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Learning for change in health and social care: Expertise by experience as a new form of civic engagement

Hanna Toiviainen and Elina Weiste

Hanna Toiviainen, Tampere University, Finland, ORCiD ID: **0000-0002-4431-1666**

Elina Weiste, Finnish Institute of Occupational Health (FIOH), Finland, ORCiD ID: **0000-0002-6879-6004**

ABSTRACT

Professionals in health and social care services need to develop competences for client involvement, to learn from the experiences of clients and patients. Trained health care volunteers with lived experiences of life and health challenges are referred to as experts-by-experience (EbEs). Practice-theory perspectives and the cultural-historical activity theory approach were used to analyze EbE participation as a form of civic engagement. A set of workshops organized in Finland is used as an example of collective development that brought together researcher-facilitators, professionals, clients, patients and EbEs to advance a shared understanding of how client involvement can be enhanced in work and everyday care. Findings highlight the contribution of EbEs to conceptual, practical, and collaborative development of practices. The authors underscore the importance of learning interventions in which EbEs participate, for a sustained development of health and social care services.

KEYWORDS (5-6)**:** client involvement, cultural-historical activity theory, Finland, learning interventions, practice theory, professional learning

Introduction

The relationships between work, learning and change offer interesting fields of exploration for adult education research (Fenwick, 2010; Malloch, et al., 2022; Rainbird, et al., 2004). In practice-based theorizing, learning is understood as being entwined in human activities rather than a separate function (Hager, et al., 2012; Reich & Hager, 2014; Schatzki, et al., 2005). Seeing learning as emergent and embedded in collective practices contradicts the behavioral-cognitive definitions of organizational learning (recently, Basten & Haamann, 2018) and extends the

analysis to include socio-material elements and different forms of agency (Fenwick, 2010; Hasse, 2013; Schraube & Sørensen, 2013) in the cultural-historical shaping of practices.

Miettinen et al. (2012) argue that the transformation of practices through human agency and reflection calls for intervention and social experimentation. They emphasize that learning for change entails influencing the *direction* of change, and that educational approaches, supplementing sociological practice theories, offer methods for this. Here, they refer to the application of the cultural-historical activity theory (Cole, et al., 2018; from here on *activity theory*), especially formative intervention models (Postholm, 2020; Sannino & Engeström, 2017) based on the theory of expansive learning (Engeström, 2015). Miettinen and colleagues (2009) notes that professional practices, such as nursing, are an outcome of *purpose* driven activities. A shared reconsideration of the purpose, in the activity theory framework *the object of activity*, is vital for changing and for improving practices.

> When an object [purpose of practices] changes, the means and division of labour also need to be transformed. For example, the medical tools and procedures developed for the treatment of infectious diseases do not on their own help in the treatment of diabetes or coronary diseases. These means need to be redesigned to meet the requirement of the changed object, a process activity theorists call 'remediation'. This development of new mediational means is a key process in learning, in whatever setting.
> (Miettinen, et al., 2009, p. 1318).

In this chapter, we build our analysis on these activity-theoretical concepts, especially on the notion of remediation and redesign of tools in transforming practices. The context of change and learning is the reform of the national health and social care system in Finland, in which *client or patient involvement* is an articulated policy goal (Jones & Pietilä, 2018) introducing a new element to the purpose of care practices. Client involvement blurs clear boundaries between knowledgeable professionals and the receivers of care; this is in part the aim of recruiting *experts by experience* (EbEs) to care units (Jones & Pietilä, 2020; McLaughlin, 2009), thereby strengthening civic engagement in specialized care practices. EbEs have lived experience of illness and are trained volunteers (Toikko, 2016). Unlike traditional volunteers (Duguid, et al., 2013, pp. 17–36), they receive modest financial compensation to work beside professionals during regular workhours. The activity of EbEs is two-fold: (1) they offer patients (or other types of clients) a low-threshold conversation space in which sharing their own experience is an important discussion tool, and they (2) mediate patients' care experiences to personnel and management in staff meetings and development events. They may also translate professional knowledge to clients (e.g., Lerner, et al., 2000).

