some supplemented their views with texts that were included in the report. Dialogue seminar three was only recorded in field notes and flip-charts with post it notes as its form was a hybrid between a dialogue seminar and a lengthy inquiry group meeting. The chapter from dialogue seminar four was written by the citizen facilitator. It was based on my field notes and an audio recording of the co-researchers' presentation and the final 1.5 hours of the seminar, in which by participants/co-researchers proposed actions. The chapter was approved with comments that were included in the report.

3.7.2.2 Transferability, dependability and confirmability

To ensure *transferability,* the data and data-collection methods have been described with thick descriptions within the limitations of scientific publication. To strengthen the *dependability* of the study, in addition to

qualitative method triangulation, an evaluation of the inquiry process was conducted at the end of phase two by competent external evaluators (Næss & Berger, 2013). Finally, triangulation (of qualitative methods, sources and investigators) also helped ensure *confirmability* with scientific requirements. Submitting the three articles to international scientific peer-reviewed journals also ensured confirmability (Lincoln & Guba, 2009).

3.7.2.3 First-person inquiry and trustworthiness

The criteria for trustworthiness do not include first-person inquiry (Kroeger, 2019; Lincoln & Guba, 2007; Torbert & Taylor, 2008) even though a researchers' inquiring first-person self-awareness as they act would seem to be useful for all types of research (Torbert & Taylor, 2008). The point of such inquiry is to constantly question what is subjectively taken for granted so that both data and feelings of consonance or dissonance can emerge and become known in real time through assonance (Torbert & Taylor, 2008). Torbert and Taylor explain that the ability to inquire while acting in a timely manner results from developing a 'triple-loop first person "super vision"' (Torbert & Taylor, 2008, p. 242). Such vision is developed through constant questioning of one's own perception, sense, awareness and experience of the outside world and of one's own behavior, feelings and thoughts.

Heron and Reason's (1997) account of practical knowledge as pre-eminent in the participatory paradigm resembles Torbert and Taylor's (2008) idea of a triple-loop vision. It also resonates with some of the personal/professional developments I experienced in the action researcher role. To use Kuhn's metaphor (1970) and think of the single case as a box, learning to look at both the inside (the interaction) and the outside (the case in light of theory) of the box from outside, rather than looking at the box from within (including relational ties, partaking in organisational culture, language, emotional engagement and more) was *part of the process*. To be specific, the goal of this thesis was not to

entirely disconnect from 'inside' experiences. However, some distance – but also deeper digging – was necessary to inform the propositional knowledge with researcher self-awareness as described by Torbert and Taylor (2008) and Heron and Reason (1997). In other words, lifting the veil of psychological defense mechanisms required continuous self-confrontation and honesty about my own psychosocial process. To this end, reflexive and confrontational questions from participants and members of the research community were extremely valuable.

3.8 Ethical considerations

3.8.1.1 Approval

The research project was submitted to the Regional Ethics Committee (REK). Their response, dated 30 June 2010, was as follows: 'The committee considers the research project to be health service development and thus not subject to disclosure for REK. The committee has no objections to the study being published' (Appendix 1: REK Project no. 2010/1641). They recommended submitting the application to the Norwegian Centre for Research Data (NSD). On 25 August 2010, NSD recommended project implementation (Appendix 1: NSD Project no. 24667). However, the NSD approval presupposed another REK application. Since I had planned to use participative observation, I needed 'clarification of whether the project requires exemption from the consent requirement for users who do not participate in the research project' (Appendix 1: REK Project no. 2010/1641-5). In short, REK's response was that they did not require exemption from the consent requirement because I was employed at the clinic, and my confidentiality consent there applied without restrictions. The research project received final approval from both NSD and REK on 26 August 2010 on the condition that I inform non-participants and participants about confidentiality considerations related to participative observation.

3.8.1.2 Information, consent and recruitment

In addition to providing information in the research consent document (Appendix 2), I conducted an information meeting for all stakeholders at the ouset of the research project. I also continuously provided information in morning meetings and in conversations with new patients/staff/leaders. A sheet with information about the research activity was posted on two information boards in the SMHS unit. I explained that I would be around as participative observer, but that I would not record anything about someone who had not signed the consent form. The consent form stated that research participation was voluntary and that all stakeholders could withdraw at any time – the data would then be anonymized. All publications would be anonymized.

In addition, because this research included a service development focus, it was expected that participants would describe the services provided by staff and leaders. This meant that some of the staff and leaders could be recognised if readers were familiar with their professional specialisation or roles in the clinic. The consent documentation also informed participants about this possibility. Finally, to ensure that all participants could contribute in collective processes without fear of other participants' indiscretion, the consent informed that when signing it they were all responsible not to reproduce names and information about the other participants.

Anyone in the SMHS or the connected activity unit and leaders above these units could participate with the exception of patients who were still in the detoxification phase. As I needed patient co-researchers who could follow the developments in the whole second phase, one of the assistant unit leaders informed me about patients who could be expected to remain in treatment for that time. I approached three patients who had already initiated contact and participated in training. They all wanted to contribute as co-researchers. The patient co-researchers advised me when it came to recruiting patients for individual interviews. I consulted

staff co-researchers about recruiting staff for individual interviews. Everyone who wanted to participate in the stage one focus group interviews and dialogue seminars was included. I decided on the group composition in stages 2-6 based on the multistep focus group method requirements and the need for heterogenic dialogue (Hummelvoll, 2008) and dialogue seminar group work.

3.8.1.3 The interview situation

The individual interviews were conducted inside the SMHS unit. Before each interview, the participants could choose where they wanted to meet the co-researchers and me: in my office, in another office or in an activity room. These rooms would be empty at different times during the day/evenings depending on what other activity was happening on the wards. The co-researchers followed the interview guide and asked follow-up questions. My role was to ensure the confidentiality agreements were signed, to audiotape the interview, and to support the co-researcher's lead, ask for clarification and provide follow-up questions. I never interfered or corrected the co-researchers; after each interview, we reflected on their co-research practice. The co-researchers adjusted their behaviour in the next interview based on affirmations and constructive critique from their co-researchers and me.

The multistage focus group interviews were conducted in an activity room in the SMHS. The co-researchers followed the interview guide and asked follow-up questions. My role involved ensuring that confidentiality agreements were signed, audiotaping and observation. I never interfered or corrected the co-researchers; after each interview, we reflected on their practice. The co-researchers adjusted their behaviour in response to affirmations and constructive critique from fellow co-researchers and me.

The dialogue seminars were held in facilities outside the clinic. The co-researchers presented the findings and facilitated dialogue among

stakeholders in plenary and group work. My role was to coordinate in collaboration with a staff member and leader, to ensure confidentiality agreements were signed, to audiotape the plenary sessions in the final dialogue seminar, to provide findings from the individual interviews and to facilitate dialogue in plenary and group work. I guided the co-researchers before and during the dialogue seminars, and we reflected on their practice afterwards.

4 Summary of the articles

This chapter describes the main results and contributions in the three articles included in the thesis. An overview of their aims/purposes, the theories used and their contribution to theory is also presented.

4.1 Article I

In the article ‘Empowerment and pathologization: A case study in Norwegian mental health and substance abuse services’ (Larsen & Sagvaag, 2018), we explored factors that may have impacted on patients’ ability to be heard when collaborating with staff and leaders to improve services. The results show that patient voices were regarded as important but not necessarily decisive as their propositions for change could be perceived as pathology-based. Patients’ feedback about fellow patients and medication, particularly opioid maintenance treatment, was reported in the results. However, barriers that prevented staff and leaders from listening to advice from patients related to these matters included a) patients not being permitted to influence other patients’ individual treatment and b) one leader’s difficulty accepting advice about medication. There also appeared to be contextual constraints that may have impacted patients’ ability to be heard in discussions about service development, including legal requirements – such as confidentiality – guidelines, organisational policy and patient expectations about satisfactory treatment. Additionally, there appeared to be a professional hierarchy between leaders, specialised treatment staff and milieu staff that may have disempowered milieu staff members in their collaboration with patients. We questioned whether staff were able to empower patients if they did not have self-empowerment skills themselves.

The results point to a constraining diagnostic organisational culture that made user involvement challenging. Stigmatisation and pathologisation of risk and contextual constraints appeared to limit patient input in

discussions about service development. In addition, staff and patients perceived empowerment as something patients were permitted by the staff and leaders. This perception was both one-sided and limiting to exploratory dialogue, as patient impact on service development was controlled by staff and leaders. We conclude that such barriers to patient involvement may limit the availability and efficacy of patients' perspectives in service development. Further, we point to a need to address stifling assumptions about patient pathology and empowerment. In particular, awareness that patients and service providers can empower each other might contribute to service users' voices being heard, making it possible for service users and providers to have a united voice when it comes to service development.

4.2 Article II

In the article 'Unlocking service provider engagement in constrained co-production partnerships' (Larsen, Sagvaag, & Karlsen, 2020), we explored critical conditions for co-production in an organisational setting constrained by organisational policy and professional codes of conduct. We investigated factors facilitating service providers' engagement in genuine co-production partnerships. We found that staff were having difficulties managing communication and power relations with patients. Certain avoidance mechanisms staff used (avoiding/changing the topic, back-stage opposition) tilted the power relationship in their favour. They avoided discussing and resolving issues directly with patients, instead approaching the leaders, other staff or the researcher. This process continued until patient co-researchers risked involuntary discharge. Through mediation and support, the conflict was resolved; however, the patient co-researchers were never told that they had risked being discharged.

In this article, we show that developing meeting spaces for dialogue appears to be vital to co-production. We also argue that focussing on service providers' professional development, including their ability to be

honest with patients, may benefit co-production. We suggest that to achieve genuine and balanced co-production partnerships between service providers and users a) the power imbalance embedded in the institutional structure must be equalised to avoid paternalistic and avoidance approaches from staff, b) a dedicated communication platform conducive to open dialogue for genuine inquiry and mutual learning must be developed, and c) effective joint learning processes must be ensured.

We propose that the following elements should be in place to unlock the potential of genuine co-production relationships: a mutual agreement, a fixed co-production meeting, joint training/roleplay, and spaces for group and individual reflexivity.

4.3 Article III

In the manuscript 'Co-creation leadership. A process study of leadership for organizational adaptability' (Larsen, Karlsen, & Sagvaag, in review) we explored how leadership may have enabled and/or stifled the co-creation of a new service in this study. The results reveal examples of leadership behaviours and styles from Uhl-Bien and Arena's integrative framework of leadership for organisational adaptability, Vroom's normative decision model and Yukl's hierarchical taxonomy of leadership behaviours. The predominant leadership behaviour observed was encouraging innovation, although delegation and external leadership were also important behaviours for a process that resulted in new service provision.

Based on our research, we propose a co-creation leadership style that comprises several leadership behaviours from the presented theories. Our analysis has implications for public management innovation and leadership and suggests a need for further exploration and conceptualisation of *co-creation leadership*. Central qualities to such leadership are

- recognising service users, providers, and formal leaders as colleagues who co-create services and value in a reciprocally empowering working alliance;
- enabling dialogue and adaptive spaces where no party is excluded and ensuring that stakeholders themselves may shape safe spaces for exploration, conflict resolution, and reciprocal empowerment;
- acknowledging that power is negotiated and relational.
- co-constructing and connecting leadership to core tasks and functions when enabling idea generation and service innovation;
- recognising consultation, facilitation and delegation as key to decision commitment and collective mobilisation;
- ambidextrously maneuvering between participation and decisiveness, care and autonomy, and production and innovation.

4.4 Overview of aims, purposes and contributions

The following table provides an overview of the three articles, specifically their aims/purposes, the theories used and their contribution to theory. These theoretical contributions represent important responses to the research question related to the main action research aim, as reported in the aims and research question. The table shows how the aims/purposes shown in table 1 resulted in propositions about strengthening 1) service user impact on service development, 2) staff engagement in co-production and 3) leadership in co-creation.

Table 6 Aims/purposes, theories used and contributions in the articles

Art.	**Aims/ purposes**	**Theory**	**Contributions**
I	To explore what may keep patients' voices from being heard when collaborating with staff and leaders to improve services. To suggest what can contribute to service user's being heard in service development collaboration with service providers.	Power (Emerson, 1962). Empowerment (Freire, 2005). Diagnostic culture (Løchen, 1970). Pathologisation (Brinkmann, 2015).	Creates awareness about concurrent diagnostic culture and reciprocal empowerment. Shows that facilitating self-empowerment among service users and providers through training, supervision and exploratory dialogue, centred on service user/provider awareness of (a) power dependence relations,and (b) barriers to and potential for service user/provider self- and reciprocal empowerment, may enable reciprocal empowerment between service providers and service users. This in turn may make it possible for these stakeholders to have a united voice when it comes to developing and transforming services.
II	To explore critical conditions for co-production interaction in a public SMHS. To suggest measures to strengthen service provider engagement in co-production.	Co-production (Osborne & Strokosh, 2013) Communicative spaces and organisational learning (Newton & Goodman, 2009; Argyris, 1995). Dialogue leadership (Isaacs, 1999)	Reveals how organisational defence mechanisms hinder double-loop learning. Proposes elements necessary to unlock the potential of genuine co-production relationships are proposed: a mutual agreement, a fixed co-production meeting, joint training/roleplay, and spaces for group and individual reflexivity.

III	To explore how involvement in leader decision-making in a PSO may affect an adaptive process. To suggest leadership behaviours that promote conditions for co-created organisational adaptability.	Co-production and co-creation (Osborne et al, 2016; 2018; Brandsen & Honingh, 2018; Voorberg et al., 2015). Hierarchical taxonomy of leadership behaviours (Yukl, 2012). The leadership framework for organisational adaptability (Uhl-Bien & Arena, 2018). The Normative decision model (Vroom, 2003).	Identifies leadership behaviours enabling co-created organisational adaptability. Proposes a co-creation leadership style with the following behaviours: Recognizing service users, providers, and formal leaders as colleagues who co-create services and value in a reciprocally empowering working alliance; Enabling dialogue and adaptive spaces where no party is excluded and ensuring that stakeholders themselves may shape safe spaces for exploration, conflict resolution, and reciprocal empowerment; Acknowledging that power is negotiated and relational; Co-constructing and connecting leadership to core tasks and functions when enabling idea generation and service innovation; Recognising consultation, facilitation and delegation as key to decision commitment and collective mobilisation; Ambidextrously maneuvering between participation and decisiveness, care and autonomy, and production and innovation.

5 Relating the articles and informing the new method

Chapter five describes how the thesis articles are related, as well as how they, in combination with the research design, have informed the practice and action research method developed in this thesis.

5.1 Listen – respond – lead

The articles are related in that they all explore how the roles and behaviours of patients, staff and leaders complement each other during organisational learning and change. Being part of this process through action and reflection also enhanced my initial conception of user involvement (Larsen & Sagvaag, 2011) to reciprocal empowerment, co-production partnership, co-innovation, co-provision of services and co-creation leadership (Boviard & Löffler, 2012; Larsen & Gordon, 2013; Larsen et al., in review; Larsen & Sagvaag, 2018; Larsen, Sagvaag, et al., 2020; Osborne et al., 2018). The common thread in the work done for all three articles was the investigation of what facilitates and hinders equal dialogue in co-production/co-creation.

Article one illustrates how patients' voices may have been hindered by a diagnostic organisational culture and contextual constraints. Also, staff's unskilled responses to patient initiatives were part of an unconstructive communication equation, as demonstrated in article two. The finding that service providers and users have the potential for mutual growth underlines the importance of enabling more constructive dialogue between these parties. Furthermore, if staff and leaders had not resisted patients' contributions, all stakeholders could have been empowered by knowledge co-created from more balanced, nuanced and exploratory dialogue. Also, as empowerment has been regarded as a complementary epistemological relationship in liberationist theory, it appeared necessary

to point out tools to facilitate reciprocal empowerment and dialogue and to strengthen the co-production partnership between patients and staff.

In the third article, the reciprocal empowerment of leaders, patients and staff was fundamental to the proposed definition of co-creation leadership, in which colleagueship was key. Enabling an adaptive space for equal and exploratory dialogue was also important. The 'success story' of the co-creation and co-provision of a new service was examined, while the leader's responsibility when encountering problematic excluding behaviours among staff was also uncovered and highlighted. Also, several leadership styles encouraging collective learning, individual development, mobilisation, participation and innovation were suggested as desirable behaviours in co-creation leadership. Leadership is seen as fluid and not just related to a formal leadership position, a view that is rooted in the first two articles' accounts of reciprocal empowerment and genuine co-production partnerships. Also, being able to ambidextrously maneuver between participation and decisiveness, care and autonomy, and production and innovation appear key.

The articles point to an organisational culture that may constrain both service users and providers in their interactions related to service development. This thesis also demonstrates that participation and real influence from service users and providers in service development can be ensured by facilitating qualitative research methods predominantly led by stakeholder co-researchers in an action research framework inspired by co-operative inquiry. Furthermore, co-creation leadership appears necessary to enable organisational adaptability in PSOs. Involvement in decision-making involvement and engagement with tension between stakeholders are central to ensuring stakeholder impact. However, to systematically change organisational culture and practice in PSOs in the future, it will be necessary to refine the research design into a co-creation knowledge-based practice and action research method that can ensure service development in terms of organisational adaptability.

5.2 A practice method and an action research method

The co-production method mentioned in article three was developed based on an action research design. However, following discussion around co-creation leadership in Larsen et al. (in review), the term has been updated in this synopsis to *co-creation method*. The co-creation method has been shaped so that citizens and practitioners may just as easily applying it as a *practice method* as scholars can use the design as an *action research method*. From now on, when talking about co-creation, the term ‘method’ will refer to both a practice method and a research method.

5.2.1 From co-production to co-creation

By the end of the intervention, a modification of the research design was proposed in the form of a co-production method, which predominantly involved changing PSOs cultures and practices to focus on co-production. This amendment also created a potential for replication in multiple-case action research studies. The co-production method included a three-phase implementation process that lasted 1.5 years: phase 1, facilitator led (3 months); phase 2, facilitator and contributor led (6 months); phase 3, contributor led (3 months). The co-production method design has not changed in light of the analyses in the three articles. Rather, its conceptualisation has been and updated and broadened.

In the literature, strategic planning/initiation of services and service implementation are often distinguished in terms of co-creation and co-production (Brandsen et al., 2018). Others include co-production in their understanding of co-creation demonstrate the interconnectedness between co-production and co-creation of value (Krogstrup & Brix, 2019; Osborne, Radnor, et al., 2016). As we know, co-creation has also been related to both service improvement and innovation in the

marketing literature (Galvagno & Dalli, 2014). Consequently, in the understanding underpinning this practice/research method, 'co-creation' includes strategic planning, initiation and innovation of services, and knowledge and value co-creation (Brandsen & Honingh, 2018; Heron & Reason, 1997; Osborne et al., 2018; Voorberg et al., 2015). Also, in the co-creation method, facilitating participative co-production of existing services is just as pertinent as facilitating co-innovation (Osborne & Strokosch, 2013; Osborne et al., 2018).

This means that when describing co-creation practice/spaces/process and so forth below, I am considering co-production as part of co-creation. The current co-creation method suggests alternative ways on integrating a *co-creation practice*, which is defined here as the way stakeholders actually collaborate to evaluate, improve, plan, initiate and innovate services. *Co-creation spaces* are key to this practice, they can be described as meeting places for mutual growth, reciprocal empowerment and exploratory dialogue among stakeholders in relation to co-created organisational adaptability (Larsen & Sagvaag, 2018; Larsen et al., 2020; Larsen et al., in review). Some examples in the co-creation method are planning meetings, the information and decision meeting, (multistep focus) group interviews, and dialogue seminars. This co-creation method can be mapped in three phases, with several paths to choose from. The *co-creation process,* then, can be described as a cultural journey (Boström et al., 2017) toward co-creation orientation, with great potential to move among and beyond these paths.

5.2.2 The co-creation method

The figure below presents the co-creation method with details about the necessary roles, tools and spaces.

Role-descriptions

Coordinator	A service provider/leader/service user/researcher
Facilitators	Skilled service users, providers, leaders.
Participants	Service users and leaders who participate in training, interviews, dialogue seminars and Ideasmithy.
Contributors	Service users, providers and leaders who take over facilitator tasks or initiate change/innovation, e.g. Ideasmithy coordinator.

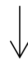
Phase 1 – Facilitator-led

1. **Training an guidance**

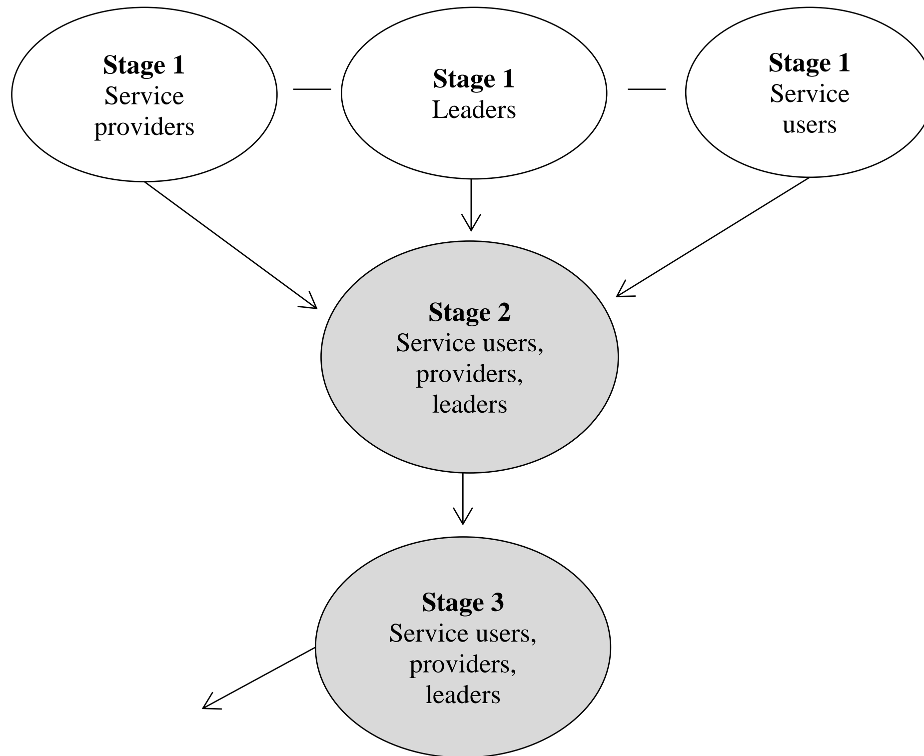
Leaders: Planning and continuous guidance
Service users, providers and leaders:

- Information and decision meeting: the co-creation method and path potential, 3 hours.
- Joint training: exploratory dialogue, communication skills, reciprocal empowerment, power awareness and co-creation leadership, 2 days.
- Ideasmithy coordinator training, dialogue facilitation, documentation and more, 3 hours, continuous guidance.

Evaluation form 1: Service quality



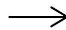
2. T6 group interviews



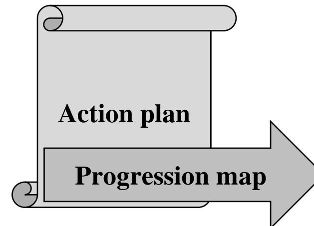
3. Priority analysis

Focus	**Service users**	**Service providers**	**Leaders**
Evaluation			
Improvement/innovation potential			
Training needs			

4. **Service development**

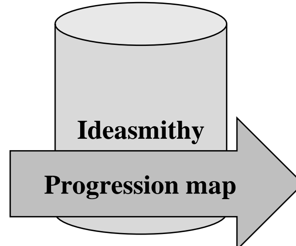


5. **Hearing**

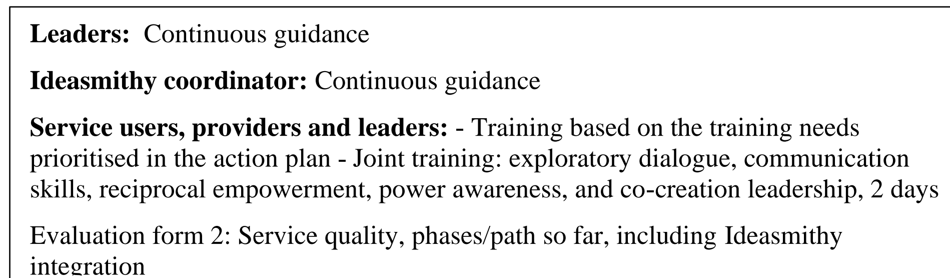


Phase 2 – Facilitator- and contributor-led

6. **Ideasmithy establishment and integration**



7. **Training and guidance**



Leaders: Continuous guidance

Ideasmithy coordinator: Continuous guidance

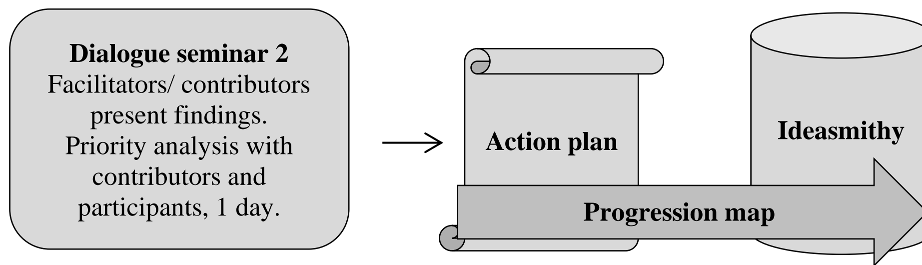
Service users, providers and leaders: - Training based on the training needs prioritised in the action plan - Joint training: exploratory dialogue, communication skills, reciprocal empowerment, power awareness, and co-creation leadership, 2 days

Evaluation form 2: Service quality, phases/path so far, including Ideasmithy integration

8. Prioritation analysis

Focus	Service users	Service providers	Leaders
Evaluation			
Improvement/innovation potential			
Training needs			

9. Evaluation/service development **10. Hearing** **11. Maintenance**



Phase 3 – Contributor-led

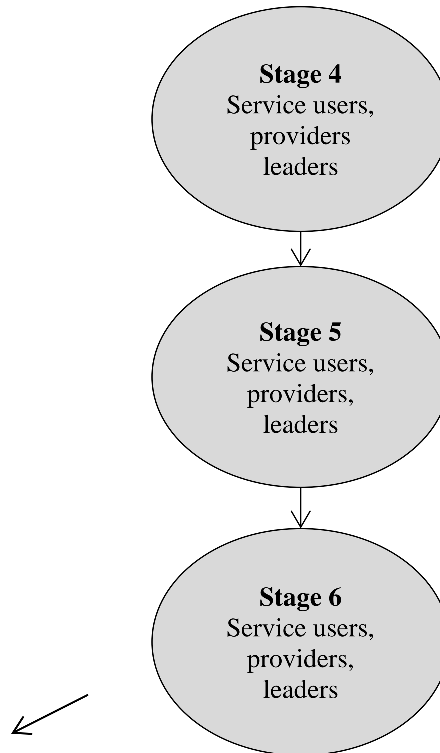
12. <u>Training and guidance</u>

13. <u>T6 group interviews</u>

Leaders: Continuous guidance

Ideasmithy coordinator: Continuous guidance

Contributors: Method training (including T6 group interviews, priority analysis, and dialogue seminar), 1 day, continuous guidance.



