Public Management Review

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/rpxm20

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To cite this article: Kristina Bakke Åkerblom & Jonathan Quetzal Tritter (02 Sep 2024): Empowered service users: peer workers co-production in Norwegian mental health and substance use services, Public Management Review, DOI: 10.1080/14719037.2024.2397471

To link to this article: https://doi.org/10.1080/14719037.2024.2397471

PUBLIC MANAGEMENT REVIEW
https://doi.org/10.1080/14719037.2024.2397471

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Empowered service users: peer workers co-production in Norwegian mental health and substance use services

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ABSTRACT

Employing citizens with first-hand experience as 'peer workers' (PW) is increasingly prevalent in mental health and substance use organizations. This Norwegian qualitative exploratory study presents three benefits of PWs identified by managers, health professionals and PWs: empowered co-production, fluid positions, and catalysing cultural change. PWs have less clearly defined roles but can exercise discretion and autonomy. As service user experts, they often have direct access to management and can promote change in professional practice in multidisciplinary settings. PWs have the potential to catalyse change and increase legitimacy and trust, but greater attention is needed to strategies that support their integration.

ARTICLE HISTORY Received 11 December 2023; Accepted 21 August 2024

KEYWORDS Co-production; peer workers; mental health and substance use services; knowledge mobilization; user involvement

Introduction

The current health policy agenda emphasizes the importance of reorganizing public services to serve better those they are intended to help. To achieve this, service organizations increasingly involve citizens and civil society organizations in developing and implementing services. The collaboration between public servants and citizens to improve existing services is generally referred to as co-production. Professionals usually manage it, but professionals can also facilitate or support citizen-led co-production (McMullin 2024). Recent research suggests that co-production may not lead to the same positive outcomes across policy fields, but it can be particularly effective in improving public value in healthcare and social services (Acar, Steen, and Verschuere 2023). However, co-production between citizens and public sector organizations (Alford 2014) to tackle complex issues and ensure citizens have more influence remains challenging and underdeveloped. In this article, we explore how employing citizens with first-hand experiences of mental health and substance use and

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Supplemental data for this article can be accessed at https://doi.org/10.1080/14719037.2024.2397471.

service use, as peer workers (PWs), in co-production roles, affects service organization, provision, and development.

Mental health and substance use service organizations commonly employ service users who have successfully overcome their challenges as peer workers (PWs) (Kent 2019; Mirbahaeddin and Chreim 2022). PWs often function as service providers in partnership with health professionals as a part of multidisciplinary teams (Åkerblom and Ness 2023; Byrne et al. 2022). However, their roles and tasks vary depending on the organization they work for. Some PWs have specific duties in evidence-based treatment programmes, some provide support based on their lived experiences, others have organizational responsibilities at different levels, including service user engagement and acting as service user representatives at a strategic level (Åkerblom and Ness 2023).

This study is situated in Norway, which is known, like other Nordic countries, for its expansive public sector, with most health and welfare services being publicly funded and managed (Ibsen et al. 2021). The government incentivizes the employment of PWs in mental health and substance use services to promote changes in service delivery and organizational structures (Åkerblom 2022). Hiring PWs is consistent with current reforms, which are underpinned by new public governance and co-creation (Åkerblom and Ness 2023), encouraging increased collaboration with citizens and service users to reinforce trust in public service organizations, strengthen democracy, and promote innovation (Torfing 2019). Furthermore, their employment aligns with the country's ongoing Trust Reform, focusing on granting more discretion and autonomy to the lower levels of organizations and enhancing communication and collaboration across services and systems (Svare, Johnsen, and Wittrock 2023).

PWs are employed specifically to utilize their personal experience and knowledge of using similar services. When they work with healthcare professionals in multidisciplinary settings, they seek to ensure that service user perspectives are integrated into the organization and delivery of services. However, specialized professionals typically oversee the operational framework and make decisions in mental health and substance use service organizations. When former service users become PWs and work alongside these professionals they may be seen as challenging health professional's authority, status, and expertise limiting the potential benefits of applying a greater diversity of knowledge and skills to service provision (Ansell and Torfing 2021).

Much research has examined the obstacles to involving PWs (Åkerblom and Ness 2023). Mental health service research has identified that well-functioning partnerships with PWs can be constrained by poorly defined roles and professional staff concerns about a lack of training (Ibrahim et al. 2020). Additionally, some professional staff may still view PWs as patients, leading them to reject advice for changing practice and instead reaffirm established approaches (Ibrahim et al. 2020). Collaborating with PWs in the co-production of services may be limited due to power differentials and service users involved in voluntary co-production risk being quickly co-opted (Croft, Currie, and Staniszewska 2016; El Enany, Currie, and Lockett 2013). Yet, involving former service users in paid positions as PWs may address issues apparent in voluntary co-production where service users may not feel able to voice their opinions (Chauhan, Croft, and Spyridonidis 2023; Park 2020).

The ability of PWs to influence co-production processes and outcomes depends on several factors, including the purpose of their involvement and the timing of their participation. Voorberg, Bekkers, and Tummers (2015) suggest that some co-production roles such as being involved in the early stages of a process, including

initiation and design, are likely to have more influence than those involved later. Co-production roles in service implementation are less likely to disrupt existing practices, while others may contribute to (re)-designing the content of services or the approach to delivery.

The need to collaborate with and activate the knowledge of those most likely to be service users during development is recognized in the co-design literature and Knowledge Mobilization models (KMb) (Langley, Wolstenholme, and Cooke 2018). Co-design practices aim to involve users in the design team, recognizing them as experts in their own experience (Trischler, Dietrich, and Rundle-Thiele 2019). This literature suggests that collaboration with those familiar with a particular context may lead to more specific and context-sensitive solutions (Langley, Wolstenholme, and Cooke 2018). Facilitating service user involvement and noting which service users are involved is vital in co-design studies (Trischler, Dietrich, and Rundle-Thiele 2019). Hence, selecting PWs and achieving effective partnerships requires facilitation and consideration of the knowledge-sharing and transfer challenges.