The contribution of EbEs in the production of public services has gained attention, recently (Jones & Pietilä, 2020; Meriluoto, 2018; Noorani, 2013; Osborne, 2018; Tse, et al., 2019). EbEs bring new knowledge about clients to professional practices. They have skills for structuring information in ways that health professionals find acceptable and relatable (Jones & Pietilä, 2020). Meriluoto (2018) notes that EbEs can align their involvement with project specific demands; this illustrates *"how the process of determining what is accepted as expertise*

is, in itself, already a value-based assessment, accepted and evaluated in relation to specific political objectives" (Meriluoto, 2018, p. 18). In this view, *knowledge* is contingent, constructed, even contested. We will examine the contribution of EbEs in light of a common stance in EbE literature that presumes that groups of EbEs hold specific types of knowledge. This refers to knowledge acquired through experience, *lay* knowledge, that contributes to specialized professional, technical knowledge, and policy knowledge.

This chapter is structured as follows. We start by describing the conceptual framework of *activity theory*. The use of formative learning interventions as an educational approach to professional practices is outlined (Engeström & Sannino, 2021). Next, we describe the client involvement workshops—in which we participated as researcher-facilitators in Finland—that provide an empirical example in this chapter. Finally, we present our analysis, with a special focus on EbEs contribution, investigating the participant efforts to improve care practices.

Learning interventions for improving professional practices

The *Social and health care professionals as experts of client involvement* project aimed to promote professional practices that enable the involvement of clients in the planning and implementation of their own care (Weiste, et al., 2021). Engaging service users in specialized care practices requires new competences from professionals (Drisko, 2017; Juhila, et al., 2021; Kujala, et al., 2018; Rule, et al., 2016). Clients, patients and EbEs play an important role in this competence development. *Client involvement workshops* were organized in Finland in 2019-2021 to bring together these types of stakeholders, and to form shared understandings for the purpose of improving client involvement in professional everyday care practices. The workshops engaged altogether five organizations and service providers from eight municipal units for health and social care services. This study focuses on one of the organizations located in a non-metropolitan hospital district.

Workshops organized in the proximity of workplaces are considered a productive way to couple workplace learning with employee-driven development of professional practices. The *Change Laboratory* approach is a formative intervention methodology aligned with cultural-historical activity theory (Daniels, et al., 2013; de Gouveia Vilela, et al., 2020; Engeström & Pyörälä, 2021; Postholm, 2020; Sannino & Engeström, 2017; Virkkunen & Newnham, 2013). In this approach, entire work units and collaborative networks are invited to participate in a process of expansive learning (Engeström, 2015). Figure 1 provides an overview of the client involvement workshops that were designed based on the activity-theory principles (Figure 1; FIOH, 2021; Kurki, et al., 2019). The design is suitable for formative learning involving clients in a broad variety of professional practice contexts (see also, Engeström & Sannino, 2021).

The following section describes the sequence of workshops organized, one by one. In all workshops, small groups worked on the assignments given by the researcher-facilitators, thereafter, summarized in general discussion. Workshop conversations were audio and video-recorded, with the consent of participants, and analyzed for further reflections in workshops.