14. <u>Priority analysis</u> (1 day)

Focus	**Service users**	**Service providers**	**Leaders**
Evaluation			
Improvement/innovation potential			
Training needs			

15. Evaluation/service development **16. Hearing** **17. Maintenance**

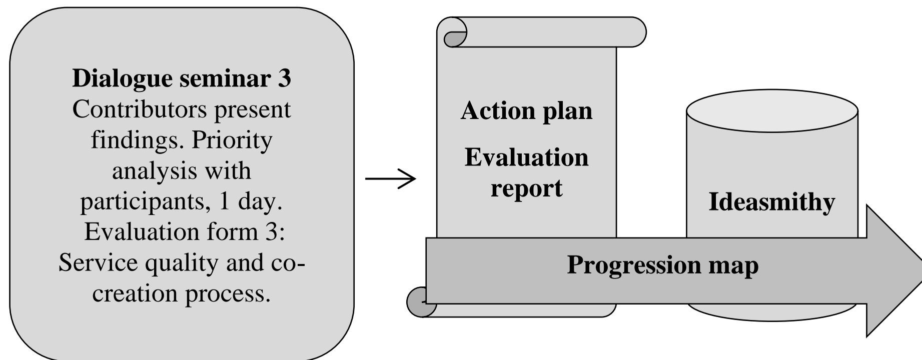


Figure 2 The co-creation method

5.2.2.1 Coordinator

Initiation, connection, overview, and long-term commitment are important to maintain a co-creation process. The process may be coordinated by an initiator (such as a service user/provider/leader/action researcher, or other stakeholders) who has knowledge about the co-creation method. The coordinator may collaborate with a team of external/internal facilitators; they should also be aware of organisational culture and how reciprocal empowerment, balanced dialogue and power, and co-creation leadership behaviours among stakeholders can benefit the co-creation process. A main task for the coordinator is to ensure that all parties (e.g. service users, service providers, and leaders) are represented as equally as possible in the roles beneath them (excepting the Ideasmithy coordinator). The coordinator initiates planning with leaders, and provides leader guidance, in addition to training facilitator and contributors in line with suggestions from this thesis. In collaboration with facilitators, the coordinator produces context-specific questions for group interviews and evaluations, as well as an evaluation report at the end of the process.

5.2.2.2 Facilitators

Trained facilitators may prepare and facilitate a co-creation process. They may be employed for this task, or they may volunteer from within an organisation. Facilitators lead the initial group interviews, priority analysis and dialogue seminars and provide training and guidance for contributors who want to take over these tasks. They also provide joint training and may engage in leader planning and guidance.

Facilitation can be either external or internal. A team of facilitators may be 'professionalised' in advance for the co-creation process through adequate training, group interview tests, roleplay, literature and guidance. Thus, the co-creation process may be co-provided as an independent service by a skilled team. However, such process can also be facilitated by internal PSO facilitators who are trained and/or informed by this thesis.

5.2.2.3 Participants and contributors

Service users, providers and leaders can participate in training, interviews, dialogue seminars and the Ideasmithy. However, participants can become contributors when individuals wish to take more responsibility in facilitating the co-creation process. Contributors may be trained and supported by facilitators to lead interviews, priority analysis and dialogue seminars. In this way, contributors increasingly take over facilitators' tasks. These skills can thereby remain in the organisation when external facilitators pull out at the end of the process. The contributor role is also available for stakeholders who wish to take on long-term responsibility (such as Ideasmithy coordinator) and/or initiate or sponsor developments/entrepreneurship.

5.2.2.4 Ideasmithy coordinator

This role is key to anchoring the Ideasmithy and thereby integrating a co-creation practice within the organisation. One person is recruited to

engage as contributor from the beginning to the end of the co-creation process. This may be a service provider or a service user. This role is part of a bottom-up approach that may strengthen equality as opposed to cementing hierarchy. The person is trained, guided and supported by facilitators to establish the Ideasmithy, document and follow up developments in minutes, an action report and a progression map. Also, in collaboration with stakeholders, it is the Ideasmithy coordinator's task to maintain the Ideasmithy meeting in the organisation.

5.2.2.5 The Ideasmithy

The Ideasmithy is a fixed meeting between service users, providers, and leaders. The Ideasmithy coordinator and two stakeholders from each of the three parties explore training needs, service quality, change propositions and innovation initiatives in this meeting. Furthermore, propositions made in group interviews, dialogue seminars and more are followed up in the Ideasmithy. Assisted by consistent documentation and the Ideasmithy coordinator, Ideasmithy members continue to monitor developments and strengthen co-created organisational adaptation in the organisation also after the intervention.

5.2.2.6 Training and guidance

Planning and guidance: Leaders and coordinator/facilitators engage in planning meetings to adapt the co-creation process to the organisational context. However, a path may also be chosen in the information and decision meeting. Leaders are consulted and provided opportunities for guidance and reflection throughout the co-creation process. They are also urged to ensure that staff and service users have opportunities for individual and group reflexivity.

Information and decision meeting: In this first collective meeting with service users, providers and leaders in an organisation, the coordinator and/or facilitators describe the co-creation method. A co-creation

process path developed in the leader planning stage is suggested and then adapted according to the agreements made between the stakeholders in this meeting. Alternatively, a path can be created in this meeting.

Joint training: Facilitators provide training in exploratory dialogue, reciprocal empowerment and co-creation leadership. Participants/contributors from all parties engage in role-play, skills training and individual and group work to enhance a) their communication and relational skills, b) their awareness of power and c) their understanding of leadership beyond formal leader positions.

Ideasmithy coordinator training and guidance: Facilitators provide individual training and guidance for the Ideasmithy coordinator in the following topics: a) exploratory dialogue facilitation, b) integrating the Ideasmithy coordinator role in the organisation (including considerations of role expectations, working hours, pay etc.), c) securing the establishment of an Ideasmithy while ensuring the attendance of multiple stakeholders, and d) documenting the process in minutes, comparative tables, reports and progression maps (including group interviews, dialogue seminars and Ideasmithy meetings).

Contributor training and guidance: Facilitators provide training so that contributors can lead T6 group interviews, priority analysis and dialogue seminars themselves.

5.2.2.7 Evaluation forms and report

Service quality, Ideasmithy integration and the co-creation process are evaluated by the stakeholders in qualitative and quantitative interview forms. Analysis of evaluations 1 and 2 are presented by facilitators in dialogue seminars 1 and 2; these findings are also included as part of the priority analysis in these dialogue seminars. The major findings in evaluations 1-3 are summarised by facilitators/coordinator in an evaluation report.

5.2.2.8 Group interviews and dialogue-seminar

The T6 (multi-stage) focus group interviews (called T6 because of the form of the model and the 6 stages) and dialogue seminars are conducted in the same manner as described in Larsen and Sagvaag (2018). These co-creation spaces may be facilitator-led in phases 1 and 2. In phase 3 contributors can be trained and supported by facilitators to take on moderator and participative observer roles themselves in the remaining three stages of the T6 interviews, conduct the priority analysis and lead the dialogue seminar themselves.

5.2.2.9 Continuous documentation

The Ideasmithy coordinator documents dialogues in minutes that are member checked by participants/contributors. Anonymised minutes from group interviews, dialogue seminars and Ideasmithy meetings are made accessible on a shared computer that all stakeholders can access. This information allows participants/contributors to prepare themselves before the next meeting, dialogue seminar, etc.

Comparative table: The Ideasmithy coordinator also arranges the topics from the T6 interviews in a comparative table that briefly summarises service users', providers' and leaders' initiatives and views. In addition to the facilitators' presentation, this table is a tool that participants can use for individual (find and explain the five most salient topics) and group (explore, explain and decide three topics that need pursuing) priority analysis in the dialogue seminar.

Priority analysis: After three stages of facilitator-led group interviews (phase 1), facilitators analyse interview minutes, observations and evaluations in an individual priority analysis. Here, the facilitator's task is to read through all documentation, point out and reflect on reasons why five particular topics were considered most salient in a particular context. Then, the coordinator facilitates exploratory dialogue in a group priority analysis between facilitators, resulting an agreed-upon number

of salient topics that should be presented in the dialogue seminar. Also, after Ideasmithy integration and evaluation of the process (phase 2), the facilitators analyse evaluation forms and progression maps and present their findings in the subsequent dialogue seminar in collaboration with the Ideasmithy coordinator. A new comparative table on issues addressed in the Ideasmithy is also produced by the Ideasmithy coordinator. The priority analyses in the subsequent dialogue seminars include the facilitator/contributor's presentations and updated comparative tables.

Action plan and Evaluation report: After each dialogue seminar, the facilitators and Ideasmithy coordinator summarise what has been agreed upon in terms of necessary actions and follow-ups. The first draft of an action plan is produced by the Ideasmithy coordinator describing the main views in the dialogues, reasons for pursuing developments and initiatives, and how to continue. This plan is member checked along with the evaluation report by the participants/contributors and made accessible in the progression map.

Progression map: This is an interactive tool that allows service providers and users in the organisation to access all the anonymised documentation (interview and Ideasmithy minutes, comparative tables, dialogue seminar presentations and minutes, action plans, evaluation reports and more). This overarching document presents the objectives from the action plan that need pursuing, follow up, or have been finalised. It is a simple word document with a table that provides an overview of topics, as table 9 below illustrates. This format allows the reader to delve deeper into a topic's path and origin through hyperlinks that are connected to documents filed on the shared computer. After each dialogue seminar, the progression map is member checked by the participants. The Ideasmithy, including its coordinator, is responsible for updating and monitoring the developments in the progression map.

Table 7 Progression map

Topic and file location	**Responsible parties**	**Status**	**Experiences/ evaluations**
User- led admissions Report. Contract. Minutes topic 1: 05.05.10, 05.05.11	Unit leader Staff member	Initiated	First evaluation: three months from initiation.
Shared computer in the living room area Minutes topic 2: 05.02.12, 05.03.12, etc.	Clinic leader Patient	In progress	Bureaucratic hurdles have been overcome. IT will make arrangements by next week.
Open kitchen 24/7 Action plan Minutes topic 3: 05.02.11, 08.08.11 05.03.12, 05.08.13 etc.	Unit leader Staff member	Rejected	Refrigerator has been placed in eating area. Patients have continued to raise the topic in the Ideasmithy

6 Discussion

In this chapter, I will discuss the role of leadership in the co-creation method and how the systematic involvement of leaders, users and providers can enable organizational adaptation in public services.

6.1 Cycles of value co-creation

When trying to distinguish between co-production and co-creation, I found that co-production was 'sandwiched' in between co-creation and co-creation of value (Larsen & Gordon, 2013; Larsen, Karlsen, & Sagvaag, 2020). However, a more adequate metaphor might be that co-creation and co-production are two paths leading to co-creation of public value, as described by Larsen et al. (in review). Osborne et al. (2018) relate 'pure' co-production to value co-creation in terms of both value-in-use and public value (Osborne et al., 2018). Involvement has its own value, which suggests that these paths may form recursive cycles of value co-creation. For instance, an individual engaging in co-creation may experience individual value while co-creating public value, which in turn may inspire more engagement.

A predominantly user-centred focus was presented in some of the theory in Larsen et al. (in review). However, we suggested that the conceptualisation of leadership related to co-production and co-creation should include an understanding of both the service providers and users valuing co-creation. Such a perspective requires a reinterpretation of Osborne et al.'s origins of value (Osborne et al., 2018): For one, enabling public services (health, welfare, education and more) may empower service users to enhance their lives, while well-functioning PSOs (and enabling public services) may empower service providers in their professional endeavours. Second, in the interaction between service user and provider there is a potential for reciprocal empowerment; if both parties are able to learn from and become

strengthened by the other, they may both grow. Finally, such empowerment and reciprocal empowerment may strengthen and be strengthened by the parties' ability to self-empower, as co-created knowledge and expertise may increase their individual professional and personal capacity to liberate themselves from oppressive structures (Larsen & Sagvaag, 2018; Larsen et al., 2020).

6.2 The role of leadership in the co-creation method

Co-creation leadership can be described as leadership that may benefit from various leadership styles and behaviours. The examples demonstrated in Larsen et al. (in review) were enabling, operational, and entrepreneurial leadership styles (Uhl-Bien & Arena, 2018); deciding, consulting (individual/group), facilitating and delegating styles (Vroom, 2000); and multiple leadership behaviours under meta categories task-oriented (monitoring operations), relations-oriented (empowerment, development), change-oriented (encouraging innovation, facilitating collective learning, advocating change), and external (representing, networking, external monitoring) leadership (Yukl, 2012). Although there are more behaviours in Yukl's (2012) taxonomy suitable for co-creation leadership, in the following discussion I will only deal with those presented in the Larsen et al. (in review) findings.

The proposition that value-in-use, and empowering services and reciprocal and self-empowerment, also applies to service providers and leaders has implications for public service leadership. In the co-creation method, leader presence is taken for granted. Moreover, it is vital that leaders, service providers and users have equal opportunities to participate and contribute. This is to ensure informed decision-making by stakeholders 'on site', and thereby the legitimacy of the co-creation process among stakeholders who engage with a desire to influence co-creation with their contributions. When the opportunity to progress, improve, and innovate presents itself, public leaders should be able to

perform with an evolving understanding of how to lead in co-creation, which may be termed a *co-creation leadership practice*.

Leader engagement in planning, training, guidance, reflection and co-creation spaces is necessary for building experientially founded practical knowledge about leading co-creation (Heron & Reason, 2006). The potential for change and initiative in the group interviews, dialogue seminars and Ideasmithy must not be underestimated. This does not mean that hasty decisions about how to progress should be forced through; some issues need further exploration. However, it is the formal leaders' job to choose the most appropriate decision-making procedure based on information about the situation (Vroom, 2000). At the same time, the public leader is not alone in performing leadership. With the co-creation method comes a repertoire of leading roles in which stakeholders may initiate and move, support, challenge and empower each other with contributions from their perspectives/expertise (Isaacs, 1999).

Leadership and role-migration are essential to enabling co-created organisational adaptation. Service users, providers and/or researchers may take on roles as coordinators, facilitators, contributors or the Ideasmithy coordinator and may thereby, together with PSO leaders, take the lead and advocate change and encourage innovation by facilitating co-creation (Yukl, 2012). As part of reciprocal empowerment, migrating into leadership roles requires genuine relationship shifts, which also includes delegated autonomy (Vroom, 2000; Yorks et al., 2008). However, such leadership relies on the formal leaders understanding of their own role and responsibility and their ability to make their own decisions and decisions with stakeholders (Larsen et al., in review). On the one hand, facilitators and coordinators may facilitate self-empowerment and development in leader guidance and Ideasmithy coordinator guidance and training (Yukl, 2012). On the other, facilitators may facilitate collective learning and reciprocal

empowerment in the joint training, and the Ideasmithy coordinator may do the same in the Ideasmithy (Yukl, 2012).

Many decisions may be made in the meeting places that the co-creation method offers. In light of analysis related to communicative spaces (Larsen et al., 2020) and adaptive spaces (Larsen et al., in review), one of the aims of the co-creation method is to open co-creation spaces. Here, decision-making can be done by deciding, consulting (individual/group), facilitating or delegating (Vroom, 2000) depending on formal leaders' ability to manoeuvre along this continuum in the presence of the other stakeholders. Naturally, as demonstrated in Larsen et al. (in review), decisions may also be postponed, persons outside these spaces can be consulted to inform the decisions made therein, and decisions with relevance to the co-creation process can also be made elsewhere in the organisation. Stakeholders may also engage in external leadership behaviours to enable new service provision beyond their own PSO (Larsen et al. in review).

Furthermore, establishing a fixed meeting for co-creation through guidance, training and learning-by-doing can ensure that a co-creation practice endures in an organisation. For instance, the Ideasmithy that was established in 2012 is still active in the SMHS in this study (Larsen et al., 2020). Such co-creation space is central to the method and to integrating a co-creation practice. In organisations where there is no equivalent meeting space for stakeholders, establishing a fixed meeting such as an Ideasmithy is recommended. However, for such meeting spaces to survive, awareness of legitimate decision-making practices is vital. Shared decision and communication practices such as facilitation, delegation, dialogue and metalogue, as well as leadership behaviours such as monitoring operations, empowering stakeholders, encouraging innovation and facilitating collective learning, may be refined through experiential learning in the presence of the other stakeholders (Isaacs, 2000; Schein, 2002; Yukl, 2012; Vroom, 2000; Newton & Goodman, 2009).

Finally, integration is essential to understanding the role of leadership in co-creation. On the one hand, in leadership that encourages organisational adaptability, the ability to connect diverging perspectives and advocate for a new organisational logic that enables connection and transitions between production, innovation and hierarchies, is a desirable quality (Uhl-Bien & Arena, 2018). Hence, entrepreneurial, enabling and operational leadership styles (Uhl-Bien & Arena, 2018) and adaptive spaces are necessary as demonstrated in Larsen et al. (in review). On the other hand, to ensure that this process deals with existing issues in their respective context and continuously improves the potential of the practice and action research co-creation method, integration can be also understood as a two-way process (Gustavsen, 2003; Hagen & Qureshi, 1996). To contextually root a co-creation process, stakeholders may adapt it through path selections and local initiatives. Thus, in addition to the goals of ambidexterity and enabling co-creation spaces, integrating co-creation practice with service practice is regarded a two-way process of preserving, giving up, and/or adopting new qualities/characteristics (Hagen & Qureshi, 1996) to benefit both the organisation's practice and the co-creation method design.

6.3 How can systematic involvement enable PSO adaptation?

Through knowledge about the co-creation method and experience with being engaged in a co-creation process, stakeholders may co-create context-specific knowledge about how to co-create organisational adaptability. Through this practice, they become acquainted with the phases, paths, spaces, and tools (such as priority analysis, evaluations, and documentation techniques) that strengthen co-creation spaces. In turn, a co-creation practice in a given organisation can persist and evolve, and organisational adaptability may benefit from this dynamic. Furthermore, evaluations of a) an organisation's cultural journey toward establishing co-creation practice and b) the co-creation method design

may enhance the opportunities for reintegrating the innovation resulting from this thesis: namely a co-created knowledge-based co-creation method that ensures service user, provider and leader impact on service development. However, it appears that leader involvement is key to enabling co-created PSO adaptation. With PSO leaders' support and presence, co-creation leadership and a locally adapted co-creation process, as proposed in the co-creation method, organisational adaptation in public services can be enabled.

6.4 Implications for practice

6.4.1 Utilising a practice co-creation method

The co-creation process may be simplified or made more complex depending on an organisation's needs. There may be different levels of intervention in a co-creation process. One possibility is to stick to the 1.5-year estimate with trained facilitators on a path through all three phases of the co-creation method. Another possibility would be to engage with phase 1 only, with or without facilitators, and ensure continuity afterwards with an Ideasmithy and/or annual dialogue seminars. Alternatively, phase 2 can be left out, and stages 2-6 can be regarded as Ideasmithy implementation, with or without the help of facilitators. It is also possible to turn the map around and successfully implement an Ideasmithy that runs continuously and use tools such as evaluation forms and priority analyses and co-creation spaces such as joint training and dialogue seminars to evaluate progress on an annual basis and determine the way forward. In other words, the time-estimates in the co-creation method are only suggestions. It is also possible to include more stakeholders than participated in the example co-creation method described above, although it would be necessary to consider the pros and cons of how this might influence the efficiency of the process. In particular, it is important to look at how these decisions may affect communication.

Furthermore, co-creation leadership is described as hands-on, with PSO leaders being immersed in the co-creation process and spaces they enable. This has implications for practice related to leader presence in co-creation processes. Also, the delegation of leadership to stakeholders who wish to engage in the many leadership behaviours that comprise co-creation leadership suggests that the role and responsibilities of PSO leaders may need to be re-examined. Also, it appears that meeting structures and decision-making procedures in PSOs may be affected and therefore should be reconsidered when engaging with co-creation. Compensation and reward systems that promote co-creation and co-creation leadership appear necessary, including employment of service users, advancement opportunities for both service users and providers and legal clarity regarding involvement.

6.4.1.1 Considerations

To decide which path to follow on the journey through and beyond the co-creation method, I suggest reflecting on the existing organisational culture. How do service providers, users and leaders communicate about and with each other? How is power managed? In what ways are problems solved, and have the assumptions and beliefs of service providers and leaders about what works been sufficiently tested in the presence of service users? What hindrances and enablers (human, practical, structural, financial issues and resources) are there to a) service user involvement, b) establishing a fixed co-creation meeting as part of the organisation's meeting structure and c) engaging with co-creation leadership? I also advise caution related to handling the co-creation process superficially. Considering the risk of co-destructing experiential value and public value co-creation with tokenism is important (Osborne et al. 2016). As pointed to in all three articles, there may be forces in the organisational culture that need to be addressed on a deeper and more long-term level in order to build genuine partnerships and constructive co-creation practices.

6.5 Possible directions for future research

Action researchers often struggle to reach congruence between theory and practice. However, local in-depth knowledge may help nuance theory, making it more applicable outside the studied context. What sets action research apart from pure, descriptive, analytic research is the link between local and society-level discourse (Gustavsen, 2014). Gustavsen (2003; 2014) reminds us of the importance of using several cases when building theory. Also, action research should focus on creating social movements (e.g. research programmes) rather that exploring the relationship between an action researcher and co-researchers in a single case project. Further, AR design should acknowledge the existence of two parallel diffusion processes that include the efforts of both researchers and stakeholders. Such broader social movements may maximise the effect of larger action research programmes as research councils and other partners, such as regional authorities, may finance necessary societal changes (Gustavsen, 2003).

Although it has not resulted in a larger AR research programme, this thesis, as a single case study, has the potential to be a seed that produces sustainable social movements (Reason, 2003). The challenge is to figure out how first- and second-person inquiry can be 'integrated with wider political processes' (Reason, 2006, p. 282). This single case may not have impacted Norwegian policy like Gustavsen's (2014) study, but it resonates with Reason's descriptions of PhD scholars who open small group inquiry spaces that expand to the wider community (Reason, 2003). This thesis, its follow-up study and subsequent facilitation of public involvement in higher education may be described as 'a series of events' 'linked to each other' 'where the meaning and construction of each event is part of a broader stream of events' (Gustavsen, 2003, p. 95-6) that have created and supported co-production and co-creation in PSOs.

Further scientific exploration of this co-creation method and of co-creation leadership may benefit PSOs with regards to general co-created service quality improvement and innovation. However, a social movement related to co-creation appears necessary beyond public services in matters of global concern. Both co-production researchers and action researchers have been orienting their efforts towards the contemporary climate crisis (Galli, Brunori, Di Iacovo, & Innocenti, 2014; Meadow, Ferguson, Zack, Horangic, & Owen, 2015; Ostrom, 2010). The latter have emphasised a particular need for AR in pursuing more sustainable environmental solutions (Bradbury et al., 2019; Holtskog & Johnsen, 2018). Several AR studies describe the emancipation of youth and children in their efforts to save the planet (Trott, 2019). Also, one of the main international contributors to the field of AR, the *Action Research Journal*, updated its purpose and acknowledged a new urgency in 2019 (Bradbury et al., 2019). Enabling human flourishing and evincing 'a deep concern for the wider ecology' (Bradbury et al., 2019, p. 14) remain the journal's principal aims, it defines 'action in support of our collective thriving on this planet' as an important measure of AR quality (Bradbury et al., 2019, p. 16).

Through the years, action researchers have argued that the way knowledge itself is produced and used, such as by merely objectively describing a problem, requires critical examination. Today, producing 'knowledge for sustainability through more action-oriented transformations research' (Bradbury et al., 2019, p. 4) is called for. Tools from the AR tradition appear particularly suited to inquiry engagement in radical individual, group and societal change (Bradbury et al., 2019). As this practice 'aims toward greater congruity between the values one espouse and the values one enacts' (Brydon-Miller et al., 2003, p. 12).

For this reason, further implementation of this co-creation method and development of the concept of co-creation leadership can contribute to research on sustainable solutions within and outside of PSOs. As Gustavsen (2003) and the PSO in this study have demonstrated, two

parallel diffusion processes that include both researchers' and stakeholders' efforts and funding may maximise the effect from larger action research programmes.

On the one hand, this co-creation method and co-creation leadership may be one possible response with regard to enabling collaboration and change across service providers and citizen hierarchies. Therefore, research that explore co-creation methodology and leadership is promoted. On the other, when writing this thesis, some potential parallel issues concerning youth leadership and managing intergenerational power and communication have become apparent. I suggest that future research focus on facilitating intergenerational reciprocal empowerment and dialogue that promotes an environmentally sustainable future for today's youth – within PSOs (such as welfare and treatment services, but also in schools and more), in local communities and in the global arena. An action research orientation, such as the co-creation method proposed in this thesis may enable collective mobilisation, double-loop learning and deep-seated and durable change.

6.6 Methodological considerations and limitations

Although service developments were recorded in the experience report, assessing whether or not the quality of treatment in this SMHS improved in this intervention was not within the scope of this study. One limitation of this thesis is that it does not present or evaluate the organisational outcomes. Hopefully, the introduction of a co-creation method and co-creation leadership encourages and enables other researchers to consider the quality of outcomes resulting from initiated co-creation processes.

6.6.1 Presentational knowing

In co-operative inquiry, presentational knowing is also regarded as a necessary part of the knowledge development phases. Although the forms of such knowing 'symbolise both our felt attunement with the

world and the primary meaning which it holds for us' (Reason 1998, p. 426), it has not been sufficiently recorded or explored in this study. Reason and Heron (2008) argue that in postgraduate studies, presentational knowledge often comes in the form of narratives or stories that are always connected to propositional outcomes. They note the importance of freer nondiscursive forms (Reason & Heron, 2008). I agree with this criticism, as balancing the collective and individual aims/empowerment posed a dilemma throughout this inquiry. Furthermore, because we did not look at presentational knowing in this study, valuable opportunities for deeper exploration of experiential and practical knowledge may have been lost. This may be regarded as a limitation of this study.

6.6.2 Co-researcher emancipation

In line with my agreement with the leaders in the PSO, interviews, dialogue seminars and participative observation were all conducted within a participatory framework. However, the fact that co-research was conducted by briefly trained stakeholders without scientific experience may be regarded as a limitation of this study. Even so, co-researcher engagement is considered a strength since these participants were from the local context and their inquiries were rooted in their reality and therefore more credible and authentic (Larsen & Sagvaag, 2011; Lincoln & Guba, 2007). Hence, the exploration appeared to go deeper into some issues which may not have seemed relevant to an outside researcher.