PW's roles are characterized by fluidity. Unlike their health professional colleagues, they rarely have formal credentials and are separate from the traditional health system hierarchy. However, PWs are often viewed as experts due to their personal knowledge as service users. Being positioned outside existing hierarchies can also create opportunities for self-definition and agency. A recent study suggests that PWs can resist co-optation by positioning themselves as non-professionals and leveraging their knowledge and expertise in co-production processes (Chauhan, Croft, and Spyridonidis 2023). However, the extent to which PWs can leverage their service user expertise as a resource depends on the fit between their background and experience and the organization where they are employed. For instance, PWs who have used services for depression may not fully understand the challenges of drug addiction. Selecting PWs with firsthand experience of particular health issues, however, is more likely to result in service user knowledge relevant to the context. How PWs leverage their service user knowledge, position themselves, and are perceived as knowledgeable experts by other stakeholders, including service users, health professionals, and managers is shaped by their familiarity with a particular service context.

In this article we explore in depth how PWs can affect service provision and assist the development of their employing organizations. We address an important gap in the literature by considering how PWs serve as co-producers through knowledge mobilization and strategically draw on their personal and professional networks to shape and catalyse change in the content, organization and delivery of services.

Our research adopted a qualitative approach, documenting the perspectives of managers, health professionals and PWs working in multidisciplinary teams in mental health and substance use service organizations in Norway. Our primary research question is: 'How do managers, health professionals, and PWs experience ways PWs affect mental health and substance use services?' In the rest of the paper, we present the main concepts informing the analysis, explain the study's methodology before presenting and discussing the findings.

Conceptual background

Citizen co-production roles

Citizens can collaborate with service organizations in various co-production roles to implement and create services. These efforts often use the prefix 'co' in conjunction with primary activities, such as co-design, co-deliver, and co-evaluate. Voorberg, Bekkers, and Tummers (2015) identify three typical roles citizens play: initiators, co-designers, and co-implementors (Voorberg, Bekkers, and Tummers 2015). The initiators are citizens who take the initiative to create services; co-designers participate in (re)-designing the content or processes of service delivery; and co-implementors take over the performance of specific activities previously carried out by a service organization (Voorberg, Bekkers, and Tummers 2015, 1347). However, the ability of citizens to influence collaborative processes and outcomes depends on the nature, timing, and purpose of their involvement (Nabatchi, Sancino, and Francesca Sicilia 2017; Steiner et al. 2023; Torfing, Hagedorn Krogh, and Ejrnæs 2020). Involving citizens as initiators and co-designers at an early stage generates greater influence than involving them later as co-implementers (Voorberg, Bekkers, and Tummers 2015). On the other hand, involvement in service provision and implementation is less likely to disrupt established practices and therefore has a lower impact (Torfing 2019). In mental health and substance use, it is common to involve individuals with lived experience in research projects (Goldsmith, Morshead, and McWilliam 2019; Wyder et al. 2021), in part a consequence of requirements for research funding. Although these individuals may influence the research topics and methodology, there is no guarantee their input will influence the actual design or development of services.

Knowledge mobilization

Knowledge Mobilization (KMb) is defined by Langley, Wolstenholme, and Cooke (2018) as 'the activation of available knowledge within a given context' (585). The active involvement of users in designing and implementing public services is a widely discussed in public management research and practice (Osborne, Radnor, and Strokosch 2016; Trischler, Dietrich, and Rundle-Thiele 2019). Co-design approaches focus on facilitating knowledge sharing to help citizens contribute to the (re)design of services. However, this can be challenging because knowledge production, sharing, and application are unique to each individual or group. KMb perspectives, as pointed out by Langley, Wolstenholme, and Cooke (2018), emphasize that knowledge is created within the context of its use, highlighting the importance of socialization and tacit forms of knowledge. This reinforces the need to collaborate with those most likely to use solutions (Oborn, Barrett, and Racko 2013). Individuals sharing experiences in a familiar context can more easily exchange knowledge as their mutual appreciation of the setting permits better exposure to tacit knowledge (Langley, Wolstenholme, and Cooke 2018); the individuals' skills, ideas and know-how, including the beliefs and mental models used to solve problems (Collins 2013). Collaboration with those who know a specific context may lead to more specific and context-sensitive solutions (Langley, Wolstenholme, and Cooke 2018). As knowledge transfer will be context-dependent, so too is what is accepted as knowledge and power imbalances and differences in expertise between individuals and groups influence both.

Social positioning

Individuals within a group may hold different social positions and exercise power differently shaped by their seniority, profession, and social connections (Battilana 2011). In service organizations, collaboration and the ability to bring about change is shaped by power dynamics and social hierarchies (Comeau-Vallée and Langley 2020). Individuals who hold higher-status positions tend to have access to greater resources, wield more power and have greater opportunities to drive change but may be content with the current situation to defend their existing social position (Battilana 2011).

In contrast, those in lower-ranking positions and at the periphery of an institutional environment can be more willing to initiate change and challenge the status quo (Battilana 2011). However, bringing about change as an individual within an organization can be difficult, as it requires convincing others to change and adopt new practices. Implementing change often depends on managers having access to relevant resources and the necessary authority.

These concepts work together to provide relevant insights into ways in which PWs can shape practice and organizational development. PWs have different entry points through their co-production roles, creating opportunities to enact agency on behalf of mental health and substance use service users. KMb perspectives emphasize the necessity of collaborating with people familiar with a particular context and highlight how the mobilization of lived experience and service user knowledge may require facilitation. For PWs to influence the organization, content, and delivery of services, utilizing their lived experience is vital. PWs are employed within multidisciplinary teams and settings, so their effectiveness depends on their relationship and interaction within these contexts. The concept of social position highlights how collaborative relationships within multidisciplinary teams are affected by power dynamics and social hierarchies and influence PWs' opportunities to initiate or influence organizational change.

