Co-funded by the Erasmus+ Programme of the European Union

Erasmus+ Project

“European Standards for Peer Support Workers in Mental Health”

Recommendations

for the placement and involvement

of peer support workers in companies or teams

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Co-funded by the Erasmus+ Programme of the European Union

These recommendations for the placement and involvement of peer support worker in companies or teams were developed as part of the Erasmus+ Strategic Partnerships project entitled "European Standards for Peer Supporters" by the project team consisting of the following partners:

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1. Introduction to the product presentation

The Erasmus+ project called "**European Profile for Peer Workers**" responds to the need to create common working standards for "recovery companions" – people who play an increasingly important role in the mental health care system by assisting the service user in their recovery. However, the specific role that peer supporters play in the recovery process varies from country to country, reflecting the different stages of development of this position. Despite the differences, there is one underlying principle underlying: the work of a peer support worker is always based on the concept of recovery support by the so-called "expert by experience."

Recovery affects all areas of life, such as social engagement, housing, income, physical health, well-being, sexuality, etc. It is a complex process that requires a methodical approach. Importantly, recovery support should be provided by qualified specialists. Despite its relatively short existence, the profession of peer support worker has yielded such promising results that it is very likely to become an important element of therapy in EU countries in the near future.

Many psychiatric and therapeutic institutions across the EU include peer support workers in their teams. The number of people employed as peer supporters, including on a permanent basis, could increase even more if institutions could rely on standardised job descriptions, entry requirements and competency profiles for the profession.

Apart from the pan-European work standards for peer support workers, our international project team, consisting of partners from Greece, the Netherlands, Germany, Norway and Poland, has also developed a job description for the position, entry requirements, competency profile, and guidelines for the placement of peer support workers in the company and therapeutic team. These standards also constitute the basis for the education of persons who wish to find employment as peer support workers.

This product was developed under the guidance of Sørlandet Hospital HF, the Norwegian partner of the project. The team of experts also included representatives delegated by the project leader Grone-Bildungszentrum für Gesundheits- und Sozialberufe gGmbH (Germany), Cedu Sp. z o.o. (Poland) and experts from the Netherlands. This product is a set of recommendations for institutions and therapeutic teams that employ, or would like to employ, peer supporters. It contains a description of the potential jobs and positions

available to peer support workers in therapeutic organisations and teams, as well as an indication of the necessary conditions and further steps for their inclusion in different areas of work and in teams.

We hope that these recommendations will become a valuable guide for employers planning to recruit peer supporters, team leaders and members, and for peer support workers themselves. We also hope that the pan-European work standards developed as part of this project will ensure transparency of the position and enable comparability and recognition of relevant competences.

On behalf of the project leader – Grone Bildungszentrum für Gesundheits- und Sozialberufe GmbH gemeinnützig – I would like to express my sincere thanks to the authors of this publication for their contribution to improving the professional status of peer support workers.

Anna Block

Project Coordinator

2. Research methodology

Introducing new functions to an institution is a difficult and complex process. There are numerous opportunities, risks and challenges. The current organisational structure is changing. Space is needed for new staff members. Old positions and roles are not adapted to the new conditions. Difficult questions arise and problems emerge. Interests and influence groups feel threatened.

By introducing peer support workers into an organisation, we also introduce a function whose competencies and tasks are mostly unclear for the external environment and the organisation. In addition, the employment of peer support workers can also lead to a situation where employees belonging to the more traditional professions (nurses, therapists etc.) for different reasons feel insecure or threatened by this new role. One could say that the new team member, who until recently needed (our) help, has now become a helper themselves. The different traditional role assignments, which until now seemed clear, become more blurred and provoke emotional reactions. The goal of this product is therefore to create a tool which will help the employees and instititions to create a quality-based and positive process of introducting the peer worker into their organisation.

To develop these recommendations, the project team first identified the types of organisations interested in employing peer support workers. A questionnaire with key questions was then created to identify possible positions, responsibilities and status of PSWs within the organisations. The next step was to determine which groups of organisations were most representative for each country and then to establish the interview process. As a result, we have the following selection of organisations and country characteristics:

1. health facilities/mental care institutions, social welfare organisations – Norway (in this country, these organisations employ the biggest number of PSWs and their status within them is the most transparent);

2. NGOs, social service organisations – Poland (there are advanced programmes and plans to involve PSWs in these organisations; the discussion concerns their role not only in health care but also in social services. NGOs already hire them).