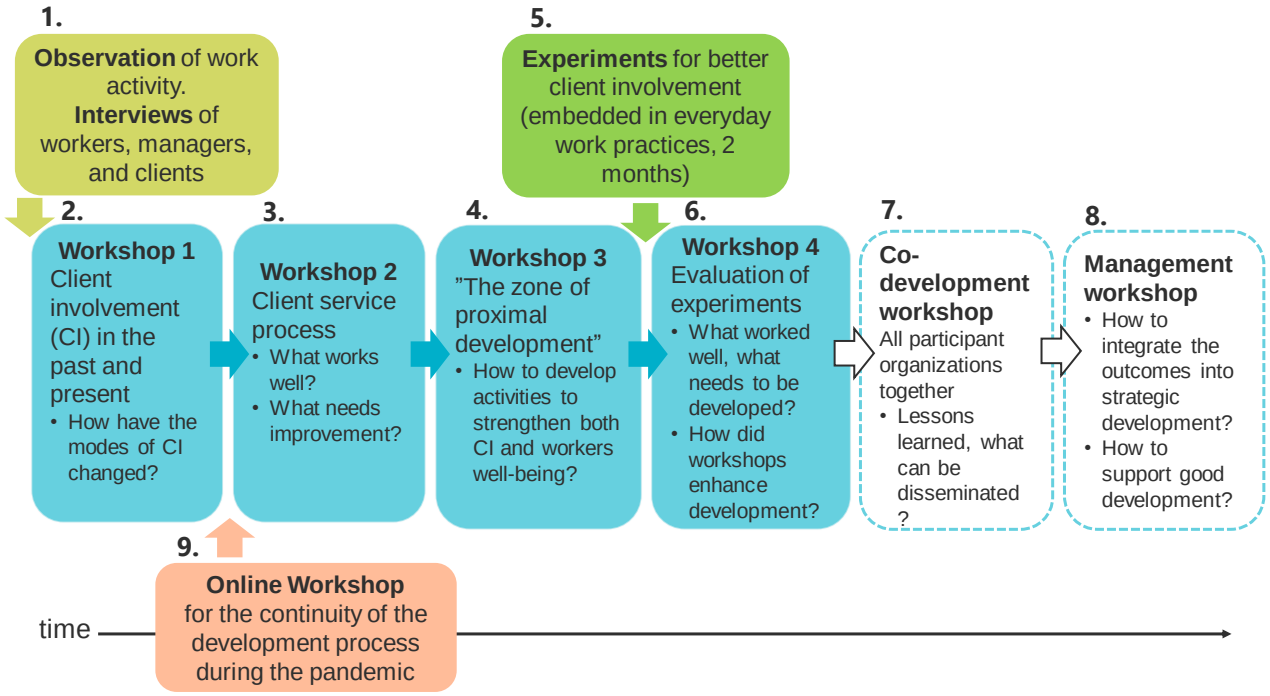

Figure 1. Client Involvement workshops. Development process in an ideal form (1–8) and taking place during the pandemic (9); figure constructed by the authors as a modification of FIOH, 2021.

Observation of professional practices and interviews with practitioners, managers, and clients

Prior to the workshops (Figure 1, phase 1), researchers collected data on professional practices and analyzed the data to construct a reference material for the collective discussion (*mirror material*, Virkkunen & Newnham, 2013). The material addressed how professional practice has developed; revealing historical layers of activity, raising new and contradictory perspectives and needs, unresolved dilemmas, and other issues aligned with the focus of each workshop session.

Workshop 1 on client involvement in the past and present

Participants constructed an overview of the history of professional practices in their organization (phase 2). Historical analysis was needed to understand the origins of the present practices, how the modes of client involvement have changed, and what needs developing. Facilitated by the researcher-facilitators their work revealed *developmental contradictions of activity* that emerge in and between professional and service-user practices. Contradictions are *"root causes of problems"* (Engeström, 2000, p. 966). The client involvement workshop provided an introduction to the identification of contradictions in professional practices, as a first step for future improvement efforts.

Workshop 2 on the client service process

Participants identified key issues for development through a close reading of current examples of service situations and sequences of practices presented in the reference material (phase 3). Groupwork and general discussion were guided by the questions: What works well? What needs improvement and in what direction? Participants were instructed to document small-scale case studies of their service encounters between Workshops 2 and 3. The assignments between the sessions provided additional material for the workshops (Kurki, et al., 2019).

Workshop 3 addressing the zone of proximal development

The third workshop (phase 4) addressed the development of professional practices using the concept of a *zone of proximal development* (Vygotsky, 1978). This refers to the supported learning actions for proceeding towards learning goals (Engeström, 2015). By working with versatile material and conceptual models, the participants collectively designed development experiments to improve both client involvement and practitioner well-being in accordance with project goals.