Methodology

This research used a qualitative exploratory approach guided by a social constructionist epistemological perspective (Gergen 2023) that acknowledges how understanding and meaning are formed through interactions between people in their social environment (Gergen 2023). This implies that knowledge creation is not impartial but is influenced by individual positions and power dynamics (Tjora 2018). This is particularly relevant in this study as we explore how different stakeholders perceive and evaluate the significance of PWs and how they create meaning and understanding through their interactions.

Data collection

Focus group discussions gathered stakeholder perceptions, opinions, feelings, and attitudes on PWs. Data from the focus groups draws on participant interactions and shared experiences rather than individual statements (Krueger and Anne Casey 2015; Tritter 2019). Methodologically, focus group data is from not only individual participants but also the interactions between them. This provides added depth beyond that provided by semi-structured interviews. In addition, focus group discussions provide

an opportunity to reflect on the composition of the multidisciplinary teams where the PWs are embedded and to explore collective responses to PWs rather than the responses of particular individuals. As the aim of the research was how PWs were perceived in-situ, this method generated data that accurately reflected this phenomenon. We anticipated that different categories of stakeholders might have distinct perspectives on these practices. Therefore, we convened separate groups for managers, professionals and PWs.

Participant recruitment and selection

The study employed purposive and convenience sampling techniques to obtain the most pertinent information or experience (Patton 2015). In phase 1, an email advertisement targeting managers with experience of employing and managing PWs was circulated to mental health and substance use service providers identified by A-Larm (the oldest national user and relative organization in the substance use field) in the five largest Norwegian cities. These sites were selected as they were likely to be early adopters of this relatively new initiative. Health professionals, in phase 2, were selected in parallel with managers recruicted in phase 1 by an email advertisement the managers forwarded to them. In phase 3, PW participants were recruited through an advertisement on the national website of the Peer Workers' Interest Association and were purposefully selected based on also having experience as user representatives in user organizations.

The data is based on 11 focus group discussions with managers, health professionals, and PWs in Norwegian mental health and substance use services conducted between May 2021 and June 2022. Due to COVID-19 restrictions, the majority of the focus groups were conducted digitally. Focus groups were carried out successively, starting with managers, health professionals, and lastly, PWs. All focus groups with managers and health professional participants were conducted digitally ensuring that these data were collected in a consistent manner. As pandemic restrictions eased in Norway, three of the four focus groups with PWs were conducted in-person in three different Norwegian cities, although one took place digitally. See Table 1 for the characteristics of participants in focus group discussions. Using digital focus groups facilitated participation by a diverse sample as individuals from across the country did not have to meet at the same place and time. Based on our experience of the focus groups with PWs there was no significant difference in the quality of the data or interactions between participants in digital rather than physical focus groups.

The data from the managers is based on 17 managers participating in four digital focus groups of 4–5 individuals, and some of the findings from these focus group interviews have been published previously (Åkerblom et al. 2023). The data from the focus groups with health professionals are based on 15 multidisciplinary mental health and substance use team members participating in three digital focus groups of 4–5 individuals. The data on PWs are based on 13 participants in three face-to-face and one digital focus group with 3–6 individuals. All focus groups were conducted in Norwegian. The extracts presented in the findings have been translated into English by the authors.

Research participants worked in different locations and were not necessarily members of the same multidisciplinary team or organization. As members of multidisciplinary teams, the participating health professionals included a range of different

Table 1. Focus group participants.

Managers		
Focus Group 1	6 Managers	Manager 1 (M1), Manager 2 (M2), Manager 3 (M3), Manager 4 (M4), Manager 5 (M5), Manager 6 (M6)
Focus Group 2	3 Managers	Manager 7 (M7), Manager 8 (M8), Manager 9 (M9)
Focus Group 3	4 Managers	Manager 10 (M10), Manager 11 (M11), Manager 12 (M12), Manager 13 (M13)
Focus Group 4	4 Managers	Manager 14 (M14), Manager (M15), Manager (M16), Manager 17 (M17)
Health Professionals		
Focus Group 5	5 Health Professionals	Music therapist (HP1), social worker (HP2), social worker (HP3), social worker (HP4), psychiatric nurse (HP5)
Focus Group 6	5 Health Professionals	Nurse (HP6), social worker (HP7), occupational therapist (HP8), social worker (HP9), psychologist (HP10)
Focus Group 7	5 Health Professionals	Psychiatric nurse (HP11), social worker (HP12), psychologist (HP13), child protection educator (HP14), social worker (HP15)
Peer Workers		
Focus Group 8	4 Peer Workers	Peer Worker 1 (PW1), Peer Worker 2 (PW2), Peer Worker 3 (PW3), Peer Worker 4 (PW4)
Focus Group 9	5 Peer Workers	Peer Worker 5 (PW5), Peer Worker 6 (PW6), Peer Worker 7 (PW7), Peer Worker 8 (PW8), Peer Worker 9 (PW9)
Focus Group 10	4 Peer Workers	Peer Worker 10 (PW10), Peer Worker 11 (PW11), Peer Worker 12 (PW12), Peer Worker (PW13)
Focus Group 11 *on Zoom*	3 Peer Workers	Peer Worker 14 (PW14), Peer Worker 15 (PW15), Peer Worker 16 (PW16)

professions. The primary objective of this study, however, was not to examine the variation between professions but this information is included in Table 1 and the extracts to illustrate how comments are distributed between participants and the focus group discussions.

This research centres on the impact of PWs in relation to managers and health professionals, whatever their professional backgrounds. Our data draws on the experiences of people working in services. We are reporting the perceived impacts of the collaboration with PWs and not collecting data on service performance. Our position is that the organizational orientation to a particular category of workers is shaped by the perceived impact they have on the organization, content and delivery of services and that this is distinct from any formal quantitative measures of 'impact'.

Facilitation of focus group discussions

Two PW co-researchers participated in this research: one male (PW1) and one female (PW2). Both contributed to developing the thematic guide for the focus groups. This guide identified themes and potential questions and served as a reference to guarantee

coverage of all topics during every focus group but was not disseminated to the participants. See Appendix 1 for an English translation of the thematic guide.