3. Companies and enterprises outside the field of health care and social assistance – Germany (in this country, there is a growing interest in peer support and the use of PSWs in business).

The research process:

1. Establishing a working group.

2. Mapping out the process, defining objectives and goals (what do we want to achieve?).

3. Finding out how IO5 fits together with the other IOs .

4. Desgining the questionnaire: how many questions, how to ask them, how many PSWs to interview, place of interview.

5. Preparing the questionnaire and selecting the institutions to be involved.

6. Sending out information and the questionnaires.

7. Collecting the answers.

8. Evaluating the results.

9. Writing a summary/memorandum based on the evaluated questionnaires about the position of the peer supporters in different organisations/companies.

10. Presenting the readymade product.

The collected questionnaires allowed us to conduct an analysis. The experts formulated general recommendations for employers.

3. Product description, recommendations, reference material

3.1 Recommendations for the successful implementation of peer support in organisations

Which preconditions are important for the successful introduction of peer support workers into organisations? When are frictions likely to occur between the team and peer support worker/care providers with experiential expertise? With the awareness of the possible processes that can play a role, adjustments can be made in time.

We speak of experiential expertise if someone

1. has long-term disruptive experiences with limitations and recovery from a psychological vulnerability or addiction;
2. has analysed and reflected on their own experiences, experiences of others and other sources of knowledge, whereby experiential knowledge is developed;
3. has learnt the skills to be able to use this experiential knowledge professionally in an appropriate manner (Dutch Professional Competency Profile for Experiential Experts, 2013).

Experiential expertise can be used in various roles (e.g. recovery support worker, educator, trainer). These roles can be combined within one function description.

The pillars underlying the development of experiential expertise are:

1. **Methodical self-help.** The group members together create space to explore and find their own meaning of experiences, new possibilities and strength.
2. **Emancipation.** There is an important task for experiential experts to change the existing frameworks of care so that the space required for recovery processes is actually created. Existing structures must make way for other (power) relationships that enable demand and client management in psychiatry.

In the professional use of peer support, the three following core tasks (with the use of own experiences) are central.

1. Support in individual recovery processes,
2. Organisation of recovery-oriented care,
3. Emancipatory influence of social processes aimed at combating stigma(tisation) and creating opportunities for social participation.

An important task in the professional use of experiential expertise is setting up and offering methodical self-help to support individual recovery processes. Lean et al. (2019) show that self-management interventions such as methodical self-help in addition to standard care improve recovery outcomes. Already at the intake for mental health treatment or support, which often involves a months-long waiting list, clients can be guided by experiential experts

to supportive training courses and self-help groups, which can help bridge the waiting period (Waterhout et al., 2020).

With the deployment of peer support in mental health, the aim is to change existing ideas and relationships, so that the space required for recovery processes is actually created and the provision of care better meets the clients' needs. Free space is an important value here. Free (diagnosis-free) space is a space offered to a person to rediscover their own life strength, make their own choices, give meaning to and find new possibilities. It is the metaphorical breathing space that everyone needs to develop in a unique and individual way. To achieve this, use can be made of experiential knowledge, professional practical knowledge and scientific knowledge.

Change leads to friction with existing structures. Therefore it is not surprising that adequate use of experiential expertise leads to tensions in a team or organisation. With awareness of these processes, adjustments can be made in time if necessary.

Based on the framework above, we formulate preconditions and points of attention in the form of recommendations to successfully make use of experiential expertise (*IO5: Recommendations for the position of peer support workers in companies and teams*). This product also provides information that can be used to develop a training course for managers (*IO6: Seminar concept for heads of psychiatric institutions and teams concerning the activities of peer supporters (entry requirements, key competences, position in the company*).

Experiential expertise can be deployed in different roles. Two commonly used ones are:

1. **Peer support worker**

   A peer support worker employed in a separate team of peer support workers, with their own role and answering to the team leader. The role of the PSW is separated from direct professional care provision: the PSW offers recovery support in the form of self-help and influences professional care by giving care providers feedback from the perspective of clients.

2. **A care provider with experiential expertise**

   A care provider with experiential expertise employed in a team of care providers, answering to the manager of that team. This person uses their personal experience with mental illness/vulnerability as an addition to their work as a professional care provider. This combined role enables them to coach their fellow care providers from both the professional and the client perspectives, and make the system more user friendly.

Differences between the two roles lead partly to differences in points of attention.