Experiments for better client involvement

The experiments were small-scale pilot studies carried out in the workshop participants' everyday practices over the course of approximately two months (phase 5). Each experiment was documented on a form describing how the pilot was carried out. The forms were shared and published for colleagues at the workplace of participating practitioners. For example, in one experiment, clients were systematically contacted three days after discharge for an interview; the interview was documented and included in their rehabilitation plan.

Workshop 4 for evaluating experiments

Participants were asked about what worked well in the pilot, and what in participants' view needed to be developed further (phase 6). How did the workshops contribute to improving practices? Practitioner experiences and observed outcomes of the experiments were assessed from the point of view of various stakeholders and practices using a wide range of questions. The fourth workshop concluded the broad participation of clients, EbEs, practitioners, and supervisors. A smaller number of the representatives of managers, department heads, and EbEs participated in the remaining two workshops.

Co-development workshop

Representatives from all district organizations participating in the client involvement project met to discuss the lessons learned (phase 7). The questions addressed what had been achieved by experiments in different contexts. Differences and similarities were scrutinized. The dissemination of the project outcomes was also discussed.

Management workshop

The commitment of leadership and management is crucial for the continuity and sustainability of employee-driven development. In each participating district organization, managers were invited to the last workshop, to discuss client involvement strategies and the establishment of concrete forums for dialogue and development in the future (phase 8). The question

of how workshop outcomes could be integrated into the strategic development at the participating organizations was addressed. The broader question of how a good development of practices could be supported moving forward was also addressed.

Online workshop

In spring 2020, the workshop process was interrupted by the outbreak of COVID-19 pandemic. It became necessary to include an online workshop to secure continuity in the client involvement project (phase 9). As the exceptional circumstances continued, all remaining workshops were carried out through video conferencing, which limited the participation of many clients and patients. In some organizations, experiments had already been carried out before lockdown, whereas at some of the participating organizations workshops had only just recently started. The online workshop analyzed in this chapter provided a discussion forum between workshops 1 and 2 (Figure 1, phase 9). However, as the following case reveals, participants started to elaborate on a *patient's consultation book* as a potential topic for an experiment to be implemented between workshops 3 and 4.

Analytical setting

We argue that efforts to improve professional practices comprise processes of learning, activity-theoretically formulated in the principle of the *remediation of activity* (Vygotsky, 1978). In practice, this emphasizes purpose-driven redesign of the means and tools that comprise and *mediate* professional practices (Miettinen, et al., 2009; Vygotsky, 1978). We have created an analytical framework with which to cover the numerous dimensions of collective change efforts as the contribution of multiple participants, perspectives, and interests. The framework is built on the definition of learning and development as collaborative concept formation (Engeström, et al., 2006; Vygotsky, 1934/1987). Rather than mere definitions of words, concepts convey *"multi-faceted and ill-bounded – sometimes monstrous – objects, ideas, and practices, which human beings and their institutions desperately try to understand and manage, or* ***conceptualize****"* (Engeström, et al., 2006, p. 47; highlight in original). Climate change and the pandemic exemplify ill-bounded global objects. Civic engagement in the production of public services represents a multi-faceted social challenge for communities to conceptualize. The contribution of the EbEs to the definition of client involvement in health and social care involves concept formation and learning in collaboration with clients, patients, professionals, and other stakeholders in the production, reception, and management of care services.

Methodologically, concept formation is thought to evolve through the interplay of everyday concepts and culturally available theoretical concepts (Vygotsky, 1934/1987). This socio-cultural understanding highlights collaboration practices and participants' capacity to bring together understandings and notions from diverse sources in order to create something new. From these methodological starting points, we propose an analytical framework for studying learning for change by means of *conceptual, practical, and collaborative efforts* to develop (theoretically: *remediate*) practices (Table 1).