Also, as a participative observer, I could continuously monitor the development of co-researcher's skills and knowledge and advise them on how to conduct research. Although interviewing was new to most of them, I never corrected the co-researchers during interviews. We explored and agreed on role behaviours in test interviews and reflected on their co-research practice after each interview. The co-researchers adjusted their behaviour in the next interview according to affirmations and constructive critique from me and their fellow co-researchers.

Guidance could include advice on suspending certainties, avoiding resistance-provoking questions, and promoting inclusive and exploratory dialogue.

I also guided the co-researchers before and during dialogue seminars, and we reflected on their practice afterwards. Finally, we continuously reflected on co-research practice throughout the knowledge development phases. Guidance related to communication between the stakeholders and the organisational structures was essential. In situations of conflict, such as those described in Larsen et al. (2020), collaboration with the leadership level was particularly important to ensure a satisfactory treatment and working environment. Also, since the AR project stirred up some of the deep-seated issues in this SMHS, mediation may have seemed like my responsibility as facilitator – but all parties contributed to this effort. Needless to say, stakeholder collaboration was vital in this context.

6.6.3 Researcher participation

On the one hand, being a researcher familiar with this professional and organisational context may have enhanced my participative observation with theoretical and context sensitivity - which may also have prevented my becoming overwhelmed by the volume of data (Dahlke, Hall, & Phinney, 2015). On the other, having embodied experience with addiction, Bjerke describes how his experiential knowledge made him read data 'as a challenge in relation to how I place myself' (Bjerke, 2010, p. 1720). At the heart of participative observation lies the 'reciprocity of perspective' between the researcher and 'the researched' (Savage, 2000, p. 326). This means that one's own lived experience is available to another. Harris (2015) suggests that disclosing embodied experience as a researcher can enhance vulnerability. She demonstrates how disclosure facilitated an interview dynamic in her study, making it 'more akin to a conversation between peers' (Harris, 2015, p. 1696). Indeed, from my perspective in the participative observer role, at certain times, the

interviews, seminars, and field situations, in co-researcher guidance and more were like conversations between peers. Exploring treatment quality/challenges among equal stakeholders unveiled prejudices and preunderstandings regarding many issues, including my own. Reflection in light of these conversations allowed me to position myself more consciously as an action researcher.

The fact that I had four dimensional knowledge that enabled proximate participation is a condition that may particularly justify the use of a revelatory single case study (Gustavsen, 2003; Lincoln & Guba, 2005; Lofthus, 2018; Reason, 2003; Yin, 2009). Proximity is necessary for the purpose of 'translating deeper understanding into making immediate improvements' (Mabry, 2008, p. 320). Everyday life observations for more than three years were also important because I saw how participants' testimonies played out as behaviours that were congruent or incongruent with what they claimed to believe (Argyris & Schön, 1974; Dahlke et al., 2015). As a participative observer I picked up on the subtleties of non-verbal communication and translated it into knowledge (Savage, 2000). For instance, if staff communication appeared paternalistic, patients' fixed eye-contact, sighs and eye-rolling could confirm my suspicion that they considered this style of communication undignified. In this way, my experience in the participative observer role informed, supported and challenged claims made and topics raised by stakeholders during the AR process. Such proximity promoted an advanced form of understanding because it is only from within the social actor's context that the researcher can understand their viewpoints and behaviours (Flyvbjerg, 2006). Merely using statistical data from larger surveys would not have enabled me to make discoveries, find the new first- and second-person inquiry insights, and cast aside preconceived notions and theories in the way this study has (Flyvbjerg, 2006; Heron & Reason, 1997). Although, such proximity may be regarded a limitation by many scientific communities, this is an investigation opportunity few social scientists have had.

7 Conclusion

In this thesis, the main aim of developing a 'user participation method' that ensures both service user and service provider impact on service development and the action aims of facilitating a) increased user participation in public service development and b) dialogue between service users and providers about service development were accomplished. However, while the joint action aim, namely to develop the services offered by this treatment facility for the better, may have been achieved through the extra competence enhancement, material upgrading and service developments resulting from this study, assessing whether the quality of treatment in this SMHS improved was not within its scope. Also, reporting all the organisational changes resulting from the study has not been a priority in this thesis. Rather, the focus has been on developments informing the main action research aim and question. This may be regarded as a limitation of this study.

The main research question – *How can participation and real influence from patients and staff in service development be ensured?* – and the synopsis research question: *The role of leadership. How can systematic involvement of leader, user and provider enable organizational adaptation in public services?* – have been answered through the description of a co-creation method and co-creation leadership.

Stakeholder involvement in designing and conducting the research has informed the three articles with co-created knowledge. The articles contribute to awareness about a) diagnostic organisational culture that limits patient involvement in service development and b) the need for self-empowerment and reciprocal empowerment among service users and providers. They also point to organisational defence mechanism and propose measures to optimise genuine co-creation partnerships. Finally, a co-creation leadership style that includes multiple behaviours for stakeholders who want to take the lead in co-creation to choose from is

proposed. This new leadership style has been defined as the ability to recognise service providers and services users as colleagues who co-create services and value in a reciprocally empowering working alliance with each other and the formal leader.

Thus, the research design and the articles have informed the co-creation method and the proposed co-creation leadership style. A co-created knowledge-based co-creation method that ensures service user, provider and leader impact on service development is therefore the main result in this thesis. The co-creation method has been described as both a practice and an action research method that citizens/service users, professionals/service providers, leaders and researchers can engage with. To enable sustainable co-created organisational adaptation, various paths that can be selected are laid out in a co-creation method map. These paths, which represent cultural journeys, may be adjusted to fit an organisation's need for change in its culture and practice. Also, in co-creation leadership, leader involvement and presence during this journey are key to enabling co-created adaptation in PSOs. The method offers multiple communicative and adaptive spaces where stakeholders can be involved in decision-making. Conceptualisation of co-creation leadership may strengthen the co-creation of services and value potential.

8 References

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PART II

List of articles

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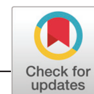

ORIGINAL RESEARCH PAPER

WILEY

Empowerment and pathologization: A case study in Norwegian mental health and substance abuse services

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Abstract

Context: Service user involvement in service development and research is an international goal. However, research illuminating the patient stakeholder role is limited.

Objective: The aim was to explore what may hinder patients' voices being heard when collaborating with staff and leaders to improve services.

Design: This action research project targeted Norwegian public mental health and substance abuse services, utilizing co-operative inquiry principles. Data were collected and member-checked collaboratively by the researcher and coresearchers.

Results: Results centre on patient involvement in services, service development and research. The patient voice was regarded as important but not necessarily decisive, as patients' change needs could be perceived as pathology-based. Patients provided feedback about fellow patients and medication—opioid maintenance treatment, in particular. Barriers to patient involvement included patients not being permitted to influence other patients' individual treatment and a leader's difficulty accepting patients' medication advice. Additionally, an apparent hierarchy among the professionals may have disempowered some staff members.

Discussion: Results point to an organizational diagnostic culture, where stigmatizing and risk pathologization may limit patient input. Empowerment appeared to be perceived as something allowed by the staff and leaders, at their discretion. Although all parties may have agreed that patient involvement was valuable, acting as a united group about opioid maintenance treatment appeared difficult.

Conclusion: Barriers to patient involvement may hinder the availability and efficacy of patients' perspectives in service development. Awareness about reciprocal empowerment might contribute to service users' voices being heard, enabling a united voice from service users and providers regarding service development.

1 | INTRODUCTION

The World Health Organization (WHO) lists service user involvement and making services more responsive to service users' needs as key objectives in their Comprehensive Mental Health Action Plan 2013-2020. There is a need for more research on service development that includes inputs from these stakeholders.[1] Although prior research has shown that patient involvement is necessary in service development, there is limited research about the patient stakeholder role.[2-9] In Norway, "user participation in

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health and social services" has been a policy aim since 1988[10] (p. 28); indeed, it was a prerequisite for upgrading public services in national action plans for mental health and substance abuse services.[11,12] However, user participation in these services has been evaluated as insufficient.[7,13] While service user participation in decision making has been explored,[14-16] obstacles to patient voices in mental health and substance abuse service development remain under-researched.

We conducted an action research project in Norwegian public specialized mental health and substance abuse services (SMHS) to explore service user participation in service development.[17-19] The study's primary objective was to develop a "user participation method" that ensured both service user and service provider impact on service development—with the idea that the process of knowledge development would benefit from patient, staff and leader involvement and participation in the research[20] and in turn could inform service development initiatives and decisions. In research, public *involvement* (when service users/patients/carers are involved in the design/delivery of the research) is often distinguished from *participation* (when data are collected from them in interviews or trials).[21] However, in the context of services and service development, user/patient *involvement* (as a term) is not used in relevant Norwegian legislation.[22-25] In national guidelines and action plans, *involvement* and *participation* are used interchangeably.[7,12,26] These two concepts are therefore distinguished in our research design but, in the rest of this article, *involvement* encompasses both participation and involvement in research, services and service development. With this approach, we investigate elements that appear to hinder patients' impact on decision making and their ability to be heard. Drawing on theories of *empowerment*[27-29] and *pathologization*,[30-32] we discuss obstacles to patient involvement and address the following question: What may keep patients' voices from being heard in their collaboration with staff and leaders to improve mental health and substance abuse services?

1.1 | Empowerment and pathologization

Emerson claims that power is relational. The power to control or influence someone "resides in control over the things he values"[33] (p. 32): How much one invests in goals mediated by another—and whether those goals can be achieved elsewhere—determines how dependent one is on that person. If one person is power-disadvantaged, *balancing operations* may be set in motion, restoring an unbalanced relation by increasing or decreasing dependence between the parties to reduce the power advantage.[33] Empowerment thus springs from power and can be interpreted as a three-term concept: strength → force → power[34] (p. 21). As such, "persons or groups that are in a situation of disempowerment shall acquire the strength and power to emerge from disempowerment"[34] (p. 21). One approach is for service providers to strengthen service users' ability to gain control over their lives.[34] Paradoxically, service providers may then assume that they are empower*ing*, rather than *collaborating with*, service users. So that, empowerment may be taken from service users and returned to them diluted, as a reproduction or magnification of oppressive practices. However, the potential for *self-empowerment* among *both* service users and providers must be considered.[35] Empowerment can be individual and reciprocal when service providers and service users engage in a joint cause—collaboration and active dialogue between the parties may thus be conducive to collective empowerment,[27] as "self-directing persons develop most fully through fully reciprocal relations with other self-directing persons"[17] (p. 3).

Freire regards oppression as a hindrance to one's pursuit of self-affirmation and liberation.[27] His liberationist philosophy is a founding part of empowerment theory,[27] in which "learning to perceive social, political and economic contradictions, and to take action against the oppressive elements of reality"[27] (p. 35) is a central tenet. Freire describes a process that makes people responsible subjects participating in history, encouraging them to pursue self-affirmation.[27] Although contextual knowledge and collective empowerment are fundamental to this theory, self-empowerment is an integral component. Individuals must seize their own empowerment when "engaged in the fight for their own liberation"[27] (p. 53). Freedom from oppression is thus "acquired by conquest, not by gift"[27] (p. 47). When in a position to embrace their freedom, the oppressed can "unveil" and confront the culture of domination through transformational action and reflection—a process Freire terms *praxis*. He argues that the oppressed must commit to unveiling the world through praxis and that dialogue can collectively empower both parties to name and transform dominant structures together.[27,28,36]

Changing public services can be challenging in an organizational culture founded on professional traditions; these patterns of assumptions represent distinctive organizational cultures that recreate problem-solving mechanisms, ensuring harmony and predictability.[37] In 1965, Løchen described an organizational *diagnostic culture* that muted the impact from the collision of roles, ideals and systems in a Norwegian psychiatric hospital.[30] In this diagnostic culture, causes of behaviour were attributed to the individual patient, hindering patients from promoting their claims because their protests could be added to existing pathological assumptions. Furthermore, patients had to be controlled because they "might use their right to codetermination in a way that is harmful to themselves or conflicts with the system"[30] (p. 219). Current literature points to a contemporary diagnostic culture wherein life problems may similarly be perceived as pathological conditions or somatic diseases.[31,32] As such, *stigmatizing pathologization* is defined as moral judgement of "inappropriate" behaviour associated with certain diagnoses, and *risk pathologization* predicts hypothetical future scenarios using "a particular susceptibility to illness"[32] (p. 286). This process can constitute discriminating stigmatization and enable self-pathologization. *Depathologization* is described as an attempt to change what is viewed as incorrect pathologization of behaviours.[32]

2 | CONTEXT

The inquiry was conducted in a voluntary inpatient SMHS treatment unit in Norway where opioid maintenance treatment (OMT) was part of the services. OMT is increasingly provided in Norway, with 7055 patients in treatment in 2013.[38] It is an "interdisciplinary specialized treatment for opioid dependence where the requisitioning of addictive medicines in a specific dosage (substitution treatment) is one measure in the overall rehabilitation process"[39] (§3). Methadone and buprenorphine (Subutex/Suboxone) aim to maintain or block opioid receptors in the brain, thereby preventing withdrawal and cravings for opioids.[40] According to OMT legislation, SMHS is responsible for initiating and downscaling medication.[39] However, national OMT guidelines state that the risks of relapse and overdose mortality are high,[40] so termination should "not be recommended unless there is good reason to believe that the patient will manage without opioids"[40] (p. 90).

2.1 | Research design

This descriptive single-case study applied the cyclical principles of action research, starting with conceptualizing and particularizing the problem and moving through several interventions and evaluations.[17-19,41-44] The inquiry was designed in line with co-operative inquiry principles[45]—researching *with* rather than *on* people seemed an appropriate way to facilitate patient, staff and leader collaboration on knowledge and service development.[46,47]

2.2 | Involvement and participation

This research design ensured that patient coresearchers (PCs), staff coresearchers (SCs), leader coresearchers (LCs) and the researcher (first author) could collaborate on developing interview guides, data collection, interpreting and disseminating findings, and proposing service changes. During the 3 years of research, a total of 109 (66 m, 43 f) consent forms were signed. Staff contributors consisted of *treatment* and *milieu* staff. In this article, both groups are defined as staff, with distinctions between the groups specified when necessary. A division between patients in OMT and other patients was made in the results.

All patients chose gift cards over cash payment as compensation for their contribution in work groups, training, interviews, dialogue seminars and disseminating findings outside the research context.[1] Staff and leaders who contributed outside regular working hours were compensated with equivalent time off.

The researcher's motivation to initiate this project was anchored[48] in her personal experience with addiction and outpatient mental health services, and her work as a social consultant in this SMHS. She facilitated the full inquiry while conducting participatory observation.[49,50] The researcher kept documentation in minutes and reports and made these accessible to the contributors. She attended all formal and most informal *service*-related meetings that were relevant to the study's objectives, including treatment, staff, management meetings and the everyday morning meeting between staff, patients and (sometimes) leaders. She provided training and supervision to qualify coresearchers to lead test interviews and 6 stages of multistage focus group interviews[2] ,[51] 10 individual interviews[52] and 4 dialogue seminars.[53] In addition to service meetings and the *scheduled inquiry* (see Figure 1), there were ad hoc *inquiry* meetings with leaders, staff and/or patients to address any issues raised in the inquiry. For example, when staff and PCs encountered communication difficulties, a dialogue meeting was facilitated to clear up misunderstandings between staff and coresearchers in the inquiry. This meeting was neither scheduled inquiry nor service meeting, but was solely to encourage dialogue because of conflict.

2.3 | Four phases of inquiry

In continuous interplay between reflection, experience and action, practice was constantly refined.[46] The project was structured according to the four phases of knowledge development in co-operative inquiry: (a) propositional knowledge—knowledge expressed in theories or statements; (b) practical knowledge—that is, skills and competence; (c) experiential knowledge—knowledge developed in "direct encounter face-to-face with persons, places or things"[54] (p. 230); and (d) critical scrutiny of the propositional knowledge—knowledge arising when the original propositions and questions are reconsidered and amended.[18,45,473] We used these phases as a framework only, as qualities from one phase may emerge (or merge with) another.[17]

Phase 1: The aim in this phase was agreement on a joint focus and to propose action.[20] Here, it was important to explore and document coresearchers' *propositional knowledge* about the SMHS.[18] There were nine researcher-led coresearch work groups—four with patients, four with staff. These SCs and PCs brainstormed about possible service developments, suggesting service improvements and training for staff and patients. They also developed interview guides for individual interviews with staff and patients and, in a final joint meeting, agreed on prioritized suggestions and established a

[1]Excepting one former patient who received remuneration for collaborating with staff to provide drug training to staff and leaders.

[2]Multistage focus group interviewing facilitates knowledge development about one topic through multiple stages; these occur predominantly with the same participants, using the same interview guide, to ensure deepening of perspectives and accumulated knowledge through explorative dialogue. A moderator encourages inquiry, supported by an observer who provides a summary of statements mid-way through the interview and at the end of each interview for member feedback. A summary of the previous interview is presented in the next interview and participants are encouraged to continue the inquiry until 'saturation' is achieved. In this inquiry, there were *eight* multistep focus group interviews in six stages (excluding the five test multistep focus group interviews in phase one—see Figure 1): *five* multistep focus group interviews in phase two and *three* in phase three. Data for this article are from three of the five multistage focus group interviews conducted by patient coresearchers in phase two (see Figure 1 and descriptions below). The number of participants and coresearchers in these selected multistage focus group interviews is listed in Table 1, below.

[3]Ideally, in a co-operative inquiry, the same inquiry group would engage in all four phases. Here, however, different stakeholders' perspectives dominated each phase—in the final phase, a co-research collaboration between the stakeholders was achieved.

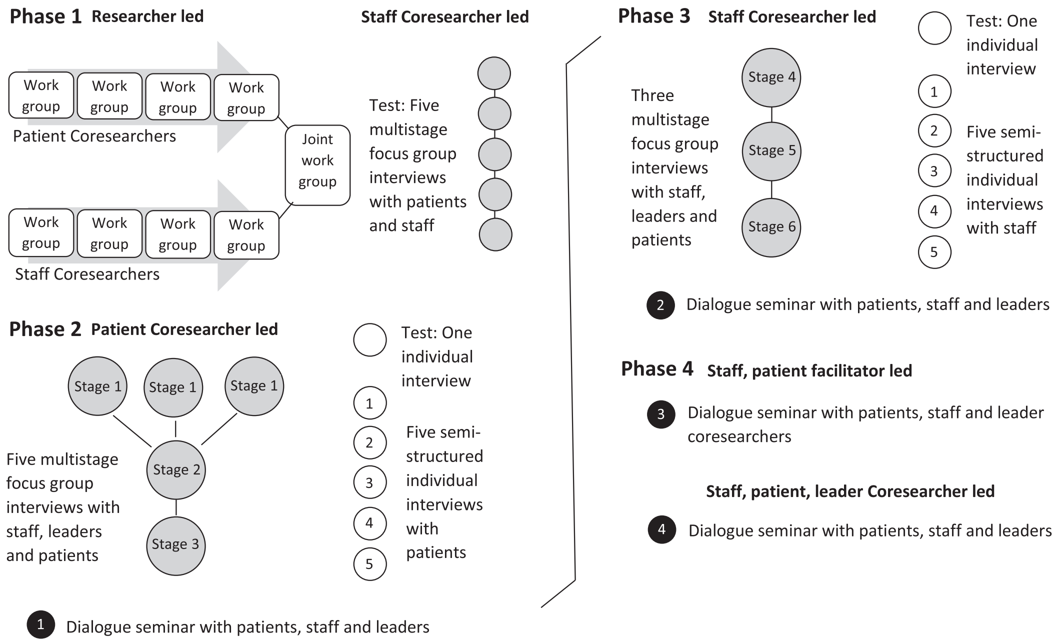

FIGURE 1 The four phases of inquiry

TABLE 1 Participation and involvement in selected data

Scheduled inquiry and ad hoc inquiry meetings	Participation	Involvement/ Coresearch
Before the inquiry One planning meeting (ad hoc)	Four leaders, one staff, one funder	
Phase 1 One joint work group		Two patients, ten staff
Phase 2 One dialogue meeting (ad hoc)	Two leaders, two staff	Two patients
Individual interviews with patients	Patients 1, 3 and 4	One patient
Multistage focus group interviews		
Stage 1: one focus group	Three leaders	Two patients
Stage 1: one focus group	Four patients	Two patients
Stage 3: one focus group	Two patients, two staff, two leaders	Two patients
Phase 3 Individual interviews with staff	Staff 3 and 5	One staff

joint focus: "to develop the services offered by this treatment facility for the better" (SCs and PCs, Joint Work Report). Their statements and propositions were documented in the Joint Work Report, which was used internally in the SMHS to inform plans and follow-up actions. The report also provided a propositional knowledge baseline regarding the service developments that followed. Multistage focus group interviewing was assessed by SCs and the researcher as a potential method.

Phase 2: This phase's aim was to explore *practical knowledge*—that is how things were done.[46] One PC conducted five semistructured interviews with patients. Of particular interest were the answers to the following questions: "Do you feel that what you say at the morning meeting is listened to?" "Do you think that it is difficult to express your opinion to staff and management for fear of consequences in your treatment?"

The interview guide for multistage focus group interviews was developed in this phase, with "What can be done to improve the

treatment in the unit?" as the main question. The subquestions were: "What works well now and what could be improved? What works less well and what is the improvement potential for this? What is the treatment potential for occupational therapy, sports, trips, outdoor groups, music therapy? What is the treatment potential among patients themselves? What role should the staff take in the [treatment] setting?"

Three of the six multistage focus group stages (see Figure 1) were conducted in this phase. Two PCs led five multistage focus group interviews (data for this article are from three multistage focus group interviews in stages 1 and 3): three separate homogeneous group interviews with staff, leaders and patients (stage 1), followed by two heterogeneous interviews (stages 2-3) with two participants from each group in stage 1 (excluding one leader who was replaced by another in stage 2). Each phase was finalized with a coresearcher-led dialogue seminar[4] where staff, leaders and patients were invited to explore service improvement potential. The suggested changes from all dialogue seminars were recorded in the Experience Report, including the individuals tasked with following them up. With highlights from the Joint Work Report also included, the Experience Report reflected the propositional knowledge acquired in each phase and informed plans and follow-up actions, as experiences and service developments were recorded within the report.

Phase 3: The focus of this phase was on *experiential knowledge*, with the aim of elaborating and challenging assumptions and gaining creative insights.[46] Here, superficial understandings from previous phases were explored as coresearchers deepened the inquiry. Two SCs conducted five semistructured interviews with staff. The answers to the following questions were of particular interest: "Do you feel that we have an overall vision to strive towards on the ward?" "Do you feel that you are able to make an impact as the primary contact person [for your patients]? Do you feel that you are heard (by the management/colleagues/the patients)?" "Does feedback from research influence practice?"

Together, the two SCs also led three heterogeneous multistage focus group interviews (stages 4-6) and a dialogue seminar.

Phase 4: The aim of this final phase was to consider the *propositional knowledge* in the light of experiences from phases 1-3.[20] This required analysing former actions and the consideration of subsequent developments. A coresearch group of two leaders, two staff and three patients analysed an extract from the Experience Report about dialogue seminars 1 and 2. These coresearchers were supported by trained facilitators—one SC from phase 3 and the other a former patient—in a smaller dialogue seminar among themselves. These facilitators also supported the coresearchers in leading the final dialogue seminar, in which patients, staff and leaders participated.

[4]Dialogue seminars comprised the following: Coresearchers presented preliminary findings and proposed changes. Participants were asked to individually prioritize five topics (from the previous presentation or their own initiative) that they wanted to pursue in further dialogue about service improvement. Participants presented their topics in heterogeneous work groups, explaining their importance. The groups discussed the topics that emerged, agreeing on three categories to present in a final plenum discussion about the need for improvement. Finally, participants presented their categories and were encouraged by coresearchers to initiate and follow up with the suggested changes. (Data for this article were not collected from the dialogue seminars.).

2.4 | Data collection

The minutes and reports were written in Norwegian and translated by a translation service. To ensure familiarity and readability, the researcher wrote in accordance with the documentation tradition in this SMHS. Therefore, these were predominantly condensed descriptions of the conversations, not verbatim transcriptions.[55-57] Some interactions, however, were quoted word-for-word. To make a clear distinction between the two, verbatim sentences are underlined below. Relevant data for this article include the Joint Report, and minutes from a planning meeting, a dialogue meeting, five individual interviews and three multistage focus group interviews (see Table 1).

2.5 | Data analysis

In this single-case study, the relationship between researcher and contributors was "one of mutual and simultaneous influence"[58] (p. 17). The minutes and reports were developed and interpreted in relationship between the contributors and researcher. Objectivity or generalization was not the intention. Rather, to ensure trustworthiness and authenticity, these data were rigorously *member-checked* by the respective contributors, following Lincoln and Guba.[58] The minutes/report were subjected to qualitative content analysis using NVivo 9.[55,59] Here, pathologization emerged as a central topic. The investigation alternated between induction and deduction, in qualitative *conventional* and *directed* content analysis.[59] The results were interpreted in the light of empowerment[17,27-29] and pathologization literature.[31,32,60,61]

The inquiry was approved by the Norwegian Centre for Research Data (NSD).

3 | RESULTS

Our results indicate that although staff and patient empowerment were generally perceived as a goal, some leaders and staff were concerned that pathology could motivate—and therefore prejudice—patients' contributions. Patients also reported having been and fearing being pathologized by staff. Further, our results point to the underlying assumption that patients were *allowed* to be involved.

3.1 | "Change needs may be pathology-based"

At the planning meeting, leaders and staff emphasized "the importance of offering satisfactory treatment" during the inquiry, urging the researcher to design the inquiry in a way that would "empower them [the staff] on par with the users" (planning meeting, leaders and staff). These participants were positive about

patient involvement, but sceptical about letting patients make decisions:

> It can be tempting in such a process to use pathological explanations to distinguish between desirable and undesirable behaviour. At the same time, the users' change needs may be pathology-based. It was emphasized in this context that the users' voice is both relevant and legitimate in this project, but not necessarily decisive. (planning meeting, leaders and staff)

Patients also reported pathologization from staff. One perceived questions about how he slept as "a bit pathologizing, it's like cosseting adult people" (individual interview, patient 4), while others feared that staff misinterpretations could affect their diagnosis.

> He is afraid of the consequences for his treatment if he says what he thinks here on the ward. … He fears that diagnoses are made based on something that the personnel have misunderstood and written about in his patient records. He has experienced that something said jokingly has been taken seriously… He finds that he needs to be careful what he says. (individual interview, patient 1)

Another patient explained how serious misinterpretations about him had been reported in his chart. He could not recognize the characteristics described—when he confronted the staff, the journal note was deleted. This experience "meant that his confidence to open up again to the personnel was undermined" (individual interview, patient 3):

> The personnel must understand that their experience is not enough, they should know what they are talking about and the consequences of communicating a misunderstanding or making an incorrect report. … He questioned whether it is possible so early in the treatment to assign such big, burdensome labels, and that it needed to reach the point where he had to justify himself. The interview subject … believed that these characteristics might provide a basis for a future diagnosis if he had not told them otherwise. (individual interview, patient 3)

Thus, patients did report experiencing pathologization; some were careful with their words for fear of being misinterpreted and consequently pathologized.