One PW co-researcher participated in each focus group discussion; PW1 attended the managers and health professionals focus groups, while PW2 participated in those with PWs. Each focus group started with the first author outlining the subject and format of the focus group and encouraging the exploration of participant's perceptions and experiences. The researcher and the PW co-researcher actively participated and ensured a smooth discussion, covering all topics. All focus group interviews were recorded and transcribed verbatim.

Data analysis

Systematic text condensation (STC) (Malterud 2012) was used to analyse the transcribed data. Based on a social constructionist stance, our analysis explores how the social relationships between actors determines what counts as knowledge. STC follows a four-step analytical procedure (Malterud 2012): (1) get an overall impression, (2) identify meaning-making units, (3) abstract the content of the meaning-making units, and (4) summarize the meanings.

The first author conducted the first step, identifying preliminary themes that emerged from the material, together with the two PW co-researchers. These primary themes were the starting point for step 2, where meaning units in the original text were identified, sorted by codes, and classified. Through specifying meaning-making units, unit subthemes were identified and the initial main themes were adjusted. In step 3, the extracted meaning units were rewritten in the first person as a continuous text for each theme (condensates). Finally, in step 4, the condensates were re-narrated in the third person and re-contextualized to 'elucidate the research question' (Malterud 2012, 800). This generates an analytic text presenting the major themes identified within the material answering the RQ, illustrated by excerpts from the original material representing the focus group discussions (Malterud 2012). The results from steps 2 to 4 were continuously reconsidered during the analytical process to ensure data credibility. The resulting findings were validated against the original transcripts and reviewed and confirmed in a meeting between the first author and the two PW co-researchers (Malterud 2012). The first and second authors discussed the findings, which form the basis of the article.

Research ethics

The Norwegian Agency for Shared Services in Education and Research gave ethical approval for the study. All participants provided informed consent. Participants replying to the first author directly were given information about the research and gave their written consent to participate. They were offered the opportunity to contact the first author after the focus group discussion for further information. The data has been anonymized. Among the health professionals participants, there was only one music therapist and one child protection educator. They are not identifiable as such professionals are commonly members of multidisciplinary teams, and study participants were drawn from service settings across Norway.

Limitations

Given the central importance of social interaction among participants in focus group discussions it is possible that participants may have emphasized their positive orientation towards PWs to impress others in the group, amplifying their intentions rather than their actual actions. We recruited participants from different service organizations and sites but did not consider the variations among these organizations, such as in-patient and acute services. Therefore, we cannot eliminate the possibility that variation in perceptions of PWs contributions may reflect a particular organizational context. The study incorporated two PWs as co-researchers with limited formal research qualifications or scientific research experience. However, their practical experience informed the data collection and enhanced the authenticity and credibility of the research.

Findings: how PWs can affect service provision and assist in the development of their employing organizations

The analysis identified three primary categories describing the ways in which PWs can affect mental health and substance use services from managers, health professionals and PW perspectives: 1) Empowered co-production roles, 2) The fluidity of the PW position, and 3) Catalysts for cultural change. Each category has related sub-themes, indicated in the text as sub-headings. (See Table 2).

Empowered co-production roles

Being present as employees within service organizations, PWs take on various co-production roles, including co-delivering, co-designing and initiating services. They serve as a liaison between service users, service providers, and the service system and they impact the content and organization of service delivery. Additionally, they identify areas for improvement and advocate for change by engaging directly with management.

Bridging the gap between professionals and service users

PWs were described as connecting and minimizing the gaps between health professionals and service users. Managers highlighted the ways that PWs serve at the border of the service, facilitating communication with service users. One said, 'PWs help us

Table 2. Illustration of the findings.

Primary categories	Sub-themes
1) Empowered co-production roles	*a) Bridging the gap between professionals and service users*
	b) Identifying areas for service development
	b) Accessing management directly
2) The fluidity of the PW position	*a) Not having clearly defined roles*
	b) Having the status of expert by experience
	c) Exercising agency
3) Catalysts for cultural change	*a) Building relationships with health professional colleagues*
	b) Developing more appropriate language
	c) Questioning what it is to act professionally

create services that are not so much- "us- the experts" and "you- the users"' (M1). Managers also mentioned how service users shared more information with PWs than professionals. Some health professionals noted difficulty forming alliances with service users and said PWs were often a safer, more efficient contact option. A psychiatric nurse in an acute hospital unit explained that there were often gaps between health professionals and service users, 'I think none of us professionals working here could ever be perceived as someone who had a rough time before' (HP10). An occupational therapist confirmed, 'With some patients, it is difficult because we are, in a way, representatives of the authorities who impose us [services] on them' (HP8).

PWs confirmed these findings, explaining that connecting with service users directly was easier for them than their professional colleagues. In addition, they mentioned that they often helped their professional colleagues to interact more productively with service users. One said, 'A part of our role is to bring the service users and professionals standing on separate islands shouting at each other together so they can start having a dialogue' (PW14). Their goal was often described as creating a platform for dialogue between two parties that felt isolated from each other.

Identifying areas for service development

Through working on the frontline, PWs often identified areas for service improvement. They explained that their lived experiences and local knowledge enabled them to comprehend situations better, 'A PW comes from a context and has some experiences that make it easier for them to contact people, get information, and easily recognize signs of this and that' (PW15). A common theme from the PW focus groups was their high level of outreach compared to their professional colleagues. As one PW noted, 'I work in an outpatient team; yet, while I work on the streets, my colleagues spend time in the office drinking coffee' (PW12).

PWs suggested that their support for service users often exceeded that provided by their professional colleagues. In different ways, they said, they were prepared to go the extra mile to help service users. A PW explained, 'Sometimes I get criticism because the service users I am responsible for are getting better help' (PW10). According to the PWs, going the extra mile meant being more available, drawing on their personal networks, providing help outside regular working hours, and persuading managers to provide what service users needed. In addition, the PWs discussed how they sometimes knew some of the service users, 'They (professionals) really cannot compare their work to mine. I know the service users from before; they are all my friends!'(PW12). Throughout the research PWs emphasized that providing support to service users based on their needs required going beyond regular service provision and acting differently from most professionals.