Conceptual development efforts refer to theoretical concepts and generalized conceptualizations or principles culturally available for the participants. Examples of key concepts in the following analysis are *client involvement*, *interaction on an equal footing*, and *hearing out patients*. We understand *practical* development efforts as the everyday conceptualization of the socio-material and experience-based notions that participants construct in relationship to patients, in and outside institutional locations—examples are rooms, tools, and everyday interaction with staff. *Collaborative* development efforts highlight participant actions that create connections between different elements and agencies in networks of care. Readiness to *connect* (see Table 1) with clients, professionals, peers, and with material resources is an important aspect of learning and innovation in networks (Toiviainen, 2022).

In this chapter, our analysis focuses specifically on data from a two-hour online workshop in early summer 2020, Finland, during the COVID-19 pandemic (Figure 1, phase 9). Ten participants from a *joint municipal hospital district* organization attended the workshop: two *development specialists*, four *professional practitioners* from psychiatric care and somatic rehabilitation, two trained *EbEs*, and two *researcher-facilitators*. Adapted from the terminology used in this organization we formulate the following pseudonyms (in addition to the positions already mentioned): ‘psychiatric practitioner’, ‘psychiatric ward’, and ‘rehabilitation practitioner’, ‘rehabilitation ward’. Detailed speaker reference is omitted to minimize the possibility to identify individual participants. The online workshop was audio recorded and transcribed verbatim. The following section paraphrases words and utterances (in *italics*) from a discussion episode in which the patient’s consultation book (PCB) was discussed and elaborated on as participants took turns to talk about the PCB.

Discussion on the patient’s consultation book as a potential tool for client involvement

The discussion followed a researcher-facilitator presentation providing a thematic summary of discussions from the previous workshop on how client involvement appears in practice. One of the twelve listed notions was the *patient’s consultation book (PCB)* that the participants had further proposed to *support the client’s memory, ability to plan, provide information to close relatives and serve as a support for bringing up issues*. The researcher-facilitator explained how this idea was presented in the previous workshop and added that participants *might want to specify their understanding of the patient’s consultation book*, inviting them to describe its idea in more detail.

A development specialist recognized the PCB as a tool that was used at the rehabilitation ward where she worked. She explained that the book served as a calendar that helped patients to overview numerous meetings with various specialists during residential treatment. She noted that this allowed to turn around the concept of consultation hours so that the patient held an active role; in this view *it was the patients who held consultation hours for professionals, rather than vice versa.* She proposed that this allowed for organizing professional practices so that practices better responded to the *patient’s point of view*.

A rehabilitation practitioner supported the development specialist's view by asserting that the PCB contributed as a weekly schedule patients had on their bedside table. This was in the practitioner view an effective way to support patient involvement, allowing patients to be *aware of what happens next and not just waiting passively in their rooms.*

The psychiatric practitioner viewed the patient consultation book as a tool that could *restore patient agency* by enabling patients to *shift from a position of object to subject*. This professional welcomed the idea of a patient holding consultation hours and thought it would be worth considering in psychiatric ward.

One of the experts-by-experience noted that the use of a patient's consultation book in rehabilitation was very helpful. Having a great deal of experience of working with patients in psychiatric care she knew that oral instruction from staff was difficult for patients to take in and remember, whereas *written material often helped patients to understand daily procedures*. In these reflections, she positioned herself in-between the patients and the professionals, understanding both sides. She explained that whereas staff tended to think that patients were aware of instructions, however, *the conditions and abilities of patients do so vary*. She also suggested that the PCB could be helpful when patients were discharged, as *a tool for securing a continuation in the care from the hospital to outpatient care and rehabilitation*.

This expert-by-experience continued by pointing out that *psychiatric patients had told her that staff did not have time to talk to them or be present* when they would have liked to share their thoughts. She explained how she had *instructed patients to write down their thoughts and schedule a suitable time with a professional to talk about concerns and issues*. This would help the patients feel that their concerns were being heard. She showed an understanding of the constraints that practitioners worked under, that *situations at the ward can change rapidly* and the professionals may not be able to keep to times they have agreed.