Although different peer support roles can be chosen, the preconditions and points of attention for the successful introduction of peer support are not necessarily different. Good

practice requires a good infrastructure. In collecting preconditions and attention points, as seen below, we consulted scientific literature on the use of peer support in mental health care (see the list of publications at the end of this document). In the United States in particular, a “school” has emerged in recent decades for research into the added value of peer support in promoting recovery and recovery-oriented care and, the conditions for using this added value to its fullest (e.g. Mowbray et al., 1997; Chinman et al., 2008; Cook et al., 2012; Davidson et al., 2012; Mancini, 2018; Nossek et al., 2021). We also drew on the Dutch Generic Module Experiential Expertise (2015), and the report on the meeting of the working group “Scaling up experiential expertise” (personal communication D. Boertien, 2020).

A. Preconditions

Deployment of peer support in mental health care institutions does not happen by itself. In recent decades, several countries have cautiously pioneered the employment of (former) clients in regular care. It has become clear from this developing practice that the success of integration of peer support in existing mental health care institutions depends on a number of preconditions.

1. Vision of recovery, recovery support and the use of expertise by experience

The implementation of peer support is not possible without an explicit vision on recovery and recovery support in the organisation that is known to all employees and sufficiently supported by management.

- **Vision documents**. The institution/organisation formulates vision documents about
    i. recovery and recovery-oriented care
    ii. the use of peer support

  and develops a corresponding policy strategy and action plan. The principles as included in both vision documents form the basis for everything that is developed and implemented in the organisation in the field of care.

- **Management**. The director and the management team support the recovery vision and the use of peer support. Both policies need commitment when implemented. Managers know enough about peer support to ensure good preconditions for its implementation. There is sufficient financial scope to roll out the recovery vision and the deployment of peer support in practice.
- **Board of Directors**. The Board recognises the value and necessity of using experiental expertise to provide recovery-oriented care. The Board supports management in the deployment of peer support. It recognises the need to facilitate recovery-oriented care bottom-up as well as top-down.

2. Cultural change

A change in organisational culture towards providing recovery-oriented care based on the use of experiential expertise is a multi-year process (Mulvale et al., 2020). This process requires commitment and contribution of all parts of the organisation. The includion of specific sub-projects within a larger overarching plan provides structure, including a plan of action and a time frame.

Preconditions for the change of culture are:

- **Project group/taskforce**. A specific project group or taskforce for the deployment of peer support in the organisation steers and monitors the content, form and pace of the process.
- **Support within the organisation**. Awareness of the added value of peer support from the perspective of the recovery vision increases support within the organisation for collaborating with experiential workers/care providers with experiential expertise. Awareness can be created through information, theme meetings, etc.

3. Terms of employment

The terms of employment of PSWs should be adequate. PSWs and care providers with experiential expertise should be treated on a par with their colleaugues, with the same rights to a permanent contract.

4. Job description

There is a clear job description preferably based on a (European) professional competency profile. This can be a job description of a PSW as a separate role, or a description of the extra tasks of a care provider with experiential expertise. The set of extra tasks can be included as an appendix to the job description of the relevant care provider

5. Education/training

Good education, training and growth of expertise are important to ultimately develop into an organisation that works in a recovery-oriented way. In concrete terms, we think of the following components:

- **Peer support worker/care provider with experiential expertise**. The PSW/care provider with experiential expertise has received appropriate training with regard to the use of experiential expertise (development of the required competencies, development of insight into one's own recovery process and knowledge of collective experiences, learning to deal with resistance, etc.). The training is provided by instructors with experiential expertise.
    - Competency profile. The education of experiential experts is based on a professional competency profile.
    - Curriculum. There is a curriculum for the education of experiential experts.

- **All employees**. All employees who work with clients have received education on recovery, recovery-oriented care and the use of experiential expertise, provided by instructors with experiential expertise.

  The consolidation of what has been learned during the training course can take place

  - through coaching on the job by PSWs/care providers with experiential expertise.
  - by inviting PSWs/care providers with experiential expertise to case discussions and team intervision.

- **Refresher training**. All other training courses for employees are in accordance with the vision documents on recovery, recovery-oriented care and the use of peer support.

- **Information for new employees**. The information programme for new employees highlights the recovery vision and working with experts by experience.

- **The organisation**. There is sufficient and ongoing attention to good practices elsewhere.
- **Learning climate**. There is a shared learning climate in which clients, close relatives, experts by experience, care providers, managers and administrators exchange knowledge with each other.