Managers said that PWs represented service users' voices and introduced new topics for discussion, 'Earlier, in our projects, we focused on the things we have learned to look for, which we have discovered is completely different from what a PW is concerned with' (M15). Managers noted that PWs could assist in improving specific issues faced by service users. All the managers declared that involving PWs who had similar experiences as the service user groups they served, was essential, 'We have benefited most when our PWs have identical experiences as our target service user group' (M9). Another manager confirmed, 'We only employ PWs with experiences of services similar to those we offer' (M2). All the managers stressed that PWs knowledge

helped them better understand the needs of specific service user groups. Moreover, some managers said they looked for PWs familiar with an area, such as those who grew up locally, as awareness of current issues in an area helped to foster communication with service users.

Having direct access to management

The focus group discussions confirmed that PWs and managers had established good communication and trust. Some managers disclosed long-standing efforts to solicit feedback from service users, which, with the assistance of the PWs, was fruitful. PWs were often confident that they had helped to improve services. 'They cannot afford to lose me now because what I have achieved in a year they have never achieved before. That disappears if they lose me' (PW13). PW discussions revealed that they had a degree of autonomy because of their relationships with managers and their accomplishments. One explained, 'My manager is flexible and trusts me; this gives me the chance to take on various tasks and expand my skills' (PW15).

In the focus group discussion, managers explained that PWs frequently questioned established practices, often in a fundamental way. Some also mentioned that PWs could help professionals notice things they missed or make them feel more confident in asking probing questions. Some managers went so far as to suggest that health professionals should listen to PWs more often as they could gain new insights and see their professional practice from a new perspective.

Additionally, the PWs said they continuously reported challenges identified by service users directly to managers. 'There is no "in-between" we go straight to the management' (PW11). Participants emphasized that they would not hesitate to report any 'bad practices' to management and considered this an essential aspect of their role as PWs. They also reported playing key roles in establishing local service user boards. PWs organized meetings of the boards and activities solely for service users providing a safe space for discussion. Occasionally, they said, they invited managers and health professionals to participate in order to communicate key points that service users raised.

While PWs reported establishing local service user boards, managers said they also asked PWs to serve on boards within the organization to inform strategic planning and governance of services. Moreover, several managers reported regularly inviting PWs to their management groups as their knowledge helped inform the discussions and better understand the needs of specific service user groups.

The fluidity of PW positions

It is common for PWs to hold fluid positions in an organization with their roles not clearly defined. Although they may lack credentialed expertise, they are often respected as knowledgeable service users, granting them expert status. However, the ambiguity around their position gives them greater flexibility in defining their organizational role and how they spend their time.

Not having clearly defined roles

Health professionals in the focus groups emphasized the need for clearly defined roles and tasks for PWs. They acknowledged that this required more attention from management, PWs, and themselves. A nurse said, 'This is a huge problem' (HP6). They discussed needing more clarity on how to use PWs in their service. An occupational therapist said, 'Generally, it is very unclear what they are supposed to do in our service' (HP8). Others revealed that PWs undertook similar tasks as the professionals. Additionally, some suggested that managers employed PWs without a plan on how to use them. A psychologist said, 'Many managers say, "We must have a PW", but then they may not know how to use them' (HP13). A social worker expressed concern that PW's undefined roles and autonomous decision-making could have negative consequences, 'The distinction between their work and spare time can become unclear if they meet people in self-help groups, at the gym or what in their spare time. - I leave work when I leave – but if they meet the service users in the evening, then their working day will be enormously long' (HP12). Some health professionals suggested that PWs needed to have their own professional environment. A social worker explained, 'Having their own professional environment can make it possible to think more systematically and for them to support each other' (HP15). Other health professionals felt that creating a professional environment would help PWs define their roles and activities and increase efficiency.

The status of an expert

Managers and health professionals value PWs highly and believe they should have been implemented earlier. A social worker said, 'We get so many questions from our service users where we are utterly blank because we have not been in that situation' (HP15). Typically, PWs were described as having influential positions in teams and workplaces and often functioning as advisors. A music therapist said, 'I often use the PW to understand better how the users feel' (HP1). While an occupational therapist noted, 'Our PW increases the whole team's competence; he sees early signs in service users that we might not notice and teaches us what these can be signs of' (HP8). Drawing on the knowledge and insights from PWs was seen as relevant for all the professionals in the multidisciplinary teams. As one social worker concluded, 'The most important task for PWs is to be available as a discussion partner for those professional employees who follow-up service users' (HP9).

Participants explained how PWs brought a different perspective and knowledge to their discussions, 'They usually have a slightly different point of view on things than we have in discussions' (HP3). PWs knowledge of service users was considered particularly valuable for service development. The music therapist said, 'It is essential that PWs are involved in those forums when new service offers are being developed' (HP1).

Some managers discussed a shift in valuing evidence-based and formal knowledge differently after recognizing the relevance of PWs' lived experiences. 'When interviewing new candidates for positions with us, I can truly tell them that experiences with mental health or substance use can be an advantage' (M6). For some managers, lived experience was a source of status, 'Those people [the ones with lived experience] are now considered as even more skilled and can get considerable authority within a field' (M14). Some managers reported including personal experience of mental health

challenges as an advantage, in job advertisements, as they regarded this as a valuable complement to formal qualifications.

A 'freer' role

PWs often reported that they had more freedom to challenge limits than their professional colleagues. Some PWs believed that their status as service users allowed them to make their own decisions. PWs acknowledged that despite being employed within the same system, they were not obligated to adhere as strictly to rules and regulations as their professional colleagues, 'We all know these rules are not meant for us, so we don't have to follow them' (PW14). PWs also explained that they were relaxed about going directly to management to address issues, whereas their professional colleagues were not. However, PWs also reported that their professional colleagues sometimes partnered with them to address issues with management, 'My colleagues always come to me and ask: Can you please raise this issue with management? Or say that?' (PW2).