At this point, another expert-by-experience joined the discussion, supporting and elaborating on her colleague's ideas. She commented on the commonplace criticism that *patients are afraid of not being heard or taken seriously when expressing their thoughts and wishes*. She softened the criticism by adding that these types of discouraging experiences *concerned not only psychiatric care, but also other health units; and even more broadly, were present in human relations in general, in all contexts*.

The first expert-by-experience narrated her own experience as a patient with temporary difficulties in producing logical speech. She felt that the doctor had not taken her symptoms seriously until she had written it down during this type of *illogical episode*. When she had shown the text to the doctor, she had felt that the doctor believed her more than when she had spoken about the difficulty. She framed this story as *additional, personal evidence of how writing can be a useful resource for a patient to be heard by professionals*.

The researcher-facilitator leading this discussion commented on the meaning of writing by theorizing about the important *meaning of written language*, its importance as a *material tool*, that

someone else can read. Both experts-by-experience agreed that it was one tool among others. To some patients, writing is a more *natural tool* for expressing oneself, whereas others find talking in a safe situation easier.

The psychiatric practitioner elaborated on the importance of the written being a material form. A patient's situation may cause very *fragmented recollections*. For instance, a *psychotic episode* may mean that a patient cannot obtain a holistic overview of care. The PCB can support the patient to form a more *holistic narration* of the treatment period, as a patient can revisit the steps taken in care interventions, by reading in the book.

The researcher-facilitator now realized that the PCB as a *concrete tool* inspired more discussion than the behavioral points on the slide addressing efforts to cooperate, to create frames and to listen to clients. In her view, the PCB helped to *highlight current practices and what might be a good way to increase client involvement*. For the researcher-facilitator the implementation of the PCB served the construction of the *zone of proximal development*, a possible direction to move in this community.

The psychiatric practitioner said that *interaction with patients on an equal footing* was something the professionals generally agreed was important, but that it was never emphasized too much. The PCB clearly highlighted the idea of *a patient being the one who defined issues for discussion; it helped patients to feel involved in their own care.* She indicated that the discussion had helped her to realize that the *PCB could add value to care practices if practices for using the consultation book were developed.*

At this point, the focus of discussion changed, and the researcher-facilitators introduced the next topic. In the closing workshop discussion, another development specialist who worked as a contact person between this participant organization and the research project, provided a summary. She noted that the *patient's consultation book could be taken up for further experimentation* in the next phases of the project (Figure 1, phases 4–5). The tool could be useful *for a range of wards*. This was challenging as the outbreak of pandemic and a major reorganization of the hospital district meant an interruption to the project. This development specialist advocated for the development of a PCB concept *as a model of activity or tool or something to enhance* [client] *involvement leaving them with a concrete goal and something to promote.*

Other participants supported the idea. The psychiatric practitioner repeated the idea of producing a holistic picture of the care period, something *slightly different* and *more personal* than a weekly timetable. The rehabilitation practitioner invited the psychiatric practitioner *to see how a patient's personal timetable system was used at her unit, possibly offering some tips for psychiatric ward.*

Interpretation

In the preceding episode, the patient's consultation book was discussed as a tool to support the agency of patients in exerting control over their own care—to enhance client involvement

(Jones & Pietilä, 2018; Weiste, et al., 2020). The personalized weekly schedule in each patient's room used at a rehabilitation unit was built on to include notes from patients. Notes written during treatment were seen as a way to support the formation of a holistic narrative and for supporting a continuity in the care trajectory from hospital to home. Viewed through the activity-theoretical framework, this demonstrates an empirical example of how redesigning a tool used in care practices contributed to a discussion on the purpose of professional practice, potentially expanding the object of activity (Engeström, 2015) to include holistic care for patients.

We interpret the elaborations on the PCB as *conceptual, practical, and collaborative development efforts* (theoretically: *remediation*; Miettinen, et al., 2009) to improve professional practices for strengthening client involvement in care (Table 1).

Table 1. Articulations of conceptual, practical, and collaborative development efforts for improved client involvement through the redesign of a patient's consultation book.