3.2 | "Permitted to be involved"

During the inquiry, staff and leaders changed attitudes towards patient involvement. Both staff and patients referred to decision making and involvement as something the patients "should be allowed to be part of" (individual interview, staff 5):

> I think we have become much more conscious of being advised by patients, so that they are involved and allowed to be more involved in decisions about their treatment than previously. I think we have become much more aware of that … The interview subject confirms that she thinks the research process is constructive, as she finds user involvement to be something positive. Because as I said just now, the patients just had to go along with what was decided by the management and therapists. (individual interview, staff 3)

> When it comes to user involvement and influencing their own treatment, the interview subject says that in a public system it is a matter of how far one is permitted to be involved. At the morning meeting, he has noted that occasionally he is given a hearing, but that issues raised can become stuck in the system and therefore feedback on patients' questions may be inadequate. (individual interview, patient 1)

Some staff and patients doubted having an influence on treatment decisions:

> Therapists and management have already decided … some matters have to be sent upwards before they come down again, in the sense that decisions must come from the therapists and the management, things cannot be resolved up front between the milieu staff and the patient. (individual interview, staff 5)

> In general, he gets a hearing at the morning meeting if it is in the interest of the staff. It is possible to raise issues, but it has no impact. (individual interview, patient 4)

However, some patients did feel heard in the morning meetings. One patient said, "If he doesn't perceive that he is understood, he can take it up on a one-to-one basis" (individual interview, patient 3).

Some leaders set barriers to patient involvement: "The management emphasizes that user involvement should not extend to patients' individual treatment, because the duty of confidentiality applies here" (leaders, stage 1). Concern for other patients was problematized by PCs in the dialogue meeting with leaders and staff:

> A patient [PC] says that it is not permitted to raise such matters. You are cut off, you're not supposed to be frustrated about it. The patients [PCs] see

> this from a different perspective and believe that some people are being maltreated. The leader says it is important to have trust in the assessments that are made. But you cannot give an answer that is absolutely correct in such cases, and you are not allowed to inform the other patients about the case… They [PCs] understand that the staff want to help, but they have special insight after years of experience and knowledge of fellow patients' situations. (PCs and leader, dialogue meeting)

In this meeting, the leader responded that it was difficult "to accept advice about medication, for example, because it can easily be manipulated" (leader, dialogue). The PCs, however, insisted on providing guidance because they "also have competence about how medicines work" (PCs, dialogue meeting).

Patients continued advising about medication, as they were concerned about large doses in OMT:

> The interviewees feel very provoked to see patients [in OMT] who are on so much medication that you can see that they are high. … they [interviewees] do not fit in with Subutex treatment because they [patients in OMT] sit around sleeping/are stoned all day and night and do not take part in activities. Seeing them triggers the craving for drugs. (patients, stage 1)

> What impression did patients who are dependent on lighter drugs get of the treatment when they saw OMT patients being allowed to get high at the state's expense? … He questioned the size of the doses and whether downscaling from Subutex was really a goal. (patient, stage 3)

One response to these concerns was that observing OMT patients could be regarded as something positive, in that it might discourage other patients: "The leader said that the experience is that OMT treatment is seen as attractive, while at the same time scaring people from going so far" (leader, stage 3). However, it seems the decision to provide OMT was never the leaders' to make: "The requirement that all functions, including OMT, be covered is part of the Health Trust's plan for substance abuse" (leader, stage 3). Even so, the patients insisted on being heard about OMT beyond this context:

> A participatory observer [PC] said it was important to stick to the realities, namely that addicts are prone to giving in to temptation. A patient urged following up this feedback, because change takes time. He also confirmed that this is a national drug and alcohol policy issue. He was supported on this point by the participatory observer [PC] and staff when he said that it is important that their experiences be listened to. (leader, PC, patient and staff, stage 3)

Some staff, patients and leaders seemed to agree that patient involvement was up to staff and leaders, but milieu staff explained that because treatment decisions were made on a higher hierarchical level, they were not allowed to make decisions in collaboration with the patients. Also, there were several distinct limitations to patient involvement.

4 | DISCUSSION

Staff and leaders pointed to a need for empowerment among patients *and* staff, resonating with Freire's descriptions of dialogue between the oppressed and the oppressors to create change.[27] However, in this context, balancing staff-patient relations seemed challenging. Leaders and staff warned that it might be tempting to "stigmatize unwanted behaviour as pathological"[32] (p. 281)—what Brinkman terms "stigmatizing pathologization".[32] Furthermore, predicting and preventing a scenario where pathology-based suggestions influence decision making may be understood as risk pathologization.[32] Patient empowerment seemed perceived as something that should be contextually controlled—a logic echoing the diagnostic culture where patients' codetermination is controlled to prevent harm[30]: Thus, pathological assumptions on the individual level may have hindered patients' ability to impact decision making on the systemic level.

Though patient involvement appeared to be a valued goal, by limiting patients' impact on decision making the power-advantaged may have ensured an imbalanced relation (following Emerson[33]). SMHS codes of conduct for staff and leaders stipulate that care of patients is their first concern, in the form of "satisfactory treatment"—a norm rooted in legal requirements, guidelines, organizational policy and patient expectations. Against this backdrop, perhaps staff and leaders believed that sometimes their own voice should carry more weight, and only so much empowerment was possible.

Many patients reported fear of becoming misunderstood and diagnosed incorrectly. One patient described confronting staff about certain characteristics in his chart that he felt were misattributed. His self-justification may thus be understood as an attempt to depathologize himself. His reaction may also be interpreted as an act of self-empowerment, as he freed himself from incorrect characteristics. This patient actively challenged "the dominant structure"[27] and was arguably self-empowered. One may also interpret this as an example of staff and leaders allowing empowerment; however, as Freire argues, empowerment is not a gift.[27] Perhaps, a balancing operation enabled this power process, whereby the patient cultivated social relations with staff and leaders, thus acquiring the power advantage to influence their behaviour.[33]

Patients were increasingly invited to be involved, and status recognition may have influenced their involvement during the inquiry. Staff and leaders began facilitating patient involvement more often, which—together with patients' experience of gratifications (via ego rewards and gift-card compensation)—may have increased relational balance and encouraged patients' involvement.[33] However, both staff and patients also referred to patient decision making and involvement as something that the staff decided to allow. Thus, in this context, empowerment appears to have been perceived as something granted by the staff and leaders, rather than an opportunity seized by the patients.[27] Furthermore, a staff-patient relational imbalance also seemed apparent, due to a linear power network where staff intermediation between patients and decision makers was central.[33] There also appeared to be a power imbalance between milieu staff, treatment staff and leaders. Interestingly, empowerment theory suggests that a disempowered staff may find it difficult to facilitate self-empowerment among patients, potentially resulting in the replication and multiplication of oppressive practices.[35] If the staff lacked experience with acting as responsible subjects participating in changing their own disempowered situation, how could they empower patients to take action against oppressive practices?

Other obstacles to patients' voices being heard were apparent, including the leaders' fear of manipulation and belief that patients should not be involved with fellow patients' individual treatment. Additionally, several patients appeared committed to contributing their perspectives on OMT, but their arguments seemed obstructed by the leaders' conviction that OMT deterrence was a positive. Freire's notion of praxis is useful in conceptualizing how these patients committed to unveiling, naming and transforming this situation.[27] As such, the patients may have begun to peel back the veil on some deeply rooted dilemmas in mental health and substance abuse treatment.

Concurrent Norwegian studies suggest that these patients were not alone—findings demonstrate strong opinions about OMT among drug users, centred around the growing illegal spread of these drugs and OMT localization.[62,63] However, in our inquiry, certain OMT issues regulated by legislation, guidelines and the Health Trust seemed impervious to patients' concerns: Although "high" patients were regarded as triggering to other patients, the SMHS was required to provide OMT; further, staff and leaders' efforts to explore downscaling treatment may have been complicated by current guidelines stating that terminating OMT was not recommended; finally, managing OMT patient confidentiality in this (new) inquiry setting may have been challenging for staff and leaders. Consequently, these contextual barriers may have hindered staff and leaders from sharing reflections on OMT with patients. Emerson describes how balancing operations can unite a group in challenging surroundings,[33] but it seems that although leaders, staff and patients agreed that patient involvement was valuable, acting as a united group—with one voice—around OMT was difficult.

5 | CONCLUDING REMARKS

Results from our study of a Norwegian SMHS treatment unit target several barriers that may have hindered patients' ability to be heard by staff and leaders: (a) feedback deemed by staff/leaders to be pathology-based would not necessarily influence decision making; (b) patients were not permitted to impact fellow patients' individual treatment; (c) empowerment seemed to be perceived as something to be controlled and granted by leaders and staff; and (d) due to contextual influences such as legislation, guidelines, organizational policy and codes of conduct, it may have been difficult for staff and leaders to listen to and explore patients advice.

We show how these barriers may limit the beneficial contribution of patients' knowledge about more responsive services. Further, we sought to explore empowerment as something that can be genuinely reciprocal, irrespective of hierarchical positions or biology. A Freirean approach to empowerment among both staff *and* patients lies in contrast to controlling patients' self-empowerment. We suggest that reciprocal empowerment can potentially be enabled by facilitating self-empowerment among service users and providers through training, supervision and explorative dialogue, centred on service user/provider awareness of (a) power dependence relations, and (b) barriers to and potential for service user/provider self- and reciprocal empowerment. This awareness might contribute to service users' voices being heard, enabling a united voice from service users and providers around developing and transforming services.

One arena for further research is how reciprocal empowerment between service users and providers can be optimized when developing services. Potentially beneficial avenues for further inquiry include: (a) exploring how to optimize communication and the quality of individual and collective contributions in service development and (b) investigating which collaborative efforts either ensure or hinder sustained service quality improvement.

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CONFLICTS OF INTEREST

Division of Psychiatry, District General Hospital of Førde has been the lead author's employer. The author's interest has been in loyalty with the action research orientation.

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Article II

Check for updates

Article

Keys to unlocking service provider engagement in constrained co-production partnerships

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Abstract

The article reports on research conducted in a public, specialised mental health and substance abuse service unit in Norway. The inquiry followed an action research framework, with patients, leaders and staff as co-researchers. Power sharing within such constrained institutions suggests that service providers risk engaging in paternalistic or avoidance approaches. Despite the inherent challenges of attempting a participative approach on an equal footing, facilitating service co-production may be served by mediation and support. Here, developing meeting spaces for dialogue between patients, staff and leaders appears vital. We argue that focussing on service providers' own professional development may be benefiting to co-production. We propose steps to unlock the potential of genuine co-production partnerships in constrained organisational settings when staff and leaders have no prior experience involving patients systematically in service development.

Keywords

Co-operative inquiry, co-production, dialogic leadership, power relationships, empathy, genuineness

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Introduction

Service providers appreciate user involvement, but can find it challenging and engage in paternalistic approaches. Professionals arguably need more competence regarding involving service users, 'particularly in relation to user centred communication and relational skills' (Bee et al., 2015, p. 1835). Researchers have focused on the needs of service users when involved in designing treatment (Stringer et al., 2008). Modest attention has been given to professionals' role in co-production (Osborne, Radnor, et al., 2016), and more research around optimising the co-production of public services is needed (Brandsen et al., 2012; Osborne & Strokosch, 2013). Here, the identification of crucial skills to optimise the potential for co-production is important, 'as well as mechanisms for enabling the development of these skills' (Osborne & Strokosch, 2013, p. 44).

Co-production partnerships

Co-production is defined as a process where service users and providers collaborate to improve, challenge, transform and innovate public service delivery (Osborne & Strokosch, 2013). It entails a different kind of relationship between service users and providers (Bovaird, 2007; Pestoff, 2012). A key challenge is to unlock the potential of *genuine co-production partnerships* (Osborne & Strokosch, 2013). In this article, we[1] explore what may strengthen service providers' engagement in co-production. We define the co-production partnership as a reciprocal 'working alliance' (Bodorkós & Pataki, 2009; Trevithick, 2003). This can be a dynamic partnership between service users and providers, where role migration (between 'teachers' and 'learners') and reciprocal empowerment are core qualities (Larsen & Sagvaag, 2018; Yorks et al., 2008).

Our study contributes to existing literature by presenting empirical records of how *participative co-production* (Osborne & Strokosch, 2013) was facilitated within a public *specialised mental health and substance abuse service* (SMHS). Participative co-production is the democratic involvement of service users and providers in service development on a strategic planning level. This article contributes to existing action research literature with a co-operative inquiry inspired approach that facilitated the participative co-production of a public SMHS. This framework (see Figure 1) may be regarded as a co-creative contribution to action research inquiry (Friedman et al., 2018).

Structural power imbalance

In health institutions (Smith et al., 2017) and total institutions (e.g. prisons) (Drake, 2014), an inherent structural power imbalance challenges the ideal of parity in action research. Neither staff nor their organisation operate in a vacuum, free to reframe all operating rules and principles: Elements like organisational policy and professional codes of conduct may constrain the relationship between service users and providers (Larsen & Sagvaag, 2018).

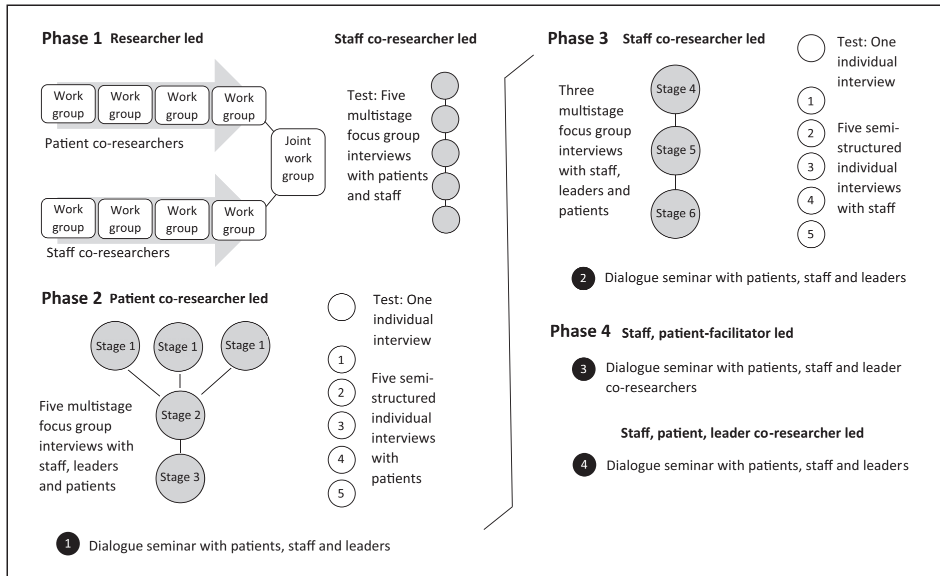

Figure 1. The four phases of inquiry.

Although admission to treatment and participation in the inquiry was voluntary for patients, staff job descriptions support power imbalance: Patients cannot take possession of their own treatment completely, but they can participate in improving selected services. However, through reports and patient records, staff may contribute to the involuntary discharge of patients who do not accept or follow the rules of treatment. For staff, this would be equivalent to 'being sacked on the spot' – an exit that, for most, would be experienced as a degrading, unexpected shock. This dilemma arose in the inquiry, where the idea was for existing services – such as consultations with specialised professionals and certain therapeutic activities (occupational and milieu therapy, sports and more) – to be co-produced on an equal footing.

Professional learning, empathy and dialogue

Communicative space in action research 'refers to the social arenas for constructive dialogue and creative problem-solving among stakeholders on issues of common concern' (Bodorkós & Pataki, 2009, p. 314). Developing uncoercive spaces for communication may result in common ground for action, transformed power relationships, more equal participation and greater democracy (Bodorkós & Pataki, 2009). Here, power is regarded as relational as it is rooted in ties of mutual dependence; balancing this dependence may equalise an imbalanced relationship, within which the parties can more equally influence one other

(Emerson, 1962). Awareness concerning process facilitation and power relationships is therefore important (Arieli et al., 2009; Ospina et al., 2004). Relational empowerment and dialogue has been argued as necessary in engaging with the subtle processes that exclude patients' voices in co-production research (Abma, 2019).

Opening communicative spaces in organisations can lead to professional learning (Eady et al., 2015). In this tradition, 'learning-in-experience' is a 'coming to know' journey where emotional labour within and about communication is essential (Newton & Goodman, 2009, p. 292). However, suppression of affect hinders processes of emotional and cognitive transition and learning. Thus, in organisations where defensive routines prevent professionals from experiencing threat or embarrassment, they may be over-protected against self-inquiry about what caused specific emotions (Argyris, 1995). *Double-loop learning* entails the modification of goals or decision-making principles in light of experience. When professionals can openly inquire into negative emotions without being interrupted by defensive routines, double-loop learning processes enable staff to redesign their actions and make persistent changes in accordance with their values (Argyris, 1995).

Emotional receptiveness between parties can evoke understanding, as the feelings of the other resonate within oneself. '"In the presence of the other" refers to a willingness to take the other inside oneself, to be affected by what they represent, to acknowledge both the validity of that experience and one's own emotional response to it' (Newton & Goodman, 2009, p. 296). This can be difficult, but facilitators can promote this capacity among participants in dialogue. Through acceptance, understanding and acting in accordance with one another's emotional responses, new and deeper knowledge may emerge and enable participants to 'engage in authentic relationships with others for mutual growth' (Newton & Goodman, 2009, p. 300).

Dialogue refocuses a group's shared attention and is regarded as important for organisational learning (Isaacs, 1999). However, personal fears and defences in combination with organisational defence routines block professional development and learning (Palus & McGuire, 2015). As such, creating a stable field of inquiry is important. Dialogue is regarded as vital to human inquiry because it can be a bounded space for 'cool inquiry' – a 'container' for the instability and intensity of human exchange (Isaacs, 1993, p. 2; Palus & McGuire, 2015). Critical, reflective dialogue may aid professional development from 'novices to experts and virtuous performers', as it supports articulating, developing, refining and changing our habitus (Eikeland, 2015, p. 387).

Dialogic leadership is described as 'a way of leading that consistently uncovers, through conversation, the hidden creative potential in any situation' (Isaacs, 1999, p. 2). It focuses on both the nature and the quality of the interaction, and this awareness can help identify imbalance in communication and reveal missing perspectives and roles. While profound directness and revealing one's subjective truth in dialogue requires courage, in such moments one's genuine voice may be truly heard. Dialogic leaders can, through self-reflection and facilitation, cultivate

practices that enhance the quality of conversation, such as (a) cultivating the capacity to listen, (b) suspending certainties, (c) respecting others and (d) 'speaking in an authentic voice and encouraging others to do the same' (Isaacs, 1999, p. 4). Isaacs is supplemented in more recent accounts concerning *mediated dialogue* – an approach in which artefacts such as images and texts enhance dialogic exploration (Palus & McGuire, 2015).

Isaacs (1999) describes dialogue action capabilities across four complementary roles: *Movers* initiate ideas, offer direction and voice their advocacy; *followers* complete the movers' initiatives by supporting them, inquiring into issues and helping others clarify; *opposers* can correct the direction by challenging and questioning the validity of the claims – they may also advocate a different path; and *bystanders* provide perspective, as they observe the process and can inquire into it. A dialogic leader must be able to take on each of these roles and facilitate their continuous interplay among the members of a group. Although dialogic leadership has been defined in relation to heads of organisations (Isaacs, 1999), in this article we interpret leadership in relation to the co-production partnership. Few studies focus on how service providers' engagement in genuine co-production partnerships can be facilitated through dialogue.

Aim

The aim of this article is to explore critical conditions for co-production interaction in a public SMHS. Genuine partnerships are the foundation for utilising knowledge that may challenge existing paradigms, and transform and co-design new services. However, it is not enough to facilitate self-empowerment among service users and expect them to begin total innovation. We suggest that, to explore the potential for optimising co-production, a crucial first step is to consider service providers' needs when collaborating with service users. This article thus addresses the following question: *In constrained organisational settings, what may facilitate service providers' engagement in genuine co-production partnerships with service users?*

Orientation

Context

A basic premise for the study was a consensus-based agreement to initiate an in-house project about increased patient involvement in an SMHS in Norway. A key objective was to improve treatment services through dialogue between stakeholders. The inquiry took place from 2010 to 2013, in a voluntary inpatient treatment unit.

At the outset of the study, the morning meeting was the only fixed shared meeting for patients, staff and leaders. Meetings were led by staff and were obligatory for patients; leaders were occasionally present. The most powerful

professional decision-making body in this unit was the multidisciplinary treatment meeting. In these weekly meetings, final decisions about therapeutic approaches and patient discharge were made by leaders, based on dialogue with staff. Staff, leaders and patients participating in the inquiry appeared to have no prior knowledge of co-production conceptualisation or experience with involving patients systematically in service development.

Design

The cyclical principles of action research (Brydon-Miller et al., 2003; Reason & Bradbury, 2008) were applied as a single case study (Flyvbjerg, 2006; Mabry, 2008; Yin, 2009), starting with conceptualising and particularising the problem in collaboration with stakeholders, and moving through several interventions and evaluations (Heron, 1996; Heron & Reason, 2008). The inquiry was designed in line with co-operative inquiry principles – researching *with* rather than *on* people seemed an appropriate way to facilitate participative co-production (Heron & Reason, 2001; Osborne & Strokosch, 2013).

This design called for particular roles, i.e. patient co-researchers (PCs), staff co-researchers (SCs), leader co-researchers and the action researcher (i.e. first author). During the action research process, these individuals collaborated on interview guides, data collection, interpreting and disseminating findings, and proposing service changes. The researcher facilitated the full inquiry while conducting participatory observation (May, 2001; Savage, 2000); documented via minutes and reports (made accessible to contributors); attended all formal and most informal *service*-related meetings relevant to the study's objectives; and provided training and supervision to qualify co-researchers to lead test interviews, 6 stages of multistage focus group interviews (Hummelvoll, 2008), 10 individual interviews (Silverman, 2006) and 4 dialogue seminars. Following the action research process, the action researcher withdrew from the action context to explore the data.

In addition to service meetings and the *scheduled inquiry* (Figure 1), there were *ad hoc inquiry* meetings with leaders, staff and/or patients to address issues raised in the inquiry: The *dialogue meeting* was facilitated when staff and PCs encountered communication difficulties, to resolve conflict between leaders, staff and PCs. In this meeting, a new fixed meeting[2] was established for patients, staff and leaders to discuss treatment quality and co-design services.

Inquiry phases

The project used the four phases of knowledge development in co-operative inquiry as a framework[3] (Heron, 1996; Reason, 1994). In phase 1, there were two co-research workgroups (one with staff, the other with patients), which then merged into one joint work group. In phase 2, one patient co-research team led multistage focus group interviews (with staff, leaders and patients), semi-structured individual interviews (with patients) and a dialogue seminar (with staff, leaders and patients).

In phase 3, one staff co-research team led multistage focus group interviews (with staff, leaders and patients), semi-structured individual interviews (with staff) and a dialogue seminar (with staff, leaders and patients). In phase 4, a co-research group of leaders, staff and patients were supported by facilitators (a staff member and a former patient) in one dialogue seminar, and then led the final dialogue seminar (with staff, leaders and patients) themselves[4] (see Figure 1).

Documentation and analysis process

Over the three years of inquiry, 109 persons (66 m, 43 f) participated. Data for this article were chosen to illustrate specific circumstances regarding communication. These data consist of preliminary[5] and cited documentation, including reports, minutes, field minutes and journal notes from phases 1 and 2. In addition, some descriptions in the 'Results' section are condensed interpretations from field notes and other data.

The cited documentation in the 'Results' section was member-checked by the respective participants (with the exception of the journal notes) (Lincoln & Guba, 2007). Member-checked field notes are regarded as 'field minutes'. Participants were urged to look for missing elements or misinterpretations; the texts were amended according to their recommendations, then accepted by the respective participants for external dissemination. The reports, minutes and journal notes were written in Norwegian and the selected findings were professionally translated. To ensure consistency, familiarity and readability, all documentation was written in accordance with the SMHS's documentation tradition. Minutes were thus predominantly condensed descriptions of conversations, not verbatim transcriptions (Hammersley, 2010; Poland, 1995). Some participants were quoted verbatim – these instances are underlined.

All data were subjected to qualitative conventional and directed content analysis using NVivo 9 (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005). The investigation was abductive (Timmermans & Tavory, 2012). Abduction jump-starts inductive and deductive reasoning, without engaging in purist dichotomies: The researcher's theoretical position is acknowledged and there is no intention to prove or falsify a theory. Rather, in abduction, induction and deduction may be repeated in an inferential creative process: as new anomalous and surprising findings emerge, new hypotheses and theories are produced (Timmermans & Tavory, 2012).

The data were *revisited* repeatedly through a process of *de-familiarisation* (theoretical cultivation and sharing ideas among communities), and *alternative casing* (creating new cases with the help of theory) (Timmermans & Tavory, 2012). Three themes[6] concerning patient–staff communication emerged from the data once the theoretical lens was applied. These themes were reconstructed into three categories[7] that were condensed, decontextualised and compared in a table. The final analysis involved marking each condensed category in the table with the following theoretical concepts: 'move', 'follow', 'oppose' and 'bystand' (Isaacs, 1999);

'genuineness'/'authenticity' (Isaacs, 1999; Newton & Goodman, 2009); 'empathy' (Newton & Goodman, 2009); and 'power' (Emerson, 1962). This produced the three themes described in the discussion.

The inquiry was approved by the Norwegian Centre for Research Data.

Results

Through our investigation of the critical conditions for co-production in mental health and substance abuse services, three themes connected to communication emerged: (1) encounters preceding the meeting, (2) communication ambience and power imbalance and (3) constraints and dialogue.

Encounters preceding the meeting

Direct communication between patients and staff seemed challenging to both parties. Several encounters preceding direct communication were common. One illustrative example occurred when a PC suggested changing the protocol for routine drug and alcohol searches. A staff member 'adopted a very humble attitude' (Journal) and 'wanted to invite the unit leader to the next morning meeting' to discuss the matter in more depth (Field minutes). However, the staff member then told the researcher that she 'thought such matters might be uncomfortable if there was insufficient time to prepare' (Field minutes). The researcher informed the PC about this concern, and he 'concluded that the morning meeting was not the appropriate arena to address such a substantial matter; he would prefer to address it in the new forum' (Journal). The PC, however, did not propose this to the staff member directly.

> I met the PC in the corridor and he seemed rather upset (his hands were shaking). He said that the staff member had informed him that the unit leader was coming to the morning meeting tomorrow and that it was wrong now. (Journal)

With support from the researcher, the PC met with the staff member and informed her about his decision. Several encounters were thus necessary to establish a suitable meeting space in which a specific topic could be discussed with relevant parties – one of many examples of the challenges around facilitating direct communication between stakeholders.