The focus groups with professionals also discussed the greater flexibility of PWs' roles. Some mentioned that this flexibility was due to fewer formal tasks and responsibilities. Others noted that PWs had slightly different functions, with one nurse stating, 'They are supposed to be more like an inspiration to our patients' (HP6). Additionally, some mentioned that patients had fewer expectations of PWs, creating greater freedom in their work. A psychiatric nurse said, 'PWs can spend a whole day driving far out (location) and fishing with a patient who wants to fish' (HP11). While the professionals recognized the importance of this kind of activity for service users, they did not feel they had the flexibility, nor the time, to work in this way.

Catalyst for cultural change

Working alongside health professionals, PWs can play an important role in enabling cultural change in the workplace. Their presence allows them to establish relationships with their professional colleagues, support and develop how they engage with service users and constructively challenge professional conduct.

PWs build relationships with health professional colleagues

PWs reported building relationships with their professional colleagues. They said they established connections through helping them improve communication with service users, 'Being employed within the services means building relationships with people I work alongside' (PW1). The health professionals also confirmed collaboration with PWs, 'I do not consider PWs as different from any other colleague' (HP12) or 'By us, PWs are involved as everyone else' (HP4). Overall, professionals said PWs were valued colleagues and their contributions and opinions were as significant as those of other colleagues.

However, some PWs reported that they sometimes felt their professional colleagues only included them for appearances' sake rather than for genuine collaboration. A PW said, 'I sometimes wonder if they really want to collaborate with us or if it is only because it looks good on paper' (PW11). Other PWs considered their opinions only taken seriously if they matched the assumptions of their professional colleagues. Nevertheless, most PWs agreed that they had become more engaged within their

workplaces as time passed, 'Now, they want to include me in all meetings' (PW3). Although initially excluded, they reported gradually earning the trust and recognition of their professional colleagues who increasingly involved them. However, this evolution happened slowly and was often dependent on individuals, 'There are so many professionals within our organization who must change their mindset for a change to happen' (PW11). Commonly, it was acknowledged by the PWs that change takes time, and their professional colleagues needed time to learn how to utilize their expertise. 'We need to give them time to understand better what the role entails and what it is about' (PW15). PWs reflected that it was important for professionals to understand and recognize their strengths before starting to use them.

Language matters

Managers and health professionals noticed that PWs frequently corrected their language. They acknowledged that professional jargon could be a barrier, dividing professionals and service users. However, managers believed that PWs could communicate in a way that bridged this gap. Health professionals reported that PW corrections were often helpful and timely. A social worker explained, 'We tend to stick to what we know, but PW's corrections make us think twice' (HP15). Most professionals agreed that having PWs around improved their language. For instance, a nurse remarked, 'It has been a significant help at our workplace' (HP6). A psychologist followed up, 'Previously, we would say, "This patient is difficult or damaged", but now we say, "I am getting frustrated because this lady expects a lot from me that I cannot provide"' (HP10). The professionals credited PWs for these types of improvement.

Questioning what it is to act professionally

According to professionals, PWs sometimes challenged their perceptions of professionalism. Some professionals discussed a long-standing principle from their education of separating different types of information, ensuring a distinction between what was 'personal, private and professional'. They explained that they had been trained not to share anything about their personal life with service users but that this prevented them from being authentic. However, PW's presence challenged this norm. A social worker said: 'The fact that the PW has come in and worked with us, using their experiences – it probably has, at least for my part, lowered the threshold for what I use of myself' (HP2).

PWs also said they prompted professionals to consider their own practice, 'I often make my colleagues reflect on how they approach service users or why they chose not to follow up on their treatment' (PW3). According to professionals, working with PWs made them reconsider how they behaved with and approached service users. Many reported increased confidence and a willingness to be more personal. An occupational therapist said, 'I have more confidence in myself at work after I have had the chance to do more like a PW does' (HP8). Most professionals highlighted how PWs helped them to act and communicate in ways that reduced the distance to service users therefore establishing stronger connections.

Discussion

PWs engage in various co-production roles in service organizations that differ from traditional service user involvement (Åkerblom et al. 2023). In the following discussion, we explore some conditions that can directly and indirectly affect PWs 'impact' and consider the ways they can influence service provision and development. We take impact to mean changes made to service content, organization, or delivery that, in our data, are described and ascribed to PWs.

PWs play a variety of co-production roles

PWs can fulfill all three co-production roles identified by Voorberg, Bekkers, and Tummers (2015): co-implementers, co-designers, and initiators. As service providers, PWs undertake tasks performed by health professionals, such as interacting with or providing service users with relevant answers, playing the role of 'co-implementers'. Moreover, they were often depicted as setting an example for health professionals helping them to establish better relationships with service users. In various ways, their presence prompted healthcare professionals to modify their engagement with service users, enhance their performance and alter their approach to recruitment. By this, PWs contributed to changing the service delivery process by playing the role of 'co-designers'. Furthermore, drawing on their experiences working on the frontline, PWs identified areas for service improvement and often acted as 'initiators' of change by approaching managers directly.

Our research reveals that PWs are often seen as an essential link between professionals and service users. In their work, they often prioritize outreach and engage with service users and systems pragmatically and unconventionally, going beyond their professional colleagues' usual practice. PWs were often described as working at the border of services as 'frontline workers' reading situations, performing their jobs passionately and finding appropriate ways to act on the spot (Van Hulst, De Graaf, and Van Den Brink 2012, 437). In addition, our findings indicate that PWs are vital in connecting service users and health professionals, acting as boundary spanners (van Meerkerk and Edelenbos 2018, 14). As boundary spanners, they bridge between professionals and service users and translate between different forms of knowledge. Sometimes, they directly educate their colleagues to better understand service users and recognize early signs of acute episodes.