Participants (categories)	*Conceptual*	*Practical*	*Collaborative*
Researcher-facilitators (two)	- PCB as a concept - written language - material tool	- PCB as a concrete tool	- connects topics across workshops - connects participants (from somatic rehabilitation, psychiatric care, EbEs) - connects comments and concepts
Development specialists (two)	- shifting practitioner/patient point of view - patient in charge of consultation hours - PCB as model for practices of client involvement - PCB as concrete goal - added value	- patient calendar during residential care - potentially helpful for other units	- practical and conceptual use of PCB - steps towards development and experiments - PCB relevant for somatic rehabilitation, psychiatric care and other units
Practitioners (four)	- patient involvement - patient agency - from object to subject - documentation (material) - fragmented recollections - psychotic episodes - holistic picture, narrative about care	- weekly schedule on bedside table - giving patient an active role (vs. waiting in the room) - PCB is a resource for the patient to return to, for forming a narrative of care interventions	- connects somatic rehabilitation and psychiatric units, and further development of PCB as a tool - connects patient agency with care practices at care units

	- equal interaction - patient defines issues, feels involved - new dimensions of PCB; slightly different and more personal - personal timetable system for patient		
EbEs (two)	- cooperation - patient's condition - continuity in care - hospital–outpatient care and rehabilitation - experiences outside care - being heard	- oral instruction difficult to take in; written material facilitates daily ward practices - staff may think patient is aware - PCB tool useful in discharge - staff lack time, patients hesitant to talk - write down thoughts and schedule suitable time with worker - situation in ward (may change) - patients' fears and difficult experiences in life; feeling of not being taken seriously	- connects the development of tools in somatic and psychiatric units - connects patients and EbEs - connects patients and ward staff, ward practices - connects practitioner and EbE perspectives - connects ward and outpatient care - connects care with the broader life of patients -connects individual experience and general topic of development

Note. PCB= patient's consultation book, EbE=expert-by-experience. The articulations draw on statements about the PCB from a total of ten online workshop participants.
Source: Authors

One of the researcher-facilitators raised questions, facilitated the discussion, and made interpretations of participant articulations. She followed the development process practices (Figure 1) by presenting outcomes from a previous workshop. When participants elaborated on the topic of patient's consultation book (PCB), the researcher made a conceptual interpretation using the cultural-historical activity theory as a lens, emphasizing an understanding of the PCB as a tool (socio-material mediation, retooling) and a potential object for further development in the project and even in other contexts (in the zone of proximal development).

One of the participating development specialists commented on the PCB and shifted the focus from the professional-driven activity to the patient perspective. The other of the two participating development specialists suggested expanding practices using the PCB in two ways: (1) using the PCB as a development experiment in the next phase of the project and (2) considering the use of the PCB at a range of different care units. The developers stayed in the background

during the remainder of the discussion, possibly to give space to practitioners and EbEs working with patients in the wards.

The practitioners viewed the PCB as a tool that focuses not only on the patient perspective, but also positions the patient as an active subject instead of an object of care. The rehabilitation representatives shared their perspectives, and the psychiatric practitioner elaborated on the added value of using a patient consultation book in psychiatric care. She was inspired by the use of the tool in somatic rehabilitation, EbE input on the usefulness of writing for patients, and the researcher reference to materiality. The practitioners recognized that a PCB could support client involvement and help to move from a fragmented to a holistic view of care.

The EbEs contributed by articulating a wider meaning of *writing* as part of the care process. Through this notion, the idea of a weekly schedule was collectively expanded into a written, holistic and experiential narration of the treatment period. This was enabled by the EbEs offering their insights about patient experiences and by EbEs serving as bridge between patients and practitioners. Building on their knowledge of patient experiences, they contributed with proposals for how to advance the development of client involved practices. For example, by giving examples from their own experiences about being heard as a patient they contributed to the development of client involvement concepts. EbEs also suggested the expanded use of patient's consultation books for assuring continuity between hospital and outpatient care.