Communication ambience and power imbalance

Issues around communication and power were ongoing. Some patients explained how staff could make them feel subordinate:

> The co-researchers from the patients report that the staff can overrule them and talk to them and set limits on them as if they were children. It is clear that the staff are above the patients and that they have the power. (Patients, joint report)

Although staff and patients were cautious about speaking openly in front of one another, patients could be explicit.

> A co-researcher has observed that patients who have previously been critical in the unit have been discharged, saying that it is not necessarily advisable to shout too loud while on the ward. As a result, co-researchers also feel uncomfortable about participating in the research project, as there may be a threat that people who create conflict or 'the one who shouts loudest' may be discharged. (Patients, joint report)

This was arguably an invitation to explore power differences, trust and empathy between the stakeholders. The patients also urged staff not to take their feedback personally. However, in their response, the staff changed the topic, thus avoiding patients' concerns about involuntary discharge:

> SCs agree that the response should be perceived as constructive feedback and that focus should be placed on the services... Patient feedback is a good way for the staff to learn and improve. At the same time, constructive criticism from patients is a great way to ensure that we do not stagnate, but move on. (Staff, joint report)

As demonstrated above, challenges arose from the ambience surrounding communication between stakeholders. Staff were perceived as paternalistic, and it appeared that some issues risked being bypassed – however important they may have seemed.

Constraints and dialogue

Involuntarily discharge became a concrete risk in the subsequent phase. One day, the researcher was urged by staff to come to multidisciplinary treatment meetings, as they were concerned that PCs might be discharged due to their co-research activities. Staff and leaders both reported that it was difficult for them to reassure decision-makers who were not participating in the inquiry. A leader reasoned, 'They don't have same *cool* as we who know the project do' (Leader, field minutes). He also confirmed that PCs could indeed be involuntary discharged. The researcher attended several meetings to observe developments and clear up misunderstandings about the nature of the co-research. A staff member also urged the researcher to intervene:

> When [the PCs] ask questions about everything and demand change, the staff feels negatively towards them. She encouraged [the researcher] to guide the co-researchers regarding their role in the environment, given that they are often 'going after' the staff. ... We agreed that I should talk with staff and leaders to facilitate a meeting where patients, staff and leaders can enter into dialogue about this challenge. (Staff and researcher, field minutes)

Staff and leaders were concerned with the communication ambience and staffs' working environment, as PCs' way of questioning existing practice was perceived as querulous and pushy. Though the PCs' involvement was essential to resolving this conflict, the urgency of their situation was kept a secret – they were led to believe that communication difficulties were the main issue.

After several mediation meetings with the researcher, staff, PCs and leaders agreed to meet to resolve the conflict and engage in dialogue. Here, a staff member appealed to the PCs' empathy:

> It makes one feel inadequate as a staff member, and perhaps the patients get the feeling that they are not respected when the staff member cannot answer all their questions. He says that when the pressure becomes too much, patients might feel as though the staff is useless when unable to provide a proper response. (Staff, dialogue meeting)

In the meeting, a leader advised the PCs to handle their new role wisely:

> The co-research also involves some trust on the part of the staff towards the patients; it would be uncomfortable if the research were used as a trump card to push things through. For example, patients threaten to use the research to get the final word in a discussion. ... The staff must be included in the dialogue... Discussing changes is good milieu therapy, but you need to have good communication and not hide in the trenches. (Leader, dialogue meeting)

The PCs understood that their communication 'can be perceived as querulous and that it may be excessive', and expressed empathy for the staff by saying 'that they will calm down a little' (Patients, dialogue meeting). They suggested establishing a fixed meeting between patients, staff and leaders. The stakeholders agreed that this would be a meeting where they could resolve conflict, practise dialogue and develop the services.

After facilitating this dialogue and attending three multidisciplinary treatment meetings, the researcher was confident that the discharge risk had been mitigated. As the above shows, the 'backstage' activity preceding direct communication was evident. It is unclear whether the researcher's guidance and several encounters preceding meetings mitigated the discharge risk; however, in such an imbalanced power hierarchy, mediation and facilitation of dialogue seemed imperative.

Discussion

The results highlight key requirements for establishing genuine and balanced co-production partnerships between service providers and users: First, the power imbalance embedded in the institutional structure must be equalised; second, a dedicated communication platform conducive to open dialogue for genuine

inquiry and mutual learning must be developed; and third, effective learning processes must be ensured.

Dialogic leadership and power

Although we identified difficulties with direct communication, complementary roles in dialogic leadership also emerged. As co-researchers, patients often proposed inquiry pathways in a 'mover' role (addressing the staff's paternalism, requiring change of search procedures, questioning existing practice, demanding change). However, the staff, when in the presence of patients, appeared hesitant to provide perspective (bystander), challenge validity (opposer) or offer new directions (mover) (Isaacs, 1999). Some staff instead took on a 'follower' role: For example, when PCs feared involuntary discharge, staff supported their initiative, taking patients' contributions as constructive feedback but avoiding addressing the patients' fears. Staff also avoided engaging in dialogue about search procedures without leaders present.

Another avoidance strategy for staff involved taking on an opposing role in 'backstage' discussions without patients present. Here, the co-researcher approach was questioned, and staff and leaders advocated a different path for patients' behaviour. This backstage opposition was one reason the dialogue meeting was facilitated, so stakeholders could cultivate a practice of direct communication. Even so, serious issues still remained hidden from the patients.

The power relationships in this setting benefit from a simplified analytical dichotomy regarding movers and followers or opposers. On the one hand, staff and leaders may have struggled with their power disadvantage. As the staff felt unable to respond constructively to patient initiatives, PCs seemed to have a power advantage. Further, co-research activity was considered a 'trump card' that forced compliance with patients' demands for change. With no previous experience with participative co-production, engaging in co-production on an equal footing with patients was a new experience for staff and leaders. On the other hand, also patients were dependent on the staff's ability to respond sufficiently. After all, in this relationship, staff and leaders held the power to 'grant or deny, facilitate or hinder' fulfilment of the inquiry's aim (Emerson, 1962, p. 32). For one, the PCs' fear of involuntary discharge may have been mitigated at such an early stage because it was a difficult topic for staff to explore with patients. Confidentiality requirements may have made dialogue challenging, as staff could not discuss the involuntary discharge of former patients.

However, staff avoided exploring the issue even on a more general level (as bystanders). Here, exclusion was at the core of this power relationship, making the stakes in this collaboration uneven: The staff's professional status protected them against exclusion, while patients were obliged to follow established rules to remain in treatment. Such a power-laden topic may have been difficult for staff to address in the presence of patients without preparation and support from leaders and colleagues. Moreover, later in the inquiry it seemed that avoiding

confrontation by excluding PCs from the conversation/information loop was crucial to balancing their power advantage. Under these constraining circumstances, patients were dependent on staff, leaders and the researcher to direct patients' behaviour (and thus have the power advantage), without revealing to them what was at stake.

Dialogue facilitation and co-production

Constructive dialogical roles seemed to be difficult for staff to enact, even if they complemented the patients' role in the co-research process. Even so, one leader demonstrated several roles in the dialogue meeting. Having observed the process, he inquired into the co-researcher role and provided perspective (bystander) when confronting the PCs about how they managed their power (opposer). Also, while completing the initiated topic of 'communication difficulty' by supporting it (follower), he advocated a different path out from the trenches (opposer) and urged patients to include staff in dialogue. This suggests that, although he did not disclose the discharge risk, the leader role modelled authentic communication.

It is possible to balance and enhance the quality of dialogue with awareness, reflection and cultivation of communicative practices and, as the power balance tilts in favour of professionals who are more securely positioned than service users, they have greater responsibility to promote inclusion through equal and authentic communication. However, the staff's avoidance and backstage opposition suggests that they were in need of training and guidance concerning inclusion and balancing dialogue and power in patients' presence. We now turn to some related opportunities for future learning-in-experience among staff.

Learning in the presence of each other

Patients appeared fairly direct about topics that seemed uncomfortable for staff; they also appeared courageous and genuine when revealing their fear of discharge. However, it seemed that patients' voices were not truly heard, as the staff appeared to engage in defensive organisational routines to avoid empathetic inquiry: They changed the topic, and, together with the leaders and researcher, pretended that communication difficulties were the reason for the dialogue meeting. The staff's unwillingness to discuss certain topics with patients without a leader present may represent another defensive routine.

Staff members may thus have protected themselves against self-inquiry about emotions triggered in meetings with patients. For instance, staff members were concerned about patients' reactions when they were unable to respond adequately to patient questions or demands. Because of this, staff may have felt the need to shield themselves, through avoidance tactics and only discussing issues in patients' absence. Staff may also have empathised with the patients' expressed needs but were unable to accept the affectivity that resonated within themselves. Either way, genuine listening would have been difficult in this context.

It may also have been challenging for staff to practise authentic communication in patients' presence, without engaging in the emotional labour necessary to understand their own feelings and needs. If so, meeting *without* patients could have been a 'cooler' path that enabled staff to meet *with* patients in the dialogue meeting. When this meeting finally occurred, it appeared to be a space where stakeholders could think, feel and develop a joint understanding. Here, staff and leaders could air their fears and PCs could empathise and agree to adjust their communication. However, this communicative space was not equal for all stakeholders. By avoiding certain issues, staff may have indirectly limited patients' contributions in the dialogue, as they lacked knowledge about the whole situation.

Secrecy may thus have prevented the direct affective exchanges that can enable deeper interpersonal relationships, communication and learning, and genuine meeting and learning on an equal footing. Further, co-production may have been delayed by organisational defence routines that allowed 'beating around the bush'. Profound directness is often listened to, as it encourages honesty and helps put things in perspective, which motivates participants to search for a solution (Isaacs, 1999). However, speaking with a genuine voice is a main challenge of dialogic leadership, and it did seem that staff needed some time before they could reveal their subjective truth in front of patients.

Further, though discussions occurring in patients' absence may have reduced conflict, they may also have postponed staffs' professional development. The patients appeared to pressure staff to inquire into their own ability to respond and change, but staff seemed to focus on efforts to change patient behaviour when experiencing uncomfortable emotions. Little was therefore revealed about staff engagement in their own 'coming to know' journey. Bypassing learning-in-experience opportunities may have hindered or postponed their emotional and cognitive transition and learning. This may in turn have kept them in a single-loop learning process, i.e. repeating attempts to solve the same problem (uncomfortable confrontations with patients), with no variation of method (avoidance) and without questioning the end goal (service quality) (Argyris, 1995).

With sufficient skills, however, the parties may have been able to support each other's double-loop learning processes and mutual growth. Informed by learning from being emotionally present in dialogue, the parties could have redesigned their actions and made more persistent changes within themselves and the services.

Methodological considerations and limitations

A participative perspective (Gayá Wicks & Reason, 2009) guided the relationship between the researcher and co-researchers. Although PCs were vulnerable due to the structural imbalance and delicacy of the themes raised in the inquiry, the project's resilience was rooted in reciprocal trust and voluntary equal participation. The project respected ethical principles of participatory action research (Winter, 1996) with the SMHS granting authorisation for its participation.

These principles required extensive consultations between participants, including transparency and access. In addition to full confidentiality, anonymity and access in the information exchange were guaranteed. Also, decisions regarding the direction and expected outcomes of the research were collective.

An action researcher is in effect a practitioner – an interventionist seeking to help client systems by making theory relevant to action (Argyris, Putnam, et al., 1985). The value of applying this perspective in co-production studies lies in the idea that knowledge should not be limited to its theoretical implications but to the practical value of the theory in use (Argyris & Schön, 1974). As an action research project, our study inherits the strengths of this kind of approach: it addressed a practical challenge (to increase patient involvement), generates new knowledge (co-production), enacted change (a fixed co-production meeting), was participatory (power sharing) and relied on a cyclical process (four phases of inquiry).

However, some have argued that a single case research design can contain pitfalls concerning methodological rigour, researcher subjectivity and external validity (Yin, 2009). Others have argued that by clarifying and developing the methodological techniques and epistemological grounding of single case studies, these issues are of little concern (Bennett & Elman, 2010; Flyvbjerg, 2006). Regarding the issue of generalisability, this is of limited relevance when the aim is one of particularisation, as in our action research project. As such, the trustworthiness of the study is not compromised by combining action research with a single case design (Lincoln & Guba, 2007). The use of an action research framework further ensured the rigour of our study. Attention to researcher subjectivity was also part of this framework and was promoted through continuous self-reflection around the ways in which emotions, reactions and preconceived notions may influence how participants and situations are perceived and recorded. Here, the steps in the abductive research cycle proved imperative across the action research process (Timmermans & Tavory, 2012).

Conclusion

In summary, findings illustrate (a) imbalanced dialogue and power, and (b) defensive organisational routines that may have slowed inquiry and double-loop learning. We conclude by proposing steps to help service providers engage in genuine co-production partnerships.

Possible keys to unlocking balanced co-production

Co-production entails a relational shift between the traditionally power advantaged and power disadvantaged. To establish genuine co-production partnerships and facilitate organisational learning, service providers need tools to unseat unproductive defensive patterns. To ensure reciprocal working alliances between the

parties, the norm must be that mutual learning happens in the presence of the other.

- We urge the development of a *mutual agreement*. This should be co-developed and signed by service users and providers (including decision-makers), and should reveal agreed-upon principles for how to approach issues of power, exclusion/inclusion, confidentiality/transparency; and expectations around trust/openness, communication, collaboration, decision-making and the scope of co-production. Such formalisation may build trust and equalise the power between the participants.
- *A fixed co-production meeting*, with a trained dialogic leader (this role may also be shared between the parties) can ensure multi-stakeholder engagement. This should be a safe, contained space for feeling, thinking, monitoring developments, building sustaining relationships and participative co-production. Here, empathy can be cultivated, threatening issues discussed, and deep-seated fears and dilemmas clarified.
- *Joint dialogue training* may encourage affective reflexivity and learning/growing together. As the stakeholders get to know each other in equal roles as learners, the co-production relationship can be strengthened. Awareness of the action capabilities in dialogic leadership may also enable service providers who are new to balancing power and dialogue. With training, supervision and cultivating constructive dialogue, staff could consciously take on complementary dialogue roles and facilitate role interplay among stakeholders. Including service users in dialogue training may ensure mutual awareness about balancing dialogue and power.
- It may also encourage service providers' truthfulness within confidentiality constraints to *encounter service users through role play/simulation*. With supervision, this might enable the participants to tactfully support the other party's genuineness and integrity in communication.
- Creating *spaces for self-reflexivity* also appears necessary. Service providers should be urged to engage in self-development, individually and in supervision groups, to learn from their emotional responses. This may increase self-honesty and the capacity to reflect while dialoguing, enhancing their capacity to genuinely listen and engage as empathic individuals.

One avenue for further research is to explore what service users and providers regard as necessary supervision, support and/or training to optimise the co-production relationship and the potential for co-innovation. Comparative cross-country action research may be needed to assess different conditions for organising co-production processes.

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Notes

1. The third person pronoun 'we', etc. refers to the first author (action researcher) and co-authors, except in the quotes in the 'Results' section. Here, 'we' can mean both participants and non-participants in the local context, depending on the surrounding descriptions.
2. The meeting, named the 'Ideasmithy', was established in 2012 and still active in 2020. It is also referred to as 'the new forum' in the 'Results'.
3. In co-operative inquiry, the same inquiry group would engage in all four phases. In our study, different stakeholders' perspectives dominated each phase; the final phase consisted of a co-research collaboration between stakeholders. Also, as presentational knowledge – e.g. knowledge expressed through story, sculpture, movement and drawing – was not explored, the co-operative inquiry method was not strictly followed (Heron, 1996): Rather, the knowledge development phases were used as a framework for facilitating co-production-focused action research using qualitative data collection methods.
4. The inquiry design is described in more detail in Larsen and Sagvaag (2018).
5. Some preliminary documentation influenced the cited documentation. In phase 1, staff and PCs member-checked each meeting's minutes; these provided the foundation for the patient work group report (four planned inquiry work groups, with three PCs participating) and the staff work group report (four planned inquiry work groups, with 10 SCs participating). Also, patient and SCs read the other group's report in preparation for the joint work group meeting. Finally, the joint work group report – based on the previous work group reports and field notes from the joint work group meeting – was member-checked by both parties. The social construction complexity of such threads is not analysed here.
6. See the 'Results' section.
7. (1) Issues raised by patients 'in the presence of' (Newton & Goodman, 2009) staff and/or leaders, (2) issues raised in the absence of patients and (3) issues raised in the presence of patients.

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Article III

Co-creation leadership.
A process study of leadership for organizational adaptability

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Abstract

The study explores how—when producing novel public services—leaders may enable and/or stifle co-created organizational adaptability. Relevant leadership models were examined empirically with data from a Norwegian public mental health and substance abuse services. Our results reveal examples of leadership behaviors and styles deduced from Uhl-Bien and Arena's integrative framework of leadership for organizational adaptability, Vroom's normative decision model and Yukl's hierarchical taxonomy of leadership behaviors. The results show that the predominant leadership behavior was encouraging innovation. Amalgamating styles and decision modes, the study proposes a definition for a co-creation leadership style, significant for understanding and practicing leadership in innovative co-creation of services and value. The analysis has implications for public service leadership and management and suggests a need for further exploration and conceptualization of cocreation leadership.

Key words: *public service innovation, organizational efficacy, co-creation, coproduction, leadership styles and decision modes*

The quest for novel public-sector organizational leadership models

Leadership and service innovation are often related in public service organizations (PSO). While a great deal of research has explored the role of co-production and co-creation, little—if any—attention has been paid to the significance of leadership in innovative co-creation. Co-creation is understood as collaboration between citizens and service providers on strategic planning and/or initiation of public services (Brandsen & Honingh, 2018). Furthermore, today's leaders must master both decisiveness and participation (Aramovich & Blankenship, 2020). The scope of this study is leadership in public services that leads to organizational adaptability, primarily in terms of service innovation (De Vries et al., 2016; Osborne & Brown, 2005). A key challenge is to explore how public service leaders can enable service users' and health and social professionals' involvement in co-creation without trading off on decision quality.

In generic terms, leadership style refers to a leader's distinctive behaviors when directing, motivating, guiding, and managing groups of people. The management field embraces numerous leadership styles, ranging from the classic four theoretical ones—autocratic, paternalistic, democratic and laissez-faire (to which can be added the transactional and transformational styles [Goleman, 2000])—to the ten or more commercial and operational styles often listed on the internet (including coaching, strategic, emotional, and charismatic styles, etc.) and the not-so-popular bureaucratic style.

Contemporary public sector leadership research considers the role of leaders in the performance of a public organization (Wright, Moynihan, & Pandey, 2011). There are numerous theories and models of public sector leadership, most of which can be classified as either traditional hierarchical models or New Public Management models (Van Wart, 2011, 2017). However, a third model has emerged, focusing on collaborative processes, democratic accountability, responsiveness, and inclusiveness (Van Wart 2011, 2017). According to Crosby and Bryson (2018, p. 1269), this model is alternately called facilitative leadership, collaborative leadership, and public values leadership. Vogel and Masal (2015, p. 1179) urge scholars to "provide insight into the particularities in the public sector, as compared to leadership in the private sector."

Ospina (2016) remarks that transformational, leader-centered models—as opposed to collective, systems-centered leadership theories—have dominated research on administrative leaders' behavior. The author argues for further embedding the domain of public leadership research within leadership studies, allowing for a cross-fertilization that advances both.

Collective leadership focuses "on creating environments in which members of various communities can collaborate effectively to deal with complex challenges" (Crosby & Bryson, 2018, p. 1270). Public leadership scholars are urged to focus on the creation of public value in theorizing and research, to examine how leadership processes and outcomes co-evolve, and to pay "more attention to how leaders and leadership can help contribute to greater realization, in practice, of important public values and greater creation of public value" (Crosby and Bryson, 2018, p. 1279).

Leadership is regarded as "the process of influencing others to understand and agree about what needs to be done and how to do it" (Yukl, 2010, p. 26). Adaptive leadership can be labeled as transformational, enabling, charismatic, and so forth, implying different styles and performances. However, leadership is not the property of a formal individual leader. Rather, it relates to both formal leadership positions and a function or task (Jacobsen, 2018). Uhl-Bien and Arena (2018) call for scholars to recognize the importance of leadership in enabling organizational adaptability. For this purpose, they also propose a new typology, launching a triadic leadership style encompassing enabling, entrepreneurial, and operational categories of leadership action.

This article contributes to models of the collaborative, collective, inclusive category, presenting a framework of co-creation leadership for public services. We draw on taxonomies of leadership styles and decision models, ideas of adaptability, innovation, collaboration and power balance, and co-creation and co-production of public services.

Theoretical Framework

Co-creation, co-production, and leadership

Co-creation and co-production have been used interchangeably to describe public involvement in value creation and innovation (Etgar, 2008; Osborne, Radnor, & Strokosch, 2016; Voorberg et al., 2015). Co-production involves public service users and providers "in any of the design, management, delivery and/or evaluation of public services" (Osborne, et al., 2016, p. 640). As multidisciplinary and contextual understandings emerge (Pestoff, 2018), it becomes increasingly challenging to distinguish between co-creation, co-production, and value co-creation. One difference is that co-creation comprises a collaboration between citizens and service providers in the strategic planning, shaping and/or initiation of public services (Brandsen & Honingh, 2018). In co-production, meanwhile, citizens and service providers co-design the service during later phases of the production cycle, while the service is being implemented. For instance, when "tenants initiate the construction of their housing, or

deliberate in a representative council discussion issues of maintenance and design," it is considered co-creation, whereas when "tenants actively collaborate in the maintenance or design of the housing," it is considered co-production (Brandsen & Honingh, 2018, p. 13).

In the private sector, co-creation has been called a transformational innovation that goes beyond improving existing services (Osborne & Strokosch, 2013). On the one hand, Osborne et al. (2016) regard service users as the driving force of innovation, speaking of "co-innovation" when describing "new forms of public service delivery within service systems" (Osborne et al., 2016, p. 648). On the other, they refer to co-production as "co-design" (Osborne et al., 2016, p. 647). Co-design means improving the performance of existing public services through active individual or collective involvement in design, evaluation, and improvement, either in the design and/or delivery and management of a particular service, or involvement in the planning and incremental improvement of the service as a whole (Osborne et al., 2016).

Like co-creation, co-production has been regarded as a value in itself, and it can lead to value co-creation (Osborne, Strokosch, & Radnor, 2018; Voorberg et al., 2015), which is when the service user and the service provider together create the value that the service user experiences when offered a public service. This is also termed value-in-use. However, value co-creation is also necessary to satisfy collective needs. Public services have societal value in the following dimensions: the value experienced (value-in-use) by the service user and wider groups (such as carers) and social, environmental, and political value (Boviard & Löffler, 2012). Co-innovation can co-create public value, as an increased capacity to produce "a broader, viable and effective contribution to society now and in the future" may resolve current and future problems (Osborne et al., 2016, p. 645). Many authors have suggested refining the conceptual frameworks of co-production and co-creation. Self-critically, Osborne et al. (2016, 2018) point to the need for further research exploring the role of service providers as partners in value co-creation.

Although the leadership literature might support such a change of perspective, literature describing co-creation or co-production and leadership is scarce. Schlappa and Imani (2018) argue that leadership in co-production emerges in "interactions through which realities are co-constructed" (Schlappa & Imani, 2018, p. 103). A leadership approach to co-production requires acknowledging reciprocal power dynamics and actions among professionals and citizens in their respective contexts. Professionals are bound by organizational controls, while citizens' contributions may not be so easily regulated or integrated into the PSOs procedures and measures. Co-production leadership must provide tools for exploring issues such as power, structure, and motivations, nurturing opportunities for dialogue about content and purpose, and

challenging assumptions and expectations rooted in dissimilar knowledge and expertise (Schlappa & Imani, 2018).

Hierarchical Taxonomy of Leadership Behaviors

Yukl (2012) describe how team, work unit and organization performance can be influenced by leadership behaviors (Yukl, Gordon & Taber, 2002; Yukl, Mahsud, Prussia & Hassan, 2019). Four meta-categories in Yukl's taximony connect to different primary objectives that involve determinants of performance. In *task-oriented leadership*, the purpose is to ensure that resources (e.g. people and equipment) are used efficiently, so that the mission of a group or organization is accomplished. This involves planning, clarification, monitor operations and problem-solving. *Relations-oriented leadership* behaviors may enhance members' skills. Commitment to the mission, identification with the organization or work unit and the leader-member relationship may also benefit. This involves supporting, developing, recognizing, and empowering behaviors. In *change-oriented leadership*, initiation, encouragement and facilitation of change are central. Advocating change, envisioning change, encouraging innovation and facilitate collective learning are behaviours in this orientation. Finally, with *external leadership* behaviors, leaders may get necessary resources and assistance, offer information about outside events and promote the interests and reputation of the organization. Networking, external monitoring and representing are described as external leadership behaviors (Yukl, 2012).

The leadership framework for organizational adaptability

When investigating organizational adaptability in public organizations in our study, three novel leadership styles emerge: enabling leadership, entrepreneurial leadership, and operational leadership. In their theoretical synthesis and integrative framework, Uhl-Bien and Arena (2018) initially define leadership for organizational adaptability as actions and processes that enable people and organizations to cope, adjust, adapt, and respond successfully to a shifting environment. *Enabling leadership* may allow tension and conflict, as well as interaction and integration between innovation and production. Uhl-Bien and Arena (2018) promote a process-focused approach to leadership, explaining how an organization's new adaptive order emerges in a change process. Initially, external (market, regulatory change etc.) and/or internal (endogenous entrepreneurs with new ideas about products, services etc.) activation triggers organizational change. Leaders respond by supporting adaptation through fostering dynamic

(exploration and innovation) and operational (production) learning and reconfiguring this knowledge into an operational capacity. Leaders may enable organizational amendability by creating an adaptive space where ideas can be forged in conflict between exploration and operationalization. Adaptive spaces are temporary and fluid: they can be physical or virtual, meetings or head space. They open up when the adaptive pressure in a situation increases and dissolve when it is reduced.

Ambidexterity is an essential quality of leadership for organizational adaptability. In a learning organization, leaders must balance exploration (e.g., creating new knowledge, skills, and processes; experimentation; innovation for future success) and exploitation (e.g., using existing knowledge, skills, and processes to produce results for current success). This entails enabling connections between individuals, groups, and networks of entrepreneurs and operators. Ambidexterity is a knowledge-based approach to leadership that involves appropriately engaging with tension as organizational knowledge develops through communities of interaction: Leaders must act as "organizational connectors" who allow conflict between "diverse, seemingly paradoxical, ideas" and create linkages that enable innovation and the emergence of novelty (Uhl-Bien & Arena, 2018, p. 92). Conflict and tension may lead to new ideas, initial adaptation, creation of meaning, and learning. Therefore, integration is central to ideas legitimacy of production and to organizational adaptability. In this context, integration means connecting, fostering new collective patterns of communication, and advocating new organizational logic that enables transitions between exploration and exploitation. Leadership that makes it possible to connect agents (i.e., people, resources, ideas, information and technology) also enables reintegration in terms of incorporating "novelty back into the operational core" (Uhl-Bien & Arena, 2018, p. 91).