6. Preparation

Proper preparation of both the team and the PSW/care provider with experiential expertise is important.

- **Tasks/responsibilities/expectations**

  The new PSW/care provider with experiential expertise is properly introduced to the team. This introductory meeting clarifies how the tasks and responsibilities of the PSW/care provider with experience expertise are demarcated from those of the regular team members and what the new employee and the other team members can expect from each other. The team is aware of the added value of hiring a PSW/care provider with experiential expertise and is familiar with the difference in tasks.

Training the manager. The manager of the team is trained for their role in the implementation of experiential expertise (see point 11: The manager, and product IO6: *Training programme for managers and leaders of therapeutic teams on the cooperation with peer supporters*).

- **Team culture**. The team and the PSW/care provider with experiential expertise must fit together. Within a team, employees form a certain culture in which one PSW/care

provider with experiential expertise may fit in better than another. (This actually applies to every new employee).

- **Stigmatisation**. The team may have prejudices with regard to the vulnerability of PSWs/care providers with experiential expertise (Chinman et al, 2008). This can lead to an unsafe working climate for the experiential expert. In the prapratory phase, attention is paid to discussing doubts and removing misconceptions among team members.

7. Hiring policy

A clear hiring policy, including orientation and training, is an important precondition for implementing peer support (Chinman et al., 2008). It can help to appoint a staff member to co-ordinate the hiring of experiential experts in order to monitor quality. Important points in this policy include:

- **Workplace**. Clients of the institution who develop into peer support workers are generally not employed in the (admissions) departments where they were treated themselves. This encourages work and care to remain separate (also in the event of any new periods of illness) and prevents confusion between the client role and the colleague role among fellow team members.
- **Choice of role**. The extent to which the manager and team have a proper understanding of and experience with the principles of recovery-oriented care influences which aspects of experiential expertise can best be chosen. If the manager and team have little or no experience with the use of peer support, it may be better to clearly separate the roles of care provider and experiential expert and employ PSWs as an independent role in the team.
- **Seniority**. With regard to experience in the field, it is not recommended to let inexperienced PSWs or inexperienced care providers with experiential expertise work alone in a team. The risk of excessively trying to fit in with the team and giving too little feedback (which can create resistance) is high. Experts by experience should preferably work in pairs (Davidson et al., 2012). A combination of a PSW and a care provider with experiential expertise can also work. An experienced PSW or care provider with experiential expertise can work alone, if necessary.
- **Recruitment of candidates**. It can be difficult to find suitable candidates for the position of PSW or experiential care provider. Potential candidates can also be found in the following “internal” ponds:
    - **Regular employees**. Regular employees with personal experience of mental illness or addiction. There is a trajectory for regular employees to develop their experiences into experiential expertise. Care providers with experiential expertise (or employees with experiential expertise in other positions) can be recruited from this network.
    - **Volunteers**. There is a trajectory for volunteers and clients from their own organisation who want to develop into experiential experts. PSWs (or

employees with experiential expertise in other positions) can be recruited from this network.

- **Valuation of experiential knowledge in all positions**. Personal experience with mental vulnerability or addiction is included as an additional advantage in the job ads for all care employees in the institution.
- **Deployment at all levels/functions**. Experiential expertise is preferably deployed at different levels/functions within the organisation (e.g. also in Human Resources and Communication).
- **Application procedure**. To ensure a proper selection of both experiential experts and other employees, it is important to include an experiential expert and/or client in every application committee. In the job interviews, questions about the candidate's knowledge and vision on recovery, recovery-oriented care and the use of peer support are included.

8. Introductory/orientation period

Sometimes experiential experts have not worked for a long time before they begin employment, or have never had a paid job at all. There is a lot at stake for the employee: getting used to the rhythm of work, getting used to being an employee, further developing skills and knowledge, dealing with any psychological vulnerabilities that still exist. In addition, it is often a matter of looking for the best way to use experiential expertise in a given context. Special attention to the orientation period is therefore necessary. The following points apply:

- Guidelines for a tailor-made orientation programme are included in the action plan of the central project group for the implementation of experiential expertise in the organisation.
- A designated contact person in the team ensures adequate reception on the first day of work and prepares the orientation programme (including a meeting with colleagues, place of work, explaining the communication/consultation structure). The aim is to make the PSW feels welcome.
- The new PSW is matched with a (senior) care provider and/or senior PSW, who is easily accessible and who stimulates communication/interaction with other team members, provides feedback etc. Preferably, this employee has already been involved in the selection procedure. The purpose of this "buddy" scheme is smooth introduction and "safe" working environment for the experiential expert.
- Job coaching can be offered to the new PSW with emphasis on the return to work, building up hours/tasks and financial matters (agreements with benefits agencies).
- Clarity in expectations, roles and tasks. Communicate openly and timely about this with the new employee (and the team).