Discussion and conclusion

Learning undertaken to improve professional practices calls for a methodology of formative interventions powerful enough for stakeholders to respond to complex problems (Sannino & Engeström, 2017). The study reported in this chapter drew on two theories. First, *practice theory* allowed us to define learning as socio-materially embedded and emergent in work and civic activities (*e.g.,* Hager, *et al.,* 2012). Second, *cultural-historical activity theory* (*e.g.,* Cole, *et al.,* 2018) provided an elaborate framework for how to study the improvement of professional practices understood as collective concept formation. The empirical case we have presented was a research project for the development of care practices with increased client involvement at regional health- and social care providing organizations in Finland.

The contribution of EbEs to the development of client involvement was introduced as a form of civic engagement in health and social care. Historically, EbE practices started as civic activism and resistance, and have since evolved to a form of representative participation. This history displays the tension-laden relationships between EbEs and health- and social-care systems (Noorani, 2013). Today, EbEs are trained to work beside professionals at care units, which changes the nature of their civic engagement and is a potential source of tension in relation to traditional volunteering in professional care practices serving clients and patients (Duguid, et al., 2013).

In societies embracing lifelong education such as Finland, the development of civic engagement is typically supported through a wide range of training courses; even non-formal

education by NGOs and liberal adult education institutions tends to resemble formalized education (Toikko, 2016). Learning for improving practices in changing contexts at work, however, focuses on a particular aspect of education, both ontologically and epistemologically. Intertwined with ongoing challenges to professional practices, learning as a separate function is not an option. We argue for a development approach with learning integrated to changes in professional practices and, even further, learning by changing practices (Engeström, 2015). This is a radical approach, considering that all knowledge sources together, from professional specialization to the most vulnerable experience, are needed to deal with and redesign the purposes in care practices, such as client involvement. To provide a concrete example of how this can play out in practice, and to encourage others to implement the learning interventions outlined, we have described in some detail the client involvement workshops we organized in 2020 in Finland.

An analytical framework was designed to identify conceptual, practical, and collaborative development efforts for the improvement of practices *(remediation)*. The contributions by EbEs, practitioners, development specialists, and researchers provided the rich empirical evidence about the development of the patient's consultation book as a tool for client involvement (Table 1). The EbEs, representing a form of civic engagement in professional practice, played an active role in this process. As expected, the EbE contributions to the improvement of professional practices added a voice of experience to the joint discussions. EbEs shared their own experiences as patients, as well as those of the patients with whom they had talked mediating patients' care experiences to professionals (see also, Lerner, et al., 2000) in ways to which professionals could relate (Jones & Pietilä, 2020). By introducing new ideas and thereby expanding a shared understanding of the purpose of client involvement they also contributed to the conceptual development in health and social care services (Elg, et al., 2012).

In line with previous research (Jones & Pietilä, 2020; Tse, et al., 2019), the EbEs were skilled in contributing to the practical aspects of development efforts. EbEs helped to add knowledge from the lived practices and experiences of clients and patients to professional practices and to the improvement of care. However, our analysis also revealed their ability to independently contribute to collaborative development efforts. EbEs helped to connect various elements of networks of care across institutional boundaries and life spheres (Table 1). We also found that the conceptual contributions were not limited to practitioners and researchers—EbEs contributed to this as well. EbEs analyzed the patients' conditions, expanded the purpose of client-centered care practices (and tools) beyond the hospital wards to outpatient care. They reminded the professionals of a core concept of client involvement: hearing clients and patients in the implementation of their care. Our findings suggest that the contributions from experts-by-experience to the improvement of care practices represent only a first step in what we anticipate will be a growing role for civic engagement and education in the development of health and social care services. This emphasizes the need for sustainable models of learning for change at work.

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Research ethics

The study was conducted in accordance with *the premises for the responsible conduct of research* (Finnish National Board on Research Integrity, https://tenk.fi/en). Permission to collect the data was obtained from the health care district and the Ethics Committee of the Finnish Institute of Occupational Health (23 November 2018). Informed, written consent, including the right to withdraw from the research, was obtained from all participants. The identity of the participants has been protected by pseudonymization and anonymization and by minimizing any indirectly identifiable data.

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