Next, *entrepreneurial leadership* works to facilitate exploration and innovation. To sustain the future viability of their organization, leaders may support the creation of new knowledge, skills, processes, and products. For instance, leaders may welcome idea-generation initiatives from endogenous entrepreneurs who recognize internal opportunities. They may also take on this role themselves. Finally, *operational leadership* produces results by exploiting the organization's resources with "selection, refinement, execution and efficiency" (Uhl-Bien & Arena, 2018, p. 98). It resides in the formal systems, structures, and processes of an organization, and it is imperative to reintegration. Operational leaders may act as sponsors of innovation by scaling reconfigured ideas from the adaptive process into the formal system in terms of operationalizing new products, services, processes, technology, and so forth.

Uhl-Bien and Arena (2018) cite the need for research that can identify leadership skills, ability, and knowledge that promote the conditions necessary for adaptive space. Qualitative and process-focused research may enable a deeper understanding of organizational dynamics and capture leaders' crucial role in an adaptive process. Uhl-Bien & Arena argue that "we need to study the many and varied ways leaders enable (or stifle) the adaptive process in organizations" (Uhl-Bien & Arena, 2018, p. 100), paying attention to the function and role of entrepreneurial, enabling, and operational leadership.

The normative decision model

According to the situational theory of leadership, which leadership style is best is contingent on the situation. Arguably, for group decision making, the best leadership model is the *normative decision model,* initially proposed by Vroom and Jago (1978) (Yukl 2010). It illustrates specific decision modes that allow leaders to make appropriate decisions to fit the situation. A main feature of these decision processes is whether decisions are made autocratically by leaders or whether team members are involved in decisions. Caillier (2020, p. 19) tested the influence of autocratic versus democratic leadership styles on leadership performance and perceptions of public service motivation and argues that democratic leaders will receive greater support from citizens than autocratic leaders.

To choose the most appropriate process, leaders must diagnose the status of a problem or decision while taking into account the seven situational variables believed to influence the effectiveness of the decision process. The rules underlying the normative decision model focus on the importance of decision quality and acceptance of the decision by subordinates (Vroom & Jago, 1978). A revised model has since emerged specifying five decision modes: *decide, consult individually, consult group, facilitate,* and *delegate* (Vroom, 2003, p. 970):

- **Decide:** You make the decision alone and either announce or "sell" it to the group.
- **Consult (individually):** You present the problem to group members individually, get their suggestions, and then make the decision.
- **Consult (group):** You present the problem to group members in a meeting, get their suggestions, and then make the decision.
- **Facilitate:** You present the problem to the group in a meeting. You act as facilitator, defining the problem to be solved and the boundaries within which the decision must be made.
- **Delegate:** You permit the group to make the decision within prescribed limits.

Further, Vroom (2000) described seven *situational factors* in the normative model to help leaders tailor their decision style to the demands of the immediate problem:

- *decision significance* for the project/organization's success,
- *importance of commitment* to the decision from team members,
- *leader's expertise* regarding the problem,
- *likelihood of commitment* to the leader's decision,
- *goal alignment*, which means group support for objectives at stake in a given situation,
- *group expertise* regarding the problem,
- *team competence* in working together and solving problems.

Vroom also proposes two models of decision making (Vroom, 2000, p. 87-88): the *time-driven model,* for decision making when time is limited, such as in an emergency; and the *development-driven model,* for when the focus is on increasing human capital through training and experience, team-building, and aligning subordinates with the organization's goals. These models enable leaders to determine the extent to which each of the seven situational factors is present, and thereby set themselves on a path toward the most adequate decision style for handling a problem (Vroom, 2003).

An amalgamated theoretical framework

Pulling together the strands of the decision contingencies and the leadership styles gives us a broad spectrum of theoretical options for studying the co-creation process. Enabling leadership, including ambidexterity, integration, and reintegration, nurtures and sustains the adaptability process, with a focus on "creating, engaging and protecting adaptive space" (Uhl-Bien & Arena, 2018, p. 98). Thus, enabling leaders create structures and processes to effectively engage with conflict and tension and create connection. Enabling leadership, with its focus on organizational adaptation, promotion of innovation, and resource management, flows into and links the other two leadership styles, namely entrepreneurial and operational
styles. Seemingly, the five decision styles identified by Vroom (2003) apply to each of three leadership styles described by Uhl-Bien and Arena (2018). Such an amalgamation can be depicted as in Table 1 below.

	Leadership styles for organizational adaptability		
	Enabling	**Entrepreneurial**	**Operational**
Decision modes	Decide	Decide	Decide
	Consult (individually)	Consult (individually)	Consult (individually)
	Consult (group)	Consult (group)	Consult (group)
	Facilitate	Facilitate	Facilitate
	Delegate	Delegate	Delegate

Table 1: Amalgamation of leadership styles and decision modes

Arguably, the strength of Uhl-Bien and Arena's (2018) approach is its triadic model of leadership for organizational adaptability. Likewise, the strength of Vroom's (2003) approach appears to be in its variation of leadership decision modus operandi. Thus, a combination of the two approaches may be productive when explaining co-creation leadership in public services.

Aim

Although a "both-and" leadership approach has been deemed necessary (Aramovich & Blankenship, 2020), neither Vroom's (2000, 2003) nor Uhl-Bien and Arena's (2018) leadership styles regard involvement and decision-making in PSOs. Therefore, the aim of this paper is to explore how involvement in leader decision-making in a PSO may affect an adaptive process and to provide suggestions for leadership behaviors (including styles) that promote conditions for co-created organizational adaptability. Will co-production of public services require leadership attributes beyond mainstream leadership styles and decision modes? To this end, the article explores the following question: *What leadership behaviors and styles may enable and/or stifle co-created organizational adaptability in PSOs?*

Orientation

In line with contingency theory, leadership should be studied in context, because leadership behavior will always vary depending on the situation (Uhl-Bien & Arena, 2018; Vroom, 2003). The OECD (2015) regards the public service context as an important part of the overall innovation agenda. A contextual perspective on leadership is far from new (Dinh et al., 2014; Oc, 2018). Uhl-Bien and Arena's (2018) leadership framework and the normative decision model (Yetton & Jago, 1978; Vroom 2000, 2003) illustrate how leadership styles impact organizational adaptability, making it possible to reach shared objectives. However, these styles do not specifically address leadership and participation in PSOs. Arguably, an interpretation of

these theories could benefit from exploring results from public services requiring more public involvement (WHO, 2013).

Context

A Norwegian public specialized mental health and substance abuse services (SMHS) unit was chosen as a proxy of a public service organization (PSO). An agreement to initiate an in-house inquiry into increased patient involvement in service development was the basic premise for the study. To ensure transparency in the inquiry process, regular meetings were held between leaders in the organization and the project moderator/researcher (first author). One purpose of the inquiry was to improve treatment services through facilitated dialogue and collaboration among stakeholders. The ambition was that the inquiry process would also inform the main aim of the change project, namely *to develop a user participation method that ensured both service user and provider impact on service development.* Before the inquiry was initiated, staff, leaders, and patients appeared to have no prior experience with systematic patient involvement in this SMHS.

The clinic where the SMHS was located housed several units. This SMHS unit had approximately 60 staff, a staff/discipline unit leader (responsible for nurses, health workers, social pedagogues/workers and more), an assistant unit leader, and a medical leader (a psychiatrist). The last of these was responsible for the therapy staff (psychologists and substance abuse specialists) and medication. The clinic leader was the immediate superior of the unit leader, while the Psychiatric Department leader (responsible for several mental health clinics) was the leader of the medical and clinic leaders in this department. In the findings, we have designated one unit leader the "immersed leader" as he was immersed in the whole inquiry and its aftermath.

Design

This single-case study (Flyvbjerg, 2006; Mabry, 2008; Yin, 2009) was designed according to the principles of action research (AR), which is cyclical in nature (Brydon-Miller, Greenwood, & Maguire, 2003; Reason & Bradbury, 2008), in line with the principles of co-operative inquiry (Reason, 1999), which privileges research *with* rather than *on* people (Heron & Reason, 2001). In AR, participative engagement is essential. Action researchers are concerned "about relevance, social change, and validity tested in action by the most at-risk stakeholders" (Brydon-Miller et al. 2003, p. 25). Their aims often include promoting social justice and

democracy, challenging oppression, and institutional change. In an AR orientation, change is created through a cycle of action and reflection (Reason & Bradbury, 2008). Stakeholders become involved as co-researchers who actively engage in communities of inquiry. Purposeful action is planned and carried out following systematic process of gathering evidence, testing practices, and making sense of findings (Reason & Bradbury, 2008).

Participative engagement resulted in several organizational changes in our inquiry. However, in AR, creating change in the real world is not enough: action researchers must become better at telling society what actually was achieved, and there must be proof behind these stories (Gustavsen, 2014). While localism can be a strength when building broader societal level action research interventions, in-depth knowledge and emotional engagement may also make it difficult for the action researcher to see the larger picture. Therefore, first-, second-, and third-person inquiry research practices have been promoted in AR to ensure subjective, intersubjective, and objective inquiry (Reason & Bradbury, 2008).

Initial conceptualization and the definition of a common aim in collaboration with stakeholders were followed by several interventions and evaluations (Heron, 1996; Heron & Reason, 2008). The four phases of knowledge development in co-operative inquiry—namely propositional, practical, experiential and propositional knowledge—were used as an AR framework for qualitative research methods (Hummelvoll, 2008; Heron & Reason 2001; Larsen & Sagvaag, 2018; Silverman, 2006). This ensured that stakeholders were fully involved throughout the whole sequence of change actions.

Participation

The inquiry included 109 (66 m, 43 f) persons who participated to a varying extent, including students and trainers. Patients, staff, leaders, and the project moderator collaborated to develop the interview guides, collect and interpret data, disseminate the findings, and propose service changes. Participation and data collection ran concurrently. The project moderator facilitated the full inquiry while conducting participatory observation (May, 2001; Savage, 2000); this included

- keeping documentation in minutes and reports and making these accessible to the contributors,
- attending all formal and most informal service-related meetings that were relevant to the study's objectives,
- facilitating work-groups with patients and staff,

- providing training and guidance to qualify participants to lead individual and focus group interviews and dialogue seminars; the researcher was also present during these interventions.

The planned inquiry was structured in the following manner:

Phase 1: Two work groups—one with staff, the other with patients—met four times each and merged into one final joint work group.

Phase 2: Five multistage focus group interviews with staff, leaders, and patients; five semi-structured individual interviews with patients; and a dialogue seminar with staff, leaders, and patients were all led by a patient inquiry team. The multistage focus group interviews were arranged in three stages. In stage 1, there were three homogeneous groups with staff, leaders, and patients, while stages 2 and 3 had two heterogeneous groups with staff, leaders, and patients.

Phase 3: Three multistage focus group interviews with staff, leaders, and patients (heterogeneous groups, stages 4-6), five semi-structured individual interviews (with staff) and a dialogue seminar (with staff, leaders, and patients) were all led by a staff inquiry team.

Phase 4: A former patient (henceforth, "citizen") and a staff member facilitated a dialogue seminar with an inquiry team of leaders, staff, and patients. The inquiry team was also supported by these facilitators in leading the final dialogue seminar, in which patients, staff, and leaders participated.

In addition to service meetings and pre-scheduled inquiry activity, ad hoc inquiry meetings were held with leaders, staff, and/or patients to address any issues raised in the inquiry: all together, there were five planning meetings where leaders decided on issues related to inquiry activity. To plan and manage the inquiry continuously, the leaders and the researcher also held numerous informal meetings. Leaders were also present in a reference group that was established in response to communication difficulties between patients and staff. The reference group met three times during the inquiry.

Issues arising from the inquiry were also discussed in monthly staff meetings. However, as in the service meetings, some issues were outside the scope of the inquiry, and there were staff present who had not consented to participate in the inquiry. Therefore, our use of the records from these meetings is limited by an agreement that only anonymized field notes would be retrieved to strengthen the contextual analysis.

The organization compensated staff and leaders who contributed outside regular working hours with equivalent time off. Inquiry-related training was fully/partly funded by

research funds (the organization covered more of these expenses as the inquiry progressed), and all patient/citizen involvement was funded by research funds.

Documentation and analysis

Our data comprised email, reports, minutes, field minutes, and journal notes that were deemed relevant to organizational adaptation and co-creation. To clarify, although we refer to co-production in the findings, in this article we explore co-creation. Two reports are of interest. The first is the Joint Report, which resulted from discussions in the phase 1 work groups. This report documented the mutually agreed upon inquiry aim (service quality improvement), along with suggestions for staff and patient training and service development. The Joint Report informed the leaders and the researcher during planning training and as the inquiry progressed. The second is the Experience Report which recorded experiences, monitored developments, and informed participants about developments in each phase. This report documented the changes suggested in all dialogue seminars and specified the individuals tasked with following them up. As it included highlights from the Joint Report, the Experience Report also reflected the propositional knowledge acquired in each phase and continuously informed plans and follow-up actions.

The participants member-checked the cited documentation (c.f. Findings, below), except for the journal notes (Lincoln & Guba, 2007). They were urged to look for missing elements or misinterpretations, and the texts were amended according to their recommendations. The minutes were predominantly condensed descriptions of the conversations, not verbatim transcriptions (Graneheim & Lundman, 2004; Hammersley, 2010; Poland, 1995). To ensure consistency, familiarity, and readability, minutes were written in accordance with the documentation tradition in this SMHS.[1]

All data were subjected to conventional qualitative and directed content analysis (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005) using NVivo 9. The investigation was abductive, as the data were revisited repeatedly through a process of de-familiarization and alternative casing (Timmermans & Tavory, 2012).

[1] Some participants were quoted verbatim in these minutes; these instances are underlined. The email, reports, minutes and journal were in Norwegian. The selected findings were translated by the authors and verified by a translation service. The inquiry was approved by the Norwegian Centre for Research Data (NSD) Project no. 24667 and the Regional Ethics Committee (REK) Project no. 2010/1641.

Findings

While tracing leadership styles and decision modes during the inquiry, we identified four ways leaders influenced co-created organizational adaptability: a) *Entrepreneurial, enabling and operational leadership, b) Endogenous entrepreneurship, c) Adaptation to ensure and enhance production* and *d) Initiating and incorporating novelty.*

Tracing entrepreneurial, enabling, and operational leadership

With the AR project, patients were invited into arenas where they had formerly been excluded: "The goal of the research is to create room for dialogue between staff and patients. Thus, it would be inappropriate to shut one of the parties out" (immersed leader and staff member, second planning meeting). One leader appeared to expect that participating patients might become "difficult"; he experienced instead that "they illustrate themes from multiple perspectives" (immersed leader, stage 1). Also, "The patients are very impatient; you feel that you are affected by their impatience and want to start such and such. However, we must stay cool-headed here" (immersed leader, reference group one,).

Leaders supported patient involvement on several occasions. Some regarded it as "good for the treatment service," "very constructive," and contributing to improving the working environment and providing better treatment (leaders, stage 1). One leader wanted "the clinic to be able to beat their chest about being a bit ahead of the game with user involvement" (leader, stage 4). Leaders also regarded inquiry activity (the introduction of new ways of interacting with patients, joint training and dialogue seminars, etc.) as competence enhancement for staff and continuously enabled staff involvement. They also continually increased the organization's financial and human resource contributions. One leader urged, "Prioritize research activity!... [I] recommend that we spend money on this" (immersed leader, reference group one). Another agreed, "This is a skill boost for the staff" (leader, reference group one).

The leaders demonstrated entrepreneurial and enabling leadership styles. They encouraged and facilitated staff and patient involvement in a context where this was entirely new and enabled both parties' presence during training and other inquiry activity. Leaders thereby facilitated dialogue, encouraging participants to express conflicting perspectives and explore new ways of interacting. Furthermore, operational leadership seemed intertwined with these two styles with regard to financial and human resource expenses.

Leaders also called for safeguarding satisfactory treatment and problematized patient involvement. They were concerned that propositions for change coming from patients would

be based on pathology (for example, using manipulation to get drugs more easily). Apparently, the leaders feared that patients would have the deciding voice. "There was a question as to whether the psychiatric clinic was obliged to initiate changes as a result of the project" (immersed leader, leaders, staff member and funder, first planning meeting). Also, there was concern that patients could externalize their problems by focusing on service development to escape their own psychosocial issues; in other words, they were not trusted to evaluate their own fitness to engage.

As a safeguarding measure, leaders and staff were consulted about patient involvement on an ongoing basis. One procedure was that the researcher sought patient approval to involve the therapist in decisions about the patient's involvement before consulting the therapist about the patient's fitness to participate; only then leaders could allow patient involvement. Also, regular meetings with, and reports from, the researcher ensured that leaders were monitoring the process. So when it came to making sure that patient involvement did not jeopardize satisfactory treatment, the operational leadership style was apparent.

Ensuring staff involvement in the change process was another way of safeguarding satisfactory treatment: "Here we see the importance of integrating the project with the staff in a good way and establishing a common understanding as early as possible" (immersed leader, leaders, staff member and funder, first planning meeting). Also, to ensure a benevolent working ambience, staff were urged to "be open with each other and utilize the competence on the ward if things become difficult" (immersed leader, leaders and staff, third planning meeting).

Adaptive spaces were created. New ideas and practices were explored through a combination of enabling leadership while operational leadership ensured service production and a justifiable and tolerant working environment.

Endogenous entrepreneurship

Early on, one leader pointed to an entrepreneurial potential related to patient-led production: "It is a condition that there must be something that can be sold. It should also be a product that you can make agreements with other companies about. In addition, you need start-up capital" (immersed leader, stage 1).

The project moderator provided a budget (approx. 10,000 euro) for innovation initiatives among the participants. One leader presented his view regarding these funds in the reference group and at a staff meeting: "The thinking among the staff should be that most of the production should be patient-led. This will be based on a collaboration, where the staff represents a continuity" (immersed leader, reference group two). Two ideas emerged, proposed

by a staff member and the immersed leader, respectively: co-delivery of activity services (such as leisure gear storage/rental) and patient-led wood production. In fact, the staff member was offered a permanent employment contract by the leaders to pursue his idea, which he accepted. However, neither a project description nor an application for funding was presented. Also, although the wood production idea gained support from the stakeholders, addressing resistance concerning security measures became too time-consuming for the leader and it did not materialize.

In short, the leaders facilitated endogenous entrepreneurship through entrepreneurial leadership. When ideas emerged, the operational leadership style was used to support and sponsoring further innovation. Also, a leader took on the role of an endogenous entrepreneur himself. Although these two ideas failed at the time, they may nevertheless have been important to the co-creation process. First, the staff member's permanent contract ensured his presence in the organization during the co-creation process described below. Second, the immersed leader had demonstrated a belief in innovation generation in both words and action. Finally, the innovation budget was still available to strengthen the following initiatives.

Adaptation to ensure and enhance production

For therapeutic reasons, patients were not allowed alcohol or illegal drugs while on the ward. However, staff and patients said staff lacked the skills necessary to spot and/or confront intoxicated patients. Early on, leaders were informed that, "The expertise the patients have in relation to observing the intoxicated behavior on the ward was much greater than what the staff can learn through training" (staff, Joint Report). An incident in which milieu staff had difficulty directly confronting an individual patient about a suspicion illustrates the problem.

> The patient believes that the suspicion of intoxication was dealt with in a panicked manner by the milieu therapist staff: On Monday morning, it was communicated that there was suspicion of intoxication and everyone was tested; Tuesday he was confronted in the [treatment] environment and today he met with the psychiatrist. He would have preferred a more private confrontation with staff. (patient, field minutes)

In this environment, another patient approached the researcher on his last day in treatment expressing a desire to contribute to the research. With the leader's support and the researcher's facilitation, this citizen, along with a staff member, wanted to plan training sessions for spotting illegitimate drug use in treatment and addressing it with milieu therapy. The leaders decided to

make this training “that year’s professional development session” (immersed leader and leader, fifth planning meeting). They announced their decision at the following reference group meeting: the training co-creation would proceed if the citizen’s former therapist was consulted and agreed. However, the staff did not automatically accept the idea of receiving training from the citizen:

> On the one hand, the staff has a lot to learn from someone who has good insight into the substance abuse milieu; on the other hand, it can make the staff feel inferior when someone comes and acts as if they know better. The safety representative and a staff member pointed out that if a former patient comes to teach, the staff may feel as though they are being lectured. The staff asked questions about what the former patient had seen here that he couldn’t talk about when he was in treatment….The safety representative expresses that there is a need to discuss this matter also at the staff meeting. (immersed leader, leader, and staff, reference group two)

The leaders agreed and thereby enabled interaction and integration between innovation and production by supporting entrepreneurship while also consulting staff. After a thorough exploration of the pros and cons of co-created training in the staff meeting, the staff also supported the initiative. The citizen gave his approval for the researcher to consult his former therapist, and the therapist supported the citizen’s involvement. Thus, co-created training also required operational leadership beyond the responsibility of the organization, as the citizen about whom the therapist needed to be consulted was no longer in treatment.

After getting positive feedback about the training session from staff and leaders, the citizen, staff member and researcher wanted to establish a new project, a Training Team: “The aim of this project is to develop teaching/training courses for an internal and an external audience” (Experience Report). The leaders again welcomed ideas from endogenous entrepreneurs. The remaining staff were only informed, not consulted, about the Training Team. The vision agreed upon by the leaders and the Training Team members was voicing co-created knowledge informed by explorative dialogue between staff, patient, and researcher perspectives.

The Training Team members decided the work scope themselves; they presented their work in meetings, seminars, conferences, universities and in the regional user organization, discussing the inquiry’s challenges and successes, as well as the citizen’s recovery.

Initiating and incorporating novelty

Being "on the road" did not just help promote the shared vision for the Training Team; it also allowed connections to be established with potential future sponsors and "clients," namely other PSOs. First, in a meeting with the Training Team, the primary funder of the AR project suggested financing a follow-up study with the aim of implementing co-production in the form of a participative organizational learning method. This co-production method emerged from the participants' and researcher's evaluations of their experiences with the inquiry design. Second, a Psychiatric Department leader at another clinic expressed interest in the study. After some meetings and correspondence between clinic and Psychiatric Department leaders, the primary funder, and the project moderator, it was agreed that the idea to provide new service provision should be pursued and additional funding applied for. Third, another unit leader from the clinic, who had observed the developments, suggested implementing the co-production method in her Mental Health Service unit. With their entrepreneurial leadership style, the funder and leaders continued to fuel hopes among endogenous entrepreneurs regarding the provision of a new service.

Soon thereafter, the Training Team was renamed the Facilitation and Training Team (FT Team), and its new purpose was to implement the chosen co-production method in two other units within the Health Trust. By then, the immersed leader had joined the FT Team and the citizen was employed by the Health Trust. As a result, the following agreement was reached:

> The FT Team will have its own accountability number so we can manage finances and staff information ourselves…The Psychiatric Department leader provides a financial guarantee for the entire period June 2013–May 2015. (immersed leader, leaders, negotiation meeting)

The operational leadership style appeared imperative to these final developments. Two Psychiatric Department leaders engaged in a financial collaboration to sponsor innovation reintegration. The clinic leader was the formal leader of the FT Team, and the cross-clinic funding agreement ensured two years of service provision and autonomy in managing monetary and human resources.

The findings in brief

The main aim of the inquiry was achieved by the end of the final phase when a new co-production method was developed. However, when it comes to understanding what leadership behaviors and styles may have enabled and/or stifled co-created organizational adaptability in

this SMHS, the findings reveal a co-creation process that led to the provision of a new public service. This result was beyond the scope of the initial inquiry. One factor that was key to initiating this co-innovation was the establishment of the FT Team, which included inquiry participants who were engaged in developing the co-production method through their involvement as formal and function/task leaders. During strategic planning and initiation of the Training Team, the FT team, and the co-production method implementation service, the co-creation process was supported by enabling, operational, and entrepreneurial leadership styles, as proposed by Uhl-Bien and Arena (2018). However, the findings point beyond these three leadership styles, amalgamating core elements of all five decision modes proposed by Vroom (2003), and of Yukl's hierarchical taxonomy (Yukl, 2012).

Discussion

Revisiting the core concepts

To investigate what leadership behaviors and styles may enable and/or stifle co-created organizational adaptability, it is necessary to distinguish between co-creation and co-production. We suggest viewing co-creation and co-innovation, and co-production and co-design as two parallel paths that connect with regard to co-creation of public value (Boviard & Löffler, 2012; Brandsen & Honingh, 2018; Osborne et al., 2016; 2018) as illustrated in figure 1 below.

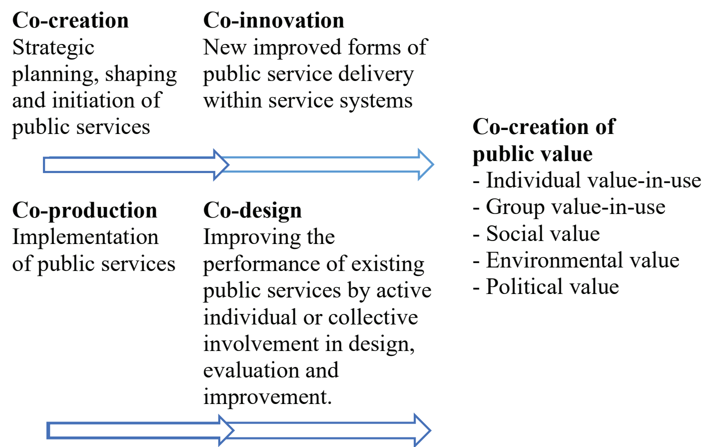

Figure 1: Co-creation and co-production paths to co-creation of public value

This metaphor allows us to distinguish between the two concepts without determining which comes first: co-creation or co-production. While one might assume that co-innovation and co-design lead to co-creation of value, we did not set out to prove whether value co-creation may recursively impact co-creation and co-production. Although further exploration of these paths appears necessary, we move on now to investigate co-creation and leadership.