The employment of PWs in the context of health and welfare services in Norway is in line with the country's ongoing Trust Reform. These reforms focus on granting more discretion and autonomy to lower levels of organizations in managing daily activities, enhancing communication and collaboration across services and systems (Svare, Johnsen, and Wittrock 2023). Trust Reform can generate more opportunities for personnel with less formal education, such as PWs, and this may also help address the human capital crisis in the health sector (Jakobsen, Løkke, and Keppeler 2023). This point is also understated in the Norwegian report, 'Time for Action', suggesting that PWs are a valuable group to explore and invest in for the future of health and welfare services (NOU 2023, 4, 137). Additionally, PWs may play a crucial role as pioneers in promoting the value of practical and contextual knowledge within service organizations also outside of the mental health sector (Wang et al. 2024).

Our research suggests that a potential implication of hiring PWs is more effective and socially inclusive mental health and substance use services as they can help to rebuild trust between marginalized citizens and public institutions. This is especially important because those needing these services the most have the least trust in the system (Marmot et al. 2020). As such, PWs could play a crucial role in restoring trust between the most deeply affected citizens and service systems (Afsahi 2022).

The role of insider change agents

Our findings suggest that daily face-to-face interactions allow PWs to establish enduring relationships with managers and professionals and gradually gain acceptance and recognition. Their interactions foster mutual trust and enhance recognition of PWs as knowledgeable service-user experts. This increased trust and expert status grants them more discretion and autonomy.

Yet, when PWs join service organizations, professionals must adapt their practice to work alongside them. Our research suggests that PWs who are empowered often tend to lead co-production initiatives, with professionals following and supporting them. As highlighted in the research on citizen and service user co-production, their success hinges on receiving adequate support from professionals and managers (McMullin 2024).

Over time, PWs start to serve as advisors, helping professionals establish better relationships with service users and fostering trust between them. Working in multidisciplinary environments allows PWs to gain insider knowledge of service organization, the nature of the work and the challenges faced by professionals and the service system (El Enany, Currie, and Lockett 2013). As a result, PWs improve their own ability to communicate in professional contexts and become less confrontational, making them a more desirable type of involved service user (Stougaard 2021) and improving their capacity to operate and collaborate within a healthcare organization.

Our analysis suggests that PWs becomes more involved and keener to contribute to service decision-making as relationships in the multidisciplinary team develop. Managers value highly PW's service user knowledge and involve them in discussions about strategic matters. Several managers said they only hire PWs with similar experiences to their target service user group and some required them to have experience of using similar services. When selecting PWs based on their service user knowledge and belonging to a service user group, they recognize them as potential 'lead users' (von Hippel 1986, 791), who are 'those who have overcome their own high needs and can provide valuable insights in developing new solutions' (von Hippel 1986, 800). As such, managers acknowledge that PWs' knowledge and insights stem from their interactions within a particular context and that some knowledge is implicit and may not be easily transferred (Oborn, Barrett, and Racko 2013). A relevant challenge to effectively utilizing PWs' knowledge is finding ways for them to share this implicit or 'sticky' knowledge (von Hippel 1994, 430).

Creating 'the right' conditions for knowledge mobilization

Collaboration between PWs and service users creates opportunities to overcome the stickiness of their own service user knowledge. Working at the frontline, PWs are

exposed to situations and contexts they are familiar with. This exposure can activate their knowledge from these experiences and apply them to new situations. When working with service users, PWs can draw on their tacit knowledge and interact differently with them than their professional colleagues. Working alongside PWs creates opportunities for professionals to explore PWs' unique understanding of services, including knowledge they cannot easily express. Professionals working within services often share a common understanding of the context, although from different perspectives, that allows them to recognize the approach and knowledge of PWs. When professionals and PWs learn from each other to understand situations from different perspectives, it helps them work more effectively together (Langley, Wolstenholme, and Cooke 2018).

Aligning PWs' backgrounds and emphasizing this reflects the principle of 'most deeply affected' (Afsahi 2022). This principle considers the backgrounds of participants, including their vulnerabilities, and accords greater legitimacy to those affected by a given issue (Afsahi 2022, 53). Marginalized citizens may not place the same level of trust in professionals or service organizations (Steen et al. 2018). The principle of most deeply affected recognizes the power imbalance between actors in a setting (Bengtson 2021) and the need to differentiate between distinct forms and degrees of affectedness in considering degrees of legitimacy. When considering those affected by an issue, it is essential to examine the influence it has, as citizens who have been deeply affected often require different and more specialized services to meet their particular needs (Åkerblom et al. 2023).

As newcomers in mental health and substance use service organizations, PWs were seen as catalysts for cultural change in the workplace. When PWs are permanently present in service organizations, they build relationships with managers and health professionals through daily interaction. When professionals recognize the strengths of PWs, they begin to trust them, facilitating both communication and co-production (Bentzen 2019). However, PWs also frequently express frustration with communication barriers created by professional jargon. Yet, health professionals commonly recognize the importance of improving their language to ensure more effective engagement with service users.

PWs working with health professionals at the point of service delivery were often told to act as constructive disruptors, demonstrating how to assist service users differently. In doing so, PWs' presence directly affects how services are arranged and provided. Another essential result of having PWs as members of multidisciplinary teams was to encourage reflection, discussion and promotion of workplace deliberativeness (Leach 2006). PWs shared their insights and discussed them daily with their professional colleagues and managers. They were told to question practices and challenge traditions, disturbing the assumed wisdom and status quo. PWs were depicted as critically examining health professionals' and managers' arguments and creating a new basis for understanding, valuing, and accepting different perspectives. Through this process, PWs opened a new reflective space where professionals could consider their practice and language and help create a more extensive shared knowledge base. However, it is less clear if an increased level of deliberation is based on representativeness, which is an essential prerequisite for ensuring democratic service delivery (Steen et al. 2018, 286).