9. Support

Experiential expertise is deployed to realise a change in values. It places high demands on PSWs/care providers with experience expertise to swim against the current and use their vulnerability in doing so (see also point 10). This requires extra attention to support in the workplace and the exchange of recovery and work experience with other PSWs/care providers with experiential expertise (Nossek et al. 2021).

- **Intervision and case discussions**. A separate support structure is offered for intervision and case discussions between PSWs/care providers with experiential expertise and a senior expert by experience.
- **Supervision**. Supervision of PSWs/care providers with experiential expertise by a senior experiential worker takes place on a regular basis.
- **Team coaching**. If the organisation works with a separate team of PSWs, a team coach can be appointed. The team coach provides individual coaching and organises group coaching where necessary.
- **Contact with the roots**. It is important for PSWs/care providers with experiential expertise to keep in touch with the roots of their knowledge. This can be done by continuing to participate in self-help groups and/or by remaining actively involved in client organisations. In this way they themselves remain well informed and at the same time they feed these organisations with their expertise.
- **Coaching regular team members**. Team members are coached in collaborating with experiential workers (in connection with recovery-oriented care) with the aim of preventing an us/them separation between experiential workers and other team members.
- **Support other employees with the experience of mental vulnerability or addiction.** An employee network can be organised where employees with personal experience can find each other. In this way, these employees can exchange experiential knowledge, support each other and increase openness in the organisation by reducing the stigma of vulnerability and sensitivity.
- **Support volunteers with the experience of mental vulnerability or addiction**. There is supportive coaching for volunteers with personal experience and clients of the institution who want to develop into an experiential expert.
- **Theme & policy meetings**. The organisation holds a number of annual theme meetings and policy days with the entire group of experiential workers to strengthen mutual contact and keep the vision of joint work up-to-date.

10. Absence policy

The absence policy should consider the specific burden associated with the critical and personal role of experiential experts in teams and in the organisation (Chinman et al., 2018). Since experiential expertise is based on a (chronic) psychiatric disorder or traumatic experience, it would be paradoxical to want to use it without taking the associated

vulnerability into account. This argues in favour of flexible handling of the applicable rules regarding absence.

- **Person-oriented absence policy.** As with any other employee with a disability, the employer is obliged to make adjustments to the working conditions where necessary. This includes personal arrangements about absence, being clear about the specific needs of the employee and the division of roles and co-ordination between employer, company doctor and own practitioner. These arrangements should be agreed upon as early as possible at the start of the employment.
- **Support recovery**. Absence policies do not always prove conducive to a person's recovery process, especially when they are overly pursued by the employer. The manager should take the employee's recovery process as a starting point for looking for a way to deal with the tensions caused by the absence policy.
- **Self-management**. The employe with experiential expertise takes responsibility for self-management of their mental health. If necessary, she/he uses methodical self-help, such as WRAP training (Cook, 2012), to become aware of the actions she/he can take to deal with vulnerability at work.

11. The manager

The manager has an important role in the implementation of experiential expertise. For this reason, it is analysed separately so that this can be integrated into the development of product IO6 (*Training programme for managers and leaders of therapeutic teams on the cooperation with peer supporters*).

- **Role model.** The manager acts as a role model for the team with regard to recovery-oriented thinking, directing the team members towards recovery-oriented care.
- **Support**. The care provider with experiential expertise receives sufficient support from the manager to be able to perform their peer support tasks. Even if the pressure on regular tasks is high, the care provider can fulfil their duties as an experiential expert.
- **Security**. There is a clear task for the manager to secure agreements with regard to preconditions and attention points (e.g. makes space for intervision).
- **Friction**. The use of experiential experts can cause friction due to their critical feedback to the team from the client's perspective. Can the team deal with this friction? Can the PSW/care provider with experiential expertise bear the tension? The manager facilitates this critical process and what can be learned from it.
- **Absence**. The experiential expert is hired in this specific position based on his personal experience of vulnerabilities. It is precisely because of these vulnerabilities that this person may at some point be unable to do their job. This field of tension must be dealt with adequately by the manager (see also Absence policy).