The findings demonstrate aspects of organizational adaptability, arguably intertwining three leadership styles (Uhl-Bien & Arena, 2018) as demonstrated in table 2 below:

<table>
<tr><th>Entrepreneurial leadership</th><th>Operational leadership</th><th>Enabling leadership</th></tr>
<tr><td>Supported co-creation of new knowledge, skills, processes and services.
Encouraged inquiry activity, co-created training, the Training Team and the FT Team.
One leader acted as an endogenous entrepreneur.
One leader engaged in the FT Team to co-provide new services.</td><td>Ensured staff and patient involvement by prioritizing inquiry activity and safeguarding sound treatment and work environment.
Sponsored staff involvement increasingly by providing human and monetary resources.
Sponsored permanent employment for endogenous entrepreneurial staff member.
Ensured adaptation of staff training to meet training needs with co-created training.
Ensured staff involvement in the Training Team.</td><td>Ensured staff and patient involvement through adaptive spaces such as interviews, meetings, dialogue seminars.
Enabled tension, conflict, and integration between perspectives.</td></tr>
<tr><td colspan="2">Engaged in a cross-clinic financial collaboration to sponsor (entrepreneurial) the FT Team, thereby scaling ideas from the adaptive process into the formal system (operational).</td><td></td></tr>
<tr><td colspan="3">Nurtured and sustained an adaptive process (enabling) with formal structures (operational) and by encouraging and welcoming idea generation (entrepreneurial).</td></tr>
</table>

Table 2: Entrepreneurial, enabling, and operational leadership in the co-creation process

All five decision-making modes were also observed (Vroom, 2003). Entrepreneurial leadership behaviors appeared to dominate, with particular emphasis on encouraging innovation in Yukl's (2012) change oriented leadership behaviors. Moreover, operational behaviors were related to inquiry implementation and operationalizing the resulting innovation (Uhl-Bien & Arena, 2018). In articular, monitoring operations appeared to enable and delay co-creation of services (Brandsen & Honingh, 2018; Yukl, 2012).

In particular, the findings demonstrate an overlap between external oriented and delegating leadership styles (Vroom, 2003; Yukl, 2012). Together with empirical examples of

a leader's protracted immersion in the inquiry as a participant and advocate (Heron & Reason, 2008), this overlap pointed to another possible leadership style that was missing from existing theoretical frameworks (Schlappa & Imani, 2018; Uhl-Bien & Arena, 2018; Vroom, 2003; Yukl, 2012).

Connected behaviors

When leaders allowed planning, initiated training, and promoted the Training Team and the FT Team, we consider this as encouraging innovation (Yukl, 2012). They appeared to value and support creativity and entrepreneurial activities and encouraged experimenting with new ideas informed by different perspectives (Uhl-Bien & Arena, 2018). Acknowledging establishment of the Training Team may also be interpreted as facilitating a joint decision (Vroom, 2003). Participating in the Training Team appeared to provide individual members an opportunity to learn from experience and develop skills. Conversely, enabling individual development may have facilitated collective learning (Uhl-Bien & Arena, 2018; Yukl, 2012). As such, inquiry participation and Training Team membership appeared to prepare the members collectively for the future performance of the FT Team, including both facilitation of joint decisions and collective learning (Uhl-Bien & Arena, 2018; Vroom, 2003). Further, the fact that the Training Team members could choose and take on missions themselves may be interpreted as a result of empowering, and thus delegating, leadership behaviors (Vroom, 2003; Yukl, 2012). When the leaders permitted autonomous decisions within this group, they also encouraged external leadership behaviors among the members (Yukl, 2012).

Overlaps

Deciding co-creation

Arguably, delegating autonomy to the Training Team appears time-effective under the circumstances. According to the time-driven model, a group can be permitted to make decisions within certain limits when the likelihood of commitment to the leader's own decision is low and the occurrence of the following situational factors is high (Vroom, 2000, 2003):

Decision significance	The Training Team could promote the organization externally.
Importance of commitment	The members themselves developed the idea, and thus could be expected to further develop it.
Leader's expertise	The immersed leader was informed by comprehensive involvement in inquiry.
Goal alignment	Leaders wanted to be pioneers in patient involvement; this team committed to co-creation of services.
Group expertise	The staff member had fully engaged in inquiry activity, the citizen had experienced the patient-role in the SMHS, and the researcher had insight into the inquiry and organization.
Team competence	The team had already managed to deliver co-created training.

Table 3: Time-efficient delegation to the Training Team

Similarly, if the decision significance about the Training Team had been low, the time-driven model advises delegation if team competence and importance of decision commitment were high and likelihood of commitment to the leader's own decision was low. In the development-driven model of situational variables, many paths lead to the delegate decision style (Vroom, 2000, 2003). As likelihood of commitment has not been examined thoroughly in these findings, we have regarded the alternative courses of action in the two models. In both, if all the other factors are high, the advice is to delegate. So, delegation seems to promote both time-efficiency and development/participation. Furthermore, the Training Team initiative came from its members, so an autocratic decision about initiation seems inadequate. These templates cannot fully explain the consequences of delegated actions in this context, but the analysis may benefit the following exploration of potential conceptualization.

In advocating and enabling co-created training and allowing the Training Team to be established, leaders appeared to encourage co-creation (Brandsen & Honingh, 2018). However, co-created training seemed to meet with resistance from staff. From monitoring the inquiry, the leaders knew about the idea that had taken root early on to meet the prevailing need for training. It may have seemed like a simple decision to make. However, the decision-making process that enabled the Training Team, and subsequently the FT Team, was more complex. On the one hand, offering permanent employment enabled continued access to an entrepreneurial staff member. This was a leader's decision (Vroom, 2003). On the other hand, while the leaders advocated, championed, and sponsored (Uhl-Bien & Arena, 2018; Yukl, 2012) the prioritization of inquiry activity, several members of staff urged more involvement in and facilitation of joint decision-making concerning the co-created training (Vroom, 2003).

Thus, the decision-making process that resulted in the Training Team appeared to cycle from an autocratic decision regarding permanent employment, to a decision based on individual consultation with the citizen and his former therapist regarding initiating co-created training (Vroom, 2003). Nevertheless, individual consultation was postponed by group consultation in the reference group and facilitation in the staff meeting. Over the course of this process, the leadership style progressed from decide to delegate (Vroom, 2003).

Monitoring operations – enabling and delaying decisions

The leaders monitored the change actions continuously and could thus make informed decisions about involvement, work environment, developments, and more. This may have prevented the process from being stifled. We found that monitoring operations may have at once enabled and delayed co-creation of organizational adaptability (Yukl, 2012). First, rather than making the decision to involve the citizen themselves, the leaders required a therapist to evaluate the citizen's fitness to participate. Second, group consultation and facilitation of joint decision-making after the leaders had decided on co-created training appeared anchored in the staff's need to monitor operations. Although autocratic decisions were seen as more time-efficient (Vroom 2003), the leaders and staff required multistage consultations/facilitations, first in the reference group and staff meeting and then with the citizen and his former therapist. The decision-making cycle, shown in figure 2, seemed to enable co-created organizational adaptability. This suggests that strategies can be improved, and employees may become more committed to their implementation (operational) if they are involved in the co-creation process (Uhl-Bien & Arena, 2018).

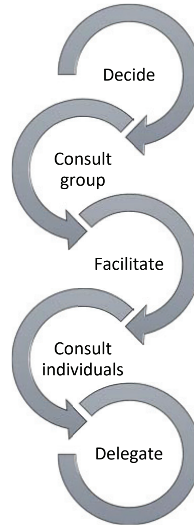

Figure 2: Decision-making cycle

Also, the extent of the PSO's responsibility regarding the citizen's role before he was employed was something of a grey area. The citizen's experience with the patient role in the SMHS was a pertinent part of the service user expertise that qualified his contribution to the co-creation. Because the issue of the citizen's role (namely whether he should be considered a patient or an employee) had not been addressed explicitly, consulting the therapist was perhaps necessary. This safeguard may have eased any fears of causing the citizen harm by involving him and potentially prevented co-creation process from being stifled.

The numerous decisions about patient/citizen involvement may have slowed co-creation. However, it seems that trade-offs between participation and decisiveness are not the only risk when integrating production and innovation in public services (Aramovich & Blankenship, 2020, Uhl-Bien & Arena 2018). When patients/citizens are monitored out of concern for their well-being, this may involve trade-offs between patient/citizen care and autonomy. Finally, the potential for reducing the amount of decisions in the decision-making cycle was apparent: a) The opportunity and ability of the patients/citizen to assess their fitness for involvement in direct communication with an inclusion-oriented (see below) therapist could ensure that the patients/citizen decide their own feasible involvement; b) If leaders had made confident decisions about co-created training, a group consultation and facilitation with staff could have been avoided.

Furthermore, there are some ethical implications associated with allowing staff to exclude patient/citizen contributions in service development. In particular, issues might arise if the argument for further delaying decision-making is based on the fear of feeling inferior due to their lack of patient knowledge. As we know, such fear is essential to organizational defense mechanisms that seek to maintain established behaviors as opposed to learning from them (Argyris & Schon, 1974). Consulting in the reference group and staff meetings without the patients/citizen present may have protected staff from having to confront their fears of losing face (Argyris, 1995). The presence of the patients/citizen might have enabled deeper confrontation and exploration of fears and exclusionary attitudes. However, it may also have led staff to censure themselves. Nevertheless, excluding the patients/citizen from group consultations and facilitation might have helped reproduce exclusionary behaviors among staff (Larsen et al., 2020). Uhl-Bien and Arena (2018) suggest that structures and processes for effective engagement with conflict and tension and connection can be created with enabling leadership. Schlappa and Imani (2018), meanwhile, urge organizations to create lightly structured spaces for interaction among stakeholders and provide citizen with opportunities to shape a context that facilitates involvement. We would argue that in PSOs, special awareness of organizational defense mechanisms and skills in inclusion, integration, and "both-and" leadership are necessary.

Delegating external leadership

After the Training Team was made autonomous, leadership appeared to be co-constructed among a group of informal leaders (Schlappa & Imani, 2018; Vroom, 2003). In this case, a distinction emerged between leadership as a formal role and leadership as a function or task (Jacobsen, 2018). Delegating external leadership behaviors were also observed (Vroom, 2003; Yukl, 2012): When representing through internal and external presentations and agreement negotiations, the Training Team promoted the organization's reputation. Representation was an important arena for advertisement and networking, as favorable relationships could provide support and resources (Yukl, 2012). Also, representation and networking enabled external monitoring in the form of environment scanning, thereby identifying opportunities for innovation reintegration (Uhl-Bien & Arena 2018; Yukl, 2012). Thus, encouraging innovation by delegating power to a team that demonstrated external leadership behaviors appears to have resulted in broader innovation sponsorship collaboration between external and internal funders (Uhl-Bien & Arena 2018; Yukl, 2012).

External leadership behaviors also appeared to strengthen the team's autonomy and thereby the chances of FT Team reintegration (Uhl-Bien & Arena, 2018; Vroom, 2003; Yukl, 2012). This observation points to theoretical overlap. Leadership as a task or function can be delegated within a prescribed limit to members of a team or organization who wish to promote and defend the interests of their team or organization through networking, representing and external monitoring (Jacobsen, 2018; Vroom, 2003; Yukl, 2012). However, this definition is not sufficient when also describing the potential for leaders' immersion as an equal member of a team that takes the lead in co-creation (Brandsen & Honingh, 2018; Heron, 1996; Schlappa & Imani, 2018).

Pulling the strands together

Four paths emerged from the empirical descriptions when the framework for leadership for organizational adaptability was applied (Uhl-Bien & Arena, 2018). Empirical descriptions of decision-making processes pointed to gaps in Uhl-Bien and Arena's framework with regard to participation (Uhl-Bien & Arena, 2018). We therefore added Vroom's account of the five decision-making styles (Vroom, 2003) and related all eight styles to the analysis of the empirical findings in light of Yukl's taxonomy (Yukl, 2012).

In short, we found that

- co-creation can involve a number of decisions and leadership styles;
- encouraging innovation leadership behavior dominated.
- monitoring operations may have both ensured and delayed co-creation.
- the theoretical overlaps between delegation and external orientation, and entrepreneurial, enabling, and operational leadership have not been sufficiently described.

Furthermore, we analyzed situational variables that may have influenced leaders' decisions regarding service innovation. Because the decisions in question had already been made, Vroom's matrixes were interpreted backwards from the type of decision to the leadership style to the situation (Vroom, 2000).

Against this backdrop, we propose a potential new leadership style that may enable organizational adaptability in public organizations related to co-creation, co-production and co-creation of value (Brandsen & Honingh, 2018; Osborne et al., 2016; Pestoff, 2018; Uhl-Bien & Arena, 2018), tentatively termed "co-creation leadership."

Defining a co-creation leadership style

The dominant focus on service user's contributions in co-production in Osborne et al. (2013; 2016) is noticeable. However, this emphasis may lead to service providers' experience of value in the interaction with service users being overlooked. This one-sidedness is limiting if both parties are expected to contribute equally. Pestoff (2018) also questions putting the responsibility for successful co-production squarely in the hands of the individual citizen/user without regard for the PSO's contributions. Therefore, we question the emphasis placed on the service user pathway without regard for the professional development of service providers.

To further explore how leadership can enable co-created organizational adaptability, we suggest viewing service providers and users as colleagues who can mutually experience interactions related to service quality and potential and well-being as valuable. Working as allies who empower each other through knowledge exchange, emotional resonance, and mutual support, they may experience increased problem-solving capacity and personal and professional development (Larsen & Savaag, 2018; Larsen et al., 2020).

There is a lack of literature on co-creation or co-production leadership, in particular on enabling leadership that includes both professionals and citizens, let alone descriptions of leaders who are immersed in co-production and co-creation. It seems necessary to further conceptualize leadership domains as they relate to users, providers, and leaders of public services. We therefore suggest a new leadership style: co-creation leadership. It relates to *co-creation of public services* in terms of strategic planning and initiation and to *co-creation of value*, which refers to service providers, users, and leaders co-creating public value and valuing a mutual experience while co-creating and innovating or co-producing and implementing public services.

A main quality of this new leadership style is that it regards service providers and services users as colleagues in a reciprocally empowering working alliance with each other and with the formal leader. When actively facilitating dialogue addressing conflicts and tension seems important (Schlappa & Imani, 2018; Uhl-Bien & Arena, 2018; Larsen et al., 2020). This may strengthen relationships and commitment and nuance the PSO's adaptability response so it becomes more applicable to the environment in question (Vroom, 2003; Uhl-Bien & Arena 2018).

Central to co-creation leadership is the enabling of adaptive spaces that include all parties with relevant expertise (Larsen et al., 2020; Uhl-Bien & Arena, 2018). In addition, service users and providers should have the opportunity to shape safe spaces, work through constraints to dialogue and action, and challenge assumptions and expectations (Schlappa &

Imani, 2018). To enable exploration, leaders must ensure a climate of mutual trust and psychological safety (Yukl, 2012). Recognizing and learning from failures may promote attitude or behavioral change and improve skills. Acknowledging that power is negotiated, relational, and dynamic appears fundamental (Schlappa & Imani, 2018). Thus, to enable idea generation and innovation, co-creation leadership need not apply only to the formal leader position; it may be co-constructed and connected to tasks and functions (Jacobsen, 2018; Schlappa & Imani, 2018). For instance, endogenous entrepreneurs among service users and providers may migrate into co-creation leadership roles where they initiate and lead certain developments. However, these co-creation leaders need support from formal leaders, who are able to encourage innovation by empowering, delegating, advocating, envisioning, and sponsoring such leadership initiatives (Uhl-Bien & Arena, 2018; Vroom 2003; Yukl, 2012). Championing and immersing themselves in the operationalization of their own ideas on behalf of the collective may also be part of formal public service leaders' repertoire (Uhl-Bien & Arena, 2018).

In co-creation leadership, facilitating dialogue; making sufficiently informed decisions; and encouraging individual development, collective learning, and innovation are specific leader behaviors that may prove to be appropriate (Vroom, 2000, 2003; Uhl-Bien & Arena, 2018). Consultation, facilitation, and delegation appear key to decision commitment and collective mobilization (Vroom, 2003). Co-creation leaders must be particularly aware of organizational defense mechanisms that seek to maintain divisions and hierarchy among stakeholders. This means that while stakeholder presence and participation in decisions and collaboration are desired norms, autocratic decisions are imperative. Perhaps more clarity regarding the juridical responsibility of PSOs vis-à-vis service providers and user roles and service user involvement can make decision-making processes more efficient. In co-creation leadership, being able to master the trade-offs between decision speed/quality and stakeholder involvement, care and autonomy, and exploration and exploitation is essential (Aramovich & Blankenship, 2020; Larsen & Sagvaag, 2018; Uhl-Bien and Arena 2018).

Against this backdrop, we propose the following definition of co-creation leadership: *the ability to recognize service users, providers, and formal leaders as colleagues who co-create services and value in a reciprocally empowering working alliance.* This definition implies that co-creation leadership is a "style" conducive to promoting innovation and improving actions in public service organizations.

Research implications

The main implication would be that there is a need to explore the conceptualization of co-creation leadership. It seems necessary to investigate whether and how public leaders may already engage in co-creation leadership behaviors and how such behaviors influence organizational adaptation. Furthermore, as public involvement adds to an already complex leadership equation, we need research that strengthens leadership development operations that empower leaders to enable co-created organizational adaptability. Essentially, professional practice and power are challenged by new forms of communication and power sharing when service users engage in changing the status quo (Larsen & Sagvaag, 2018; Larsen et al., 2020).

Co-creation leadership embeds more role aspects than are found in the taxonomies of Vroom (2003), Uhl-Bien and Arena (2018) and Yukl (2012) separately. Our findings indicate that further research is needed on both the theoretical underpinnings of our key concept (co-creation leadership) as well as on empirical comparisons of successful organizational adaptation of co-creation/production of public services.

Our study also lends support to Yukl's (2012) suggestion that more meta-categories should be added to the hierarchical taxonomy of leadership behaviors. Possible new behaviors include demonstrating ethical and social responsibility. Encouraging and modelling ethical behavior and opposing unethical practices are behaviors in line what we have described concerning advocating a new organizational "inclusion logic" in co-creation leadership. Also, some behaviors that potentially encourage "corporate social responsibility" (Yukl, 2012, p. 79) appear to correspond to descriptions of co-creation leadership: Yukl proposes exploring decision-making behaviors that include stakeholder need, and decisions and actions that benefit customers, employees, the organization, communities, or the environment. Therefore, future research should explore how to refine the concept of co-creation leadership to become a new meta-category in the hierarchical taxonomy of leadership behaviors.

Practical implications

Unlike leadership for organizational adaptability, co-creation leadership is hands-on, with leaders immersing themselves in the adaptive process and spaces they enable. Awareness of multiple leadership behaviors may help leaders engage in highly complex situations. Leaders must also advocate a new organizational logic that allows their presence and transitions between exploration and exploitation (Uhl-Bien & Arena, 2018). Enabling and sustaining adaptive spaces where stakeholders can create connections, interact, share power, and constructively challenge assumptions, knowledge, and defense mechanisms is not an easy task for a leader.

Yet demonstrating leadership capacity and skill at delegating and sharing power while modelling constructive communication within a transforming power relationship appears required when leading successful co-creation processes.

We argue that when leaders participate in the adaptive process, it may improve decision quality and ensure inclusion of stakeholders. Also, leaders' own professional development may benefit, as staying removed from the process would deprive them from experiencing reciprocal empowerment through stakeholder contributions and opportunities for individual growth and collective learning first-hand. Much like Uhl-Bien and Arena (2018), we suggest that to pursue organizational adaptability, PSOs need to reconsider compensation and reward systems that promote distant, fast, routine solutions. For one, innovation and human growth require room to explore – and with exploration comes learning from mistakes. Therefore, rigid and constraining PSO structures, cultures, and practices should be changed to include opportunities for involvement, individual and collective learning, and organizational adaptability. Not surprisingly, such change may be pursued through co-creation and co-production. Finally, in addition to service user/citizen involvement in meetings about service development, formalities ensuring such inclusion and the employment of these stakeholders may promote co-created organizational adaptability.

Besides, it is not conceivable that all these leadership role characteristics or styles would be represented in a single person. Debatably, the kind of co-creation leadership proposed in this article points to the need for *leadership teams* that include on equal footing leaders who meet the different requirements of the entrepreneurial, operational and enabling leadership styles as mapped in Table 2.

Methodological considerations and limitations

A key strength of the study is that it was rooted in reciprocal trust and voluntary equal participation. A participative perspective guided the relationship between the project moderator and participants (Gaya Wicks & Reason, 2009). We obtained authorization for participation from the SMHS, in line with the ethical principles of participatory action research (Winter, 1996). These principles also required extensive consultations between participants, offering transparency and access in the information exchange. Also, decisions regarding the direction and expected outcomes of the research were collective.

Knowledge should not be limited to its theoretical implications but should also extend to the practical value of the theory in use (Argyris & Schon, 1974). As an action research project, our study addressed a practical challenge (to increase patient involvement), generated

new knowledge (co-creation leadership), enacted change (organizational change and innovations), was participatory (power sharing), and relied on a cyclical process (inquiry phases).

A single-case research design can have pitfalls, including researcher subjectivity and a lack of methodological rigor and external validity (Yin, 2009). However, such difficulties may be counteracted by clarifying and developing the methodological techniques and epistemological grounding of single-case studies (Bennet & Elman, 2010; Flyvbjerg, 2006). Generalizability is of limited relevance in this instance as the aim of our action research has been particularization. As such, taking an action research approach has not compromised the trustworthiness of our single case study (Lincoln & Guba, 2007). The use of a co-operative framework (Heron & Reason 2001) further ensured the rigor of our study, including the researcher's continuous self-reflection. Thus, the steps in the abductive research cycle and first-person inquiry proved imperative throughout the action research process (Chandler & Torbert 2003; Timmermans & Tavoy, 2012).

Conclusion

Co-creation leadership as an instrument of organizational adaptability is performed in a particular setting, namely where co-creation of public services is unfolding, and draws on elements from the leadership models and taxonomies we have mentioned. The specific requirements of co-creation leadership style include

- recognizing service users, providers, and formal leaders as colleagues who co-create services and value in a reciprocally empowering working alliance;
- enabling dialogue and adaptive spaces where no party is excluded and ensuring that stakeholders themselves may shape safe spaces for exploration, conflict resolution, and reciprocal empowerment;
- acknowledging that power is negotiated and relational.
- co-constructing and connecting leadership to core tasks and functions when enabling idea generation and service innovation;
- recognizing consultation, facilitation and delegation as key to decision commitment and collective mobilization;
- ambidextrously maneuvering between participation and decisiveness, care and autonomy, and production and innovation.

As recommended by Vogel and Masal (2015) and demonstrated in the case presentation, co-creation leadership requires specific contextual characteristics: a) an organizational culture and practices that allow leadership to fluctuate, b) some stability and permanence over time, c) equality in communication flow, d) the ability to reverse and change or adjust decisions ad hoc, and e) a positive contribution-reward balance for all stakeholders. This study also indicates that some leadership models in private and public sector organizations are commensurable, as Vogel and Masal (2015) have suggested. Differences in context might explain the use of diverse leadership styles in the public and private sectors. Further, as Ospina (2016) argues, co-creation leadership requires a broader spectrum of leadership characteristics than usually found in private or public sector organizations separately. Arguably, co-creation leadership is a robust formula that can be used in situations where common hierarchical forms of power are leveled out, and where the overall ambition is to co-produce and co-innovate quality services.

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Appendices

Appendix 1 – Letters of approval: REK 1-2, and NSD

UNIVERSITETET I BERGEN
Regional komité for medisinsk og helsefaglig forskningsetikk, Vest-Norge (REK Vest)

Tone Larsen
tone.larsen@enivest.net
Psykiatrisk klinikk
Helse Førde

Deres ref	Vår ref	Dato
	2010/1641	30.06.10

Ad. Prosjekt: Brukermedvirkning i tjenesteutvikling.

Det vises til prosjektsøknad, datert 27.05.2010.

REK Vest behandlet søknaden i møte den 17.06.2010.

Et økende antall rapporter anerkjenner effektene av å inkludere bruker av helsetjenester som medforsker i prosjekter med fokus på brukermedvirkning.
Utgangspunktet for denne studien er en planlagt omorganisering av tverrfaglig spesialisert rusbehandling. Bruker og tjenesteyter ved [navn på enheten] i Helse Førde ønskes inkludert på et tidlig tidspunkt i gjennomføringen slik at de selv får være med å utforme handlingsplanen.

Komiteen anser forskningsprosjektet som helsetjenesteutvikling og dermed ikke fremleggelsespliktig for REK. Komiteen har ingen innvendinger til at studien publiseres.

Komiteen innvilger søknad om unntatt offentlighet for deler av protokollen med hjemmel i personopplysningsloven § 13.

En gjør oppmerksom på at prosjekter som innebærer behandling av personopplysninger (herunder avidentifiserte opplysninger) skal fremlegges for personvernombudet.

Ved tak:
Søknaden avvises da prosjektet ikke er fremleggingspliktig. Prosjektet kan således i prinsippet gjennomføres uten godkjenning fra REK, som ikke har innvendinger mot at resultatene evt. blir publisert.

Vennlig hilsen

Jon Lekven
leder

Anne Berit Ølmheim
sekretariatsleder

Postadresse:
REK Vest
Postboks 7804
5020 Bergen

E-post: rek-vest@uib.no
Hjemmeside:
http://helseforskning.etikkom.no/xnet/public
Org no. 874 789 542

Regional komité for medisinsk og helsefaglig forskningsetikk, Vest-Norge
Telefon 55 97 84 97 / 98 / 99

Besøksadresse:
2. etasje, sentralblokken, Haukeland universitetssykehus

(Brevet er godkjent for elektronisk utsending uten signatur)

Kopi:
Forskningsansvarlig: post@helse-forde.no

Ny ordning fra 01.07.09:
En gjør oppmerksom på at denne søknaden er vurdert i henhold til helseforskningsloven, som ble satt i kraft 01.07.09. Dette innebærer at REK fra og med denne dato har kompetanse til å godkjenne opprettelse og endring av forskningsbiobank, å innvilge dispensasjon fra taushetsplikt og å gi tillatelse til bruk av personopplysninger til forskning. Saker som er søkt Helsedirektoratet, NSD eller Datatilsynet vedrørende ovennevnte, vil utelukkende bli behandlet av REK. Dette for å unngå parallellbehandling av saker nå i overgangsfasen.

De regionale komiteene for medisinsk og helsefaglig forskningsetikk foretar sin forskningsetiske vurdering med hjemmel i helseforskningsloven § 10, jfr. forskningsetikkloven § 4.
Saksbehandlingen følger forvaltningsloven. Komiteenes vedtak etter forskningsetikklovens § 4 kan påklages (jfr. forvaltningsloven § 28) til Den nasjonale forskningsetiske komité for medisin og helsefag. Klagen skal sendes REK Vest (jfr. forvaltningsloven § 32). Klagefristen er tre uker fra den dagen du mottar dette brevet (jfr. forvaltningsloven § 29).

UNIVERSITETET I BERGEN
Regional komité for medisinsk og helsefaglig forskningsetikk, Vest-Norge (REK Vest)

Tone Larsen
tone.larsen@enivest.net
Psykiatrisk klinikk
Helse Førde

Deres ref	Vår ref	Dato
	2010/1641-5	26.8.10

Ad. Prosjekt: Brukermedvirkning i tjenesteutvikling

Det vises til din henvendelse, datert 23.8.10, der en ønsker avklaring av hvorvidt prosjektet krever unntak fra samtykkekravet for brukere som ikke deltar i forskningsprosjektet.