Pws' fluid social positions

PW's positions are characterized by fluidity. They are not employed based on formal credentials or expertise like their professional colleagues and thus do not fit into the traditional service hierarchy. Nevertheless, PWs are highly regarded for their understanding of the challenges and needs of service users. Our findings show that they differentiate themselves from professionals and leverage their service user knowledge as a resource (See also Chauhan, Croft, and Spyridonidis 2023). Health professionals frequently seek them out for advice on how to serve service users better and some advocate for their inclusion in all service development forums. Managers value their knowledge and involve them in service development processes and strategic boards. Some managers said job advertisements now listed lived experience of mental health or substance use challenges as a desirable attribute for health professionals. PWs' expert service user knowledge grants them a particular status within multidisciplinary teams and service settings.

While expert service user knowledge grants PWs status, it does not bind them to existing service frameworks. Instead, it seems to give them greater opportunities for self-definition. Our findings show that PWs do not conform to the usual hierarchy in established services. Instead, they actively differentiate themselves from these formal and informal structures, relying on their expertise as service users as the basis for their employment, a source of validity different from professional knowledge. In our study, PWs preferred to remain outside service and organizational hierarchies as it helped them to retain flexibility and opportunities to define aspects of their role and responsibilities.

PWs hold a particular hierarchical position in multidisciplinary teams and service settings due to their service user expert status, their understanding of service users and their direct access to managers. Their extensive knowledge as service users often provides differential access to management and, therefore, indirect access to formal power. Managers grant them informal capital and a status distinct from their professional colleagues by involving them in various organizational roles and tasks. This helps PWs become more 'powerful' within the multidisciplinary teams and service settings than would be expected from uncredentialed employees in mental health and substance use service organizations. Hence, PW's social position, knowledge of the organization, access to management, and acknowledged expertise as service users can amplify their voices within multidisciplinary workplace settings.

The ways PWs influence service delivery and organizations

Although some PWs are not directly involved in core service duties, they acquire a deep understanding of their organization and the challenges faced by their professional colleagues. PWs, as employees of service organizations, can play a crucial role in creating an environment that is conducive to co-production by positively influencing how multidisciplinary teams collaborate. This knowledge enables them to work effectively with professionals and enhance their co-production capacity. PWs in the workplace can help fulfill the ideal of deliberativeness (Leach 2006). Establishing relationships and gaining professional colleagues' trust helps create a nonconfrontational environment where health professionals may relinquish actual

or assumed constraints. PWs and their health professional colleagues working together can co-create a foundation of shared knowledge, resulting in new possibilities for service co-production. PWs bring fresh perspectives and knowledge, which may increase professionals' acceptance of different viewpoints, enhance communication, encourage reflective practice and promote more constructive interactions between professionals and service users.

Both managers and health professionals recognize the essential function of PWs as boundary spanning. Through this function, PWs can help service organizations fulfill a social obligation by more quickly connecting service users to services. Moreover, PWs are described as effectively bridging between service users and health professionals. Their role at the boundary of services facilitates communication with service users. This enables PWs to assist their professional colleagues to connect with service users and create a platform for dialogue and collaboration between the two parties. However, PWs need to be perceived as trusted actors by professionals and service users to fulfil this bridging function.

Not all healthcare professionals are equally satisfied with PWs, even though they have learned how to work with them. The majority of professionals in our study stated that they were not involved in service transformation. Ironically, while managers have improved the involvement of service users in organizational development, other employees in the organizations may not be so readily involved. Those working alongside PWs must 'live and manage' such changes despite their limited involvement.

Representative bureaucracy research suggests that public organizations should employ those who actively represent society's diversity, as this affects their legitimacy and trustworthiness (Johnston, Alberti, and Kravariti 2024). When public employees reflect and represent the communities they serve, this affects public service provision, institutional trust, and representative bureaucracies (Jakobsen, Løkke, and Keppeler 2023). This further emphasizes the importance of matching PWs' background and service experience with the multidisciplinary team or service setting and the specific service user groups. Hence, it is important to consider the potential credibility that can flow from PWs' experiential knowledge when recruiting and hiring them, pointing to the necessity of correctly identifying the characteristics needed to represent the most 'deeply affected' (Afsahi 2022).

Conclusion and implications

In Norway, the employment of PWs is a relatively new practice and therefore many health professionals and managers have little or no experience of working with them and many organizations do not have adequate policies in place to support effective integration. There is evidence that different health professionals respond in different ways to service user involvement. Therefore, we expect that within multidisciplinary teams, some professions might be slightly more resistant to the participation of PWs than others. Future research could usefully explore the relationship between professional background and orientation to PWs as well as those structures and policies that can most effectively support their role as catalysts for change. Our research is the first to document how PWs adopt fluid positions and function as boundary spanners who use their personal experience, connections and relationships to shape services around the needs of service users.

The human capital crisis threatens public service provision and requires the reconsideration of recruitment and selection processes (Jakobsen, Løkke, and Keppeler 2023). Our research identifies how PWs can play a crucial role in rebuilding trust in public institutions among marginalized citizens, who are often deeply affected and have little trust in the system. PWs, by acting as a bridge between service organizations and service users, increase legitimacy and trust. However, to maximize this benefit, PWs and health professionals should visibly represent the communities they serve. Hence, our research has implications for healthcare institutions hiring practices of both PWs and professional staff.

In Norway and Finland, we see the expansion of PWs not only in mental health, but also in other areas, such as cancer (Jones and Pietilä 2020). Introducing lived experience-informed 'mental health advocates' to address mental health workforce issues has recently been adopted by organizations outside the mental health sector, such as the energy sector in Australia, as a novel human resource management practice (Wang et al. 2024). PWs may serve as pathfinders to increase the acceptance and relevance of service user lived experience in the workplace. PWs are not the solution to the wide range of challenges facing health services in developed countries but they can address some existing challenges and help to ensure provision is shaped by the needs of service users and the most deeply affected and catalyse development in a way that generates increased legitimacy and trust.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the Foundation Dam, Norway, under Grant 2020/FO298954. TITLE PAGE Empowered Service Users: Peer Workers Co-production in Norwegian Mental Health and Substance Use Services.

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