REK Vest v/ leder behandlet saken.

REK presiserer at dette er et forskingsprosjekt, men prosjektet er ikke fremleggingspliktig for REK da formålet er helsetjenesteutvikling, ikke ny kunnskap om helse og sykdom. Behov for unntak fra samtykkekravet for annen type forskning skal dog vurderes av REK.

All forskningsdeltagelse skal som hovedregel være basert på samtykke. Spørsmålet i denne saken er om det kreves unntak fra samtykkekravet for informasjon man kan komme over fra andre, ikke forskningsdeltakere, på avdelingen/posten. Forskingsmetoden deltagende feltobservasjon representerer store utfordringer med hensyn til personvernet. I en situasjon der pasienter skal observeres direkte eller indirekte er det ikke til å unngå at personidentifiserbare helseopplysninger kommer frem uten at de er relevante for prosjektet og uten at det var tilsiktet.

Etter en helhetsvurdering er REK av den oppfatning at det ikke er behov for å innhente samtykke fra disse i denne saken. Forskeren har jobbet på avdelingen som sosialkonsulent frem til 30.6.10 og skal tilbake til samme jobb når forskningsprosjektet er ferdig. Forskeren vanker allerede i pasientenes private "hjem", og kan dermed langt på vei sies å ha kjennskap til opplysningene, jf. helsepersonelloven § 23. REK legger videre vekt på at helseopplysninger fra disse ikke skal inngå i prosjektet og det ikke vil foretas noen nedtegnelser/fotografering/opptak. REK legger til grunn at forsker vil se bort i fra eventuelle helseopplysninger som fremkommer gjennom spontane meddelelser på avdelingen som ikke er utbedt. Det presiseres at forskers taushetsplikt under alle omstendigheter gjelder uinnskrenket.

REK legger også vekt på at forsker har en avtale med institusjonen og dermed har forankret prosjektet med ledelsen lokalt. REK anbefaler at deltagerne på institusjonen gjøres kjent med prosjektet før oppstart ved oppslag slik at forskers tilstedeværelse ikke skaper noen uro.

Postadresse:
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Regional komité for medisinsk og helsefaglig forskningsetikk, Vest-Norge
Telefon 55 97 84 97 / 98 / 99

Besøksadresse:
2. etasje, sentralblokken, Haukeland universitetssykehus

Vennlig hilsen

Jon Lekven
leder

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Tone Larsen
Psykiatrisk klinikk - Seksjon Tronvik
Helse Førde
6995 KYRKJEBØ

Vår dato: 25.08.2010 | Vår ref: 24667 / 3 / JSL | Deres dato: | Deres ref:

TILRÅDING AV BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 05.07.2010. Meldingen gjelder prosjektet:

24667	*Brukermedvirkning i tjenesteutvikling*
Behandlingsansvarlig	*Universitetet i Stavanger, ved institusjonens øverste leder*
Daglig ansvarlig	*Tone Larsen*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

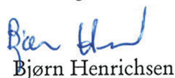
Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, vedlagte prosjektvurdering - kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://www.nsd.uib.no/personvern/prosjektoversikt.jsp.

Personvernombudet vil ved prosjektets avslutning, 30.12.2013, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen


Bjørn Henrichsen

Juni Skjold Lexau

Kontaktperson:Juni Skjold Lexau tlf: 55 58 26 35
Vedlegg: Prosjektvurdering

Personvernombudet for forskning

Prosjektvurdering - Kommentar

24667

Det behandles sensitive personopplysninger om helseforhold, og om at en person har vært mistenkt, siktet, tiltalt eller dømt for en straffbar handling (jf. pol § 2 nr 8 bokstav b og c).

Utvaglet består av 50-100 ansatte og brukere ved en enhet ved psykiatrisk klinikk i et helseforetak i Norge. Formålet med prosjektet er å legge til rette for brukermedvirkning i tverrfaglig spesialisert rusbehandling til menn og kvinner med narkotika-, medisin- og/eller alkoholavhengighet, og å integrere brukerkunnskapen i behandlingspraksis. Noen deltakere kan ha en tilleggsdiagnose, mens andre ikke har det. Det vil kun bli inkludert samtykkekompetente personer i prosjektet. Utvalget informeres i første omgang på et felles informasjonsmøte, men det vil også bli utlevert et fyldig informasjonsskriv (jf. informasjonsskrivet mottatt per e-post 25.08.2010). Utvalget samtykker skriftlig og muntlig til deltakelse.

Opplysningene samles inn gjennom spørreskjema, personlig intervju, gruppeintervju, observasjon og deltakende observasjon. Det registreres direkte og indirekte personidentifiserende opplysninger i prosjektet. Direkte personidentifiserende opplysninger oppbevares separat fra det øvrige datamaterialet. Det vil bli benyttet lydopptak og det kan bli aktuelt å benytte videoopptak.

Det tas høyde for at det behandles personopplysninger om tredjeperson, da brukerne kan komme til å omtale tjenesteyterne ved institusjonen. Tredjepersoner vil bli muntlig og skriftlig orientert om prosjektet. Vi minner forøvrig om at tjenesteyterne ikke har anledning til å oppgi personidentifiserende opplysninger om brukerne, da denne informasjonen er taushetsbelagt.

Lyd- og videoopptak og navnelister slettes, og det øvrige datamaterialet anonymiseres senest ved prosjektslutt, 30.12.2013. I publisering av studien kan noen av tjenesteyterne være indirekte personidentifiserbar ved at det opplyses om hvilken stilling vedkommende innehar. Det innhentes imidlertid samtykke til dette.

Vi forutsetter at det innhentes nødvendige tillatelser fra øvrige instanser. Vi tenker da spesielt på at det undersøkes hvorvidt det vil være nødvendig å søke om dispensasjon fra taushetsplikten hos REK. Dette fordi forsker, gjennom sin tilstedeværelse ved institusjonen (observasjon, møtedeltakelse, videoopptak o.l.), kan få tilgang til taushetsbelagt informasjon om brukere som ikke har samtykket til deltakelse.

Vi forutsetter at utkast til spørreskjema, intervjuguider, observasjonsguider, dialogmøteguider m.m. ettersendes ombudet før igangsetting av disse delene av prosjektet.

Appendix 2 – Inquiry consent, and elaborated consent

Forespørsel om deltakelse i forskningsprosjektet

"Personal- og brukermedvirkning i tjenesteutvikling"

Bakgrunn og hensikt
Dette er en forespørsel til deg om å delta i en forskningsstudie som har som mål å utvikle tjenestetilbudet på ved psykiatrisk klinikk i Helse Førde. Studien vil være basert på medvirkning fra både brukere og personal, og formålet med studien er å legge til rette for økt brukermedvirkning i utvikling av offentlige tjenester.

Helse Førde, 6800 Førde er både ansvarlig for forskningsprosjektet og databehandlingsansvarlig.

Hva innebærer studien?
Denne studien er lagt opp til at det skal være en planleggingsdel, en gjennomføringsdel og til slutt en formidlingsdel. Det er behov for at representanter for brukere og personal deltar i alle delene av forskningsprosjektet. Prosjektperioden er fra august 2010 til desember 2013, og det er ikke forventet at hver enkelt kan delta i hele perioden. Studien vil bestå av kompetanseheving/kursing, individuelle intervjuer, fokusgruppeintervjuer, gruppearbeid, dialogkonferanser (presentasjon og dialog mellom brukere og personal) og formidling av forskningsresultatene (eks. lage informasjonsbrosjyrer, presentasjoner m.m.). Alle intervjuene blir tatt opp på lydbånd, og der dette ikke forstyrrer gruppeprosessene blir gruppearbeidet og dialogkonferansen også tatt opp på lydbånd. Disse opptakene er kun til analyse av prosessen, og vil bli gjengitt i anonymisert form i publisering av studien. Dersom vi i løpet av forskningsprosessen finner ut at vi vil bruke lydopptak, video eller bilde i media eller i presentasjoner utenfor kan dette gjennomføres, men dette innebærer at det underskrives på et eget samtykke om dette.

Frivillig deltakelse
Det er frivillig å delta, og du kan når som helst trekke deg fra prosjektet uten å oppgi grunn. Dersom du trekker deg vil alle data om deg bli anonymisert og dette vil ikke få konsekvenser for ditt forhold til forsker, behandlere, arbeidsgiver eller andre. Avsluttes du deltakelsen uten at å gi beskjed om at du trekker deg, vil forsker bruke ditt bidrag til forskningen på samme måte som beskrevet.

Forskningsprosjektet er ikke tenkt som en del av selve behandlingen som tilbys, dermed opprettholdes terapi- og aktivitetstilbudene uavhengig av dette prosjektet. Hovedtanken med prosjektet er allikevel å utforske forbedringspotensialet på forskningssamarbeidet vil derfor kunne bidra til endring i disse tilbudene.

De som ikke ønsker å være med i studien fortsetter bare som vanlig i behandling og blir ikke registrert eller referert til i forskningen. Da jeg vil være tilstede ved institusjonen, kan jeg likevel indirekte få tilgang til taushetsbelagt informasjon om brukere som ikke har samtykket til deltakelse, gjennom observasjon og tilstedeværelse på møter og lignende. Regional Etisk Komité har derfor godkjent at jeg kan gjøre dette, så lenge denne informasjonen ikke benyttes i prosjektet. Resultatene fra studien vil jeg søke å publisere i nasjonale og internasjonale tidskrift, i tillegg er tanken å utvikle en mer tilgjengelig erfaringsrapport/brosjyre i samarbeid med brukere og personal.

Personal- og brukermedvirkning i tjenesteutvikling
Tone Larsen – Helse Førde / Universitetet i Stavanger

Hva skjer med informasjonen om deg?
Forsker/prosjektleder er underlagt taushetsplikt og alle opplysningene/dataene i forskningen behandles konfidensielt. En kode knytter deg til dine opplysninger gjennom en navneliste som lagres på et annet sted enn resten av dataene. Det er kun prosjektleder som har adgang til navnelisten og som kan finne tilbake til deg. Navnelisten og indirekte personidentifiserende opplysninger, lydopptak, foto/video blir slettet ved prosjektets avslutning, senest 31.12.2013.
Opplysninger som registreres om deg er navn, kjønn og alder. Navnet blir byttet ut med et pseudonym i resultatformidling. Deler av personalgruppen får i tillegg registrert profesjon eller ansvarsområde. Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien.

Forskningsprosjektet er meldt inn til Regional Etisk Komité (REK: Prosjektnr. 2010/: 2010/1641) Personvernombudet for forskning, Norsk Samfunnsvitenskapelig Datatjeneste (NSD: Prosjektnr: 24667). REK har godkjent min tilstedeværelse på ██████████ og personvernombudet tilrår at prosjektet gjennomføres.

Lønn og kompensasjon
Brukerne får lønn for sin deltakelse. Satsen er kr. 300,- for deltakelse i avtalt intervju, samling, arbeidsmøte eller presentasjoner utover dette. I arbeid med produksjon av tekst og utvikling av erfaringsrapport/brosjyrer avtales godtgjørelse på forhånd.
Personalet får avspasering for deltakelse utenfor ordinær arbeidstid.
Reise, opphold og materialbruk som er avtalt på forhånd, kompenseres for økonomisk mot godkjent kvittering.

Deltakernes ansvar
I denne studien har alle deltakerne et ansvar for å bidra til et positivt samarbeidsklima, hvor man respekterer hverandre og gjør sitt beste for å gi konstruktiv og ærlig tilbakemelding i hele prosessen. Alle deltakerne har et ansvar for at opplysninger om meddeltakere oppbevares konfidensielt. Når samtykket signeres, signerer man samtidig på å ikke gjengi navn og opplysninger som kan identifisere noen av de andre deltakerne.

Rett til innsyn og sletting av opplysninger om deg
Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har rett til å få korrigert eventuelle feil i de opplysningene som er registrert i forskningsprosjektet. Dersom du trekker deg fra dette prosjektet, vil innsamlede opplysninger om deg bli anonymisert.

Informasjon
Prosjektdeltakere vil bli orientert så raskt som mulig dersom ny informasjon blir tilgjengelig som kan påvirke deltakerens villighet til å delta i studien.
Prosjektdeltakere skal opplyses om mulige beslutninger/situasjoner som gjør at deres deltagelse i studien kan bli avsluttet tidligere enn planlagt
Som deltaker har du rett til å få informasjon om utfallet/resultatet av studien. Ta kontakt med forsker/prosjektleder ved studiens avslutning dersom du ønsker denne informasjon.

Veileder Hildegunn Sagvaag (tlf: 51834236 epost: hildegunn.sagvaag@uis.no) og biveileder Jan Erik Karlsen ved Universitetet i Stavanger har også tilgang til datamaterialet.
Universitetet i Stavanger (Postadresse: 4036 Stavanger) ved administrerende direktør Per Ramvi er databehandlingsansvarlig.

Studien har full finansieringsgaranti fra Regionalt Kompetansesenter for Rusforskning i Helse Vest (KORFOR), og planen er å søke Helse Vest om midler til videre finansiering

Dersom du ønsker å delta, undertegner du samtykkeerklæringen.
Informasjon eller spørsmål til studien, kan rettes til prosjektleder/forsker.

Prosjektleder Tone Larsen kan kontaktes på tlf: **95 83 04 47** eller
epost: **tone.larsen@helse-forde.no**

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Samtykke til deltakelse i forskningsprosjektet

Jeg har mottatt skriftlig og muntlig informasjon og er villig til å delta i forskningsprosjektet

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Dato

Signert av prosjektdeltaker/medforsker

Jeg bekrefter å ha gitt informasjon om forskningsprosjektet

Dato

Signert av prosjektleder/forsker Tone Larsen

Personal- og brukermedvirkning i tjenesteutvikling
Tone Larsen – Helse Førde / Universitetet i Stavanger

Utdypende forklaring om forskningsprosjektet

Bakgrunn

Forskningsprosjektet baseres på medvirkning fra både pasienter og personal, og formålet med denne studien er å legge til rette for økt brukermedvirkning i utvikling av offentlige tjenester. Ønsket er at både pasienter og personal er med som medforskere helt fra planlegging og gjennomføring av endring (selve forskningsprosessen) til formidling av resultatene (eks. lage informasjonsbrosjyrer, presentasjoner m.m.). Pasienter som ønsker å delta kan ikke være i avrusningsfasen.

For at skal kunne forbedres er det både behov for pasientenes og personalets innsikt i og erfaringer med behandlingen som tilbys. Begge gruppene har kompetanser som er viktige for en helhetlig oversikt av forbedringspotensialet for og dette er grunnen til at du blir spurt om å delta i prosjektet. Målet med studien er at folk føler seg trygge nok til å komme med forslag til endring, samtidig som at man har påvirkningskraft nok til å kunne videreføre disse endringsforslagene. Studien vil være delt opp i tre deler: Planlegging, gjennomføring og samarbeid/formidling.

Et handlingsorientert forskningssamarbeid

Planleggingsdelen begynner i august 2010 og varer ut oktober samme år. Oppgaver for medforskere fra pasientene og personalet i planleggingsdelen: Utvikle spørsmål til intervju i gjennomføringsdelen, kartlegge behov for forbedring, planlegging kompetanseheving/kursing for pasienter og personal.

Gjennomføringsdelen begynner høsten 2011 og vil vare til vår/forsommer i 2013. Denne delen starter med kompetanseheving/kursing for pasienter og personal. I gjennomføringsdelen benyttes en reviderte intervjuguide i medforskerledede intervjurunder med pasienter og personal (pasienter intervjuer pasienter og personal intervjuer personal). Først gjennomføres fem individuelle intervjuer med pasienter for å kartlegge deres syn på behandlingstilbudet og hva som bør ha prioritert fokus i en endringsprosess. Det vil også bli fem medforskerledede gruppeintervjuer med personal, ledelse og pasienter om forbedringspotensialet for behandlingstilbudet. Neste skritt er et samarbeid mellom forsker og medforskerne fra pasientene om å presentere deres erfaringer med behandlingstilbudet for personal og ledelse, og komme med forslag til endring i et dialogseminar. Pasientene underviser personalet og det tilrettelegges for dialog (i f. eks gruppearbeid, fellesdiskusjon m.m) om temaene som er tatt opp. Personalet får tilslutt i oppgave å observere egen praksis utfra selvobservasjonsskjemaer som medforskerne har utviklet.

Personal- og brukermedvirkning i tjenesteutvikling
Tone Larsen – Helse Førde / Universitetet i Stavanger

Etter en selvobservasjonsperiode er det nå personalet sin tur å lede medforskningsprosessen og å bli intervjuet (fem individuelle intervju og tre gruppeintervju). Dette er for å kartlegge deres syn på behandlingstilbudet, deres tanker om hva som er blitt formidlet i dialogkonferansen og hva som bør ha prioritert fokus i en endringsprosess. Deretter starter personalet i samarbeid med forsker arbeidet med å formidle sine tanker om endringspotensialet i ett nytt dialogseminar. Etter dialogseminaret blir det pasientenes tur å registrere personalets praksis i observasjonsskjema som er utviklet av personalmedforskerne.

Samarbeid/formidlingsdelen begynner våren 2013, og nå samles både personal og pasienter i et samarbeid hvor prosessen evalueres. Her er det viktig å få frem om det er skjedd forbedring, i så fall hvilke endringer og hva dette innebærer. Samtidig vil det være relevant å formidle erfaringene som er gjort og hvilket potensial for utvikling som fremdeles finnes på [redacted].

For å få dette godkjent som en doktorgrad må forsker publisere til sammen 4 artikler i nasjonale og internasjonale tidskrift. Erfaringene fra prosjektperioden gjøres også tilgjengelig i en erfaringsrapport/brosjyre som er laget i samarbeid med pasienter og personal. Dette produktet vil kunne distribueres slik at andre kan både få innblikk i hvordan man kan øke brukermedvirkning i offentlige tjenester, i tillegg til lærdom om selve endringsprosessen. Formidling kan også bety eksterne presentasjoner fra pasienter og personal. Tanken er at pasienter og personal selv avgjør målgruppene som erfaringene bør formidles til lokalt, regionalt eller nasjonalt.

Fordeler og ulemper

Noen av fordelene med medforskningen og forskningsprosjektet i sin helhet vil kunne bli forbedring av behandlingstilbudet i tillegg til en personlig utvikling blant deltakerne. Det å snakke foran grupper av ulik størrelse kan både gi god trening i presentasjon, men det kan gjøre at man eksponerer seg mer enn det som er tenkt fra begynnelsen av. Derfor er det viktig at deltakerne sammen med forsker vurderer på hvilken måte man er komfortabel med å presentere noe, for det er ikke et krav for å være med i studien at man står for formidlingen. For de som føler at de er klare for å presentere noe for målgrupper utenfor [redacted] er det viktig å vurdere hvilke forholdsregler som bør gjelde, slik at man ikke eksponeres mer enn ønskelig.

Noe som kan oppleves som en ulempe er gjenkjenningspotensialet lokalt for faggrupper med lav representasjon (overlege, psykolog, enhetsleder). Studiet er anonymisert, men i presentasjoner og formidling vil det være en risiko for gjenkjenning av at det er [redacted] som er organisasjonen som studeres. En måte forsker har valgt å møte denne utfordringen på er at direkte sitater og referater fra møter og intervjuer godkjennes av medforskere/deltakerne før de kan benyttes i offentliggjøring.

Ved spørsmål ta kontakt med Tone Larsen på tlf: 95 83 04 47
eller epost: **tone.larsen@helse-forde.no**

Appendix 3 – Interview guide: Individual interviews with staff

Spørsmål til individuelle intervju med personale

Visjon og behandlingsfilosofi
Hva er ditt mål i møte med pasientene?
Opplever du at vi har en overordnet en visjon å strekke oss etter på posten?
Støtter behandlingsfilosofien for posten målet ditt i møtet med pasienten?

Motivasjon
Hvordan kan du motivere pasientene til å nå målet sitt med behandlingen?
Skal vi stille flere/mer krav vedrørende deltaking?
Har du noen idé om hva vi kan gjøre om pasienten viser manglende deltaking/interesse for avtaler og ukeplaner?
Hvordan takler du at pasientene endrer atferd?

Kommunikasjon
Hvordan kan du bygge gode relasjoner til en pasient. Har du noen eksempel?
Hvor mye pasientkontakt opplever du at du har i gjennomsnitt i løpet av en arbeidsdag
Opplever du at pasientene tar nok kontakt?

Hvordan kan en opprettholde avdelingens rammer og innhold i behandlingen?

Hva er viktig for deg i arbeidet med pasienten, rutine eller endring?

Hva kan være positiv/negativt med organiserte samtalegrupper for pasientene der personalet ikke deltar?

Primærkontakt
Hvordan ser du på rollen som primærkontakt?
Føler du at du har gjennomslagskraft som primærkontakt, opplever du å få gehør?
(hos ledelsen/kollegaer/hos pasientene)
Føler du deg trygg i rollen som primærkontakt? (Begrunn svaret)
Får du oppfølging/veiledning i forhold til rollen din?

Bemanning ut fra pasientenes behov
Føler du at kursing og fagoppdatering går i veien for den innsatsen du kan gjøre i behandlingen?
Har du tanker om bemanningen på [navn på enheten]?
Har du opplevd situasjoner/tidspunkt der du som personal har reagert på bemanningen på din vakt?

Økonomikartlegging, oppfølging og handling
Føler du som miljøpersonal at du blir orientert om hele situasjonen til pasienten?
Hva vektlegges mest, sosiale, medisinske eller andre behov?
Blir det fort nok iverksatt tiltak i forhold til behov utenfor institusjonen?
a) økonomi
b) jobb
c) planer om utskriving
d) ettervern/tilbud i kommunen
e) bosted

Lik og ulik behandling
Får alle pasientene lik behandling uansett fremtreden, og gjelder dette for
a) de som ikke roper høyest?
b) de som kan oppfattes som konfliktskapere?
c) de som fremstår som trygge og sterke?
d) de som ruser seg på huset?
e) de som ruser seg på permisjon?
f) de som ikke kommer tilbake fra permisjon?
Hvilke tiltak blir vurdert når dette skjer?

Taushetsplikt
Hvor langt bør taushetsplikten strekke seg for
a) personalet?
b) pasientene?

Rusing
Klarer du å se om en pasient er ruspåvirket?
På hvilken måte ser du det?
Trenger du å få styrket din kompetanse på rusfeltet?
Kan vi nyttiggjøre oss erfaringer og kunnskap fra pasienter/brukere?
Hva tenker dere om at tidligere pasienter/brukere som underviser personalet?
Tror du pasientene er trygg på at rusing blir oppdaget?

Rustesting
Hva er dine erfaringer vedrørende rustesting av pasienter?
Er rutinene gode nok, eller er det noe som bør endres?

Konsekvenser ved rusing på avdelingen
Har vi de samme reglene i begge etasjer eller praktiseres ulike konsekvenser?
Er det rom for unntak?
På hvilken måte blir rusing på klinikken håndtert overfor
a) den som ruser seg
b) medpasienter: de involverte (inkludert de som ikke er medskyldig) og de uinvolverte?
c) personalet

Personal- og brukermedvirkning
Påvirker tilbakemeldingene fra forskningen praksis?
Hvordan tilrettelegger ledelsen for personal- og brukermedvirkning?
Har du påvirkningskraft i forhold til utvikling av behandlingstilbudet?
Hvordan opplever du at du tilrettelegger for brukermedvirkning?
Opplever du at denne forskningsprosessen er konstruktiv?

Appendix 4 – Interview guide: Individual interviews with patients

Spørsmål til individuelle intervju med pasienter

1. **Forventninger**

a) Hvilke forventninger hadde du før du kom i behandling?

b) Hvordan opplever du at behandlingen er i forhold til forventningene?
Hva er viktig for deg når du kommer i behandling?

c) Hva slags forventninger har du til egen brukermedvirkning i behandlingen?

2. **Kommunikasjon**

a) Har du noen erfaringer med at personalet viser pasientene hensyn og respekt?

b) Hvordan opplever du de individuelle samtalene med personalet og behandlere?

c) Hvordan opplever du å bli spurt om planene for dagen?

d) Opplever du å få gehør for det du sier på morgenmøtet?

e) Hvordan påvirker det deg når du blir hørt / du ikke bli hørt? Spør du mer eller gir du opp?

f) Syns du det er vanskelig å uttrykke det du mener ovenfor personal og ledelse av frykt for konsekvenser i behandlingen?

g) Hva synes du om at det er dannet et forum der pasienter, personal og ledelse møtes og diskuterer saker?

Tror du at pasientenes sak når frem og bidrar til forbedring av behandlingen?

3. **Motivasjon**

a) Hva motiverer deg til å delta i aktivitetene?

b) Er det noen personer som bidrar til å motivere?

c) Hva oppfatter du som motiverende og hva oppfatter du som mas fra personalet?

d) Hvem blir du mest motivert av: Personale eller medpasienter, og hvorfor er det slik?

4. **Utstyr og bemanning**

a) Er det behov for nytt utstyr for å gjennomføre aktivitetene?

b) Har du forslag til nye aktiviteter som kan slå an?

c) Opplever du at det er nok personale på jobb?

d) Føler du at personalet kan møte deg og dine behov?
Hva er positivt og hva er negativt?

5. Behandlingstilbudet

a) Føler du deg trygg på posten?

b) Hva bidrar til at du føler deg trygg/utrygg?

c) Hvordan opplever du gruppeaktivitetene som arrangeres på [navn på enheten]?

d) Hva er rettferdig individuell behandling?

e) Hva skal til for å skape en god atmosfære på posten, i aktivitetene, på turer osv?

f) Hva tenker du om at behandlingstilbudet er både for menn og kvinner?

g) Hvilke muligheter opplever du at du har til å påvirke egen behandling?

h) Hva syns du om kontrollrutinene på huset?
Eks. Kontroll av post, bagasje og handleposer?

6. Kompetanse

a) Savner du noen kompetanse blant personalet?

b) Blir du imøtekommet når du ber om å få behandling fra de ulike behandlerne?

c) Hva tenker du at personalet trenger av kunnskap for å se rusing?

d) Føler du at du får brukt dine evner og din kompetanse i behandlingen?

e) Hva syns du om å bidra i praktiske gjøremål i posten som vask, mat, oppussing m.m.?

f) Hvordan opplever du at det er å ha studenter i posten?

Har du noe å tilføye?

Appendix 5 – Interview guide: Multistep focus groups

Flerstegsfokusgruppe intervjuguide

Hovedpørsmål: Hva kan gjøres for å forbedre behandlingen ved [navn på enheten]?

- Hva er bra nå og hva kan gjøres bedre?
- Hva er mindre bra, og hva er forbedringspotensiale her?
- Hva er behandlingspotensialet på arbeidsterapien, idrett, turer, utegruppa, musikkterapi?
- Hva er behandlingspotensialet pasienter i mellom?
- Hvilken rolle skal personalet innta i miljøet?