B Points of attention

When experiential expertise is used properly, friction occurs. This is logical because the use of experiential expertise is aimed at aligning the institutional world more closely with the life-world of clients. The input of the PSW/care provider with experiential expertise brings up sore spots in the team's working methods and dealing with clients. These and other points that create tension are discussed below.

1. Work load

Workload can be a risk factor threating the successful implementation of peer support in different ways.

- In the event of a high work load for the team, the extra tasks of the care provider with experiential expertise can be jeopardised if the regular care work is given priority. A (diagnosis-) free space in the work of PSW/care providers with experiential expertise must also be guaranteed, so that they can stay in the vicinity of clients without any agenda and can be approached, so that clients are provided with the space to develop in their own unique way.
- When the added value of the use of experiential expertise is seen in the organisation, there is a risk that the PSW/care provider with experiential expertise will be asked to become involved in too many initiatives and will be part of many working groups. This can be at the expense of other tasks, such as being in contact with clients.
- Sometimes the experiential expert may be asked to draw up comprehensive policy plans or proposals to that end, but they lack the corresponding knowledge.

2. Wearing two hats

A care provider with experiential expertise can get caught between their loyalty to clients and to their team. This problem can be addressed at intervision or supervision meetings.

3. Client file

The care provider with experiential expertise makes use of the client’s file, just like their colleagues in the team. PSWs, on the other hand, are in a different position; they are not part of care provision and they generally do not read client files so that an open attitude towards clients can be ensured.

4. Relationship of trust and privacy

A care provider with experiential expertise is part of the treatment or counselling team and is expected to share information about clients in the team. A PSW is generally not part of the team. Therefore, sharing sensitive information about a client with the team is dependent on the client’s consent. Explicitly asking the client for permission or inviting the client to team meetings in which his/her case is discussed can largely solve the privacy problem.

5. Coercion and pressure

If the situation so requires, an experiential expert can become involved in situations involving coercion or pressure. This can create a moral dilemma, especially if the experiential worker themselves has had to deal with coercion in the past. Preferably, the PSW/care provider with experiential expertise should be actively involved in the prevention of coercion, asking the client for their own solutions or offering them a choice. If coercion is nevertheless necessary, it is better not to require the PSW or experiential care provider to execute coercive measures. Their presence is preferred in the aftercare and evaluation of the incident with the client.

6. Distance and proximity

As a care provider one usually keeps some professional distance, while a PSW comes close to clients by sharing their experience in an appropriate way. The concept of professional proximity is still under development and the choice of the appropirate distance/proximity can feel ambiguous to the care provider with experiential expertise.

7. Living world and institutional world

A care provider is part of the institutional world, while a PSW is more in touch with the living world of the clients. The living world and the institutional world are often incompatible. It is precisely in this area that the care provider with experiential expertise is able to indicate where the institutional world can better connect with the client's life. This can cause tension in the care provider with experiential expertise if the rest of the team is not receptive of this.

8. Encapsulation

Sometimes the use of experiential expertise becomes encapsulated in existing structures. In this way, the use of experiential expertise is in line with existing care. When there is no friction, there will be no change to better adapt care to the clieants' needs, and the contribution of PSWs will serve a limited purpose.

9. Resistance and loneliness

An experiential expert can coach employees in the workplace in providing recovery-oriented care because he/she can articulate the client's perspective. This can create resistance, resulting in isolation. That is why preference is given to two PSWs or two care providers with experiential expertise (or a combination of these two roles) per one team.

10. Expertise

Unsuccessful experiences are often at the expense of the experiential experts. Do not let teams start experimenting with the use of experiential expertise themselves, but let the teams make use of the expertise of a project group/working group.

11. Insecurity

The combination of little work experience, a pioneering position without many guidelines and a psychiatric history can give rise to insecurity among experiential experts. There is a risk that they may feel an excessive need to prove themselves or allow their performance to excessively depend on the team's or organisation's appreciation. This can be at the expense of the critical purpose of their function.

12. Personal skills

The experiential expert is often lower in the pecking order than others in the team. Much depends on their personal skills, whether they are able to take their proper role in the team.

13. Open attitude

There may be rigid ideas among regular employees about the characteristics of a "good experience expert" without an open conversation and the space to investigate and learn. A reflective open attitude remains important.

C. Final recommendations

This project provides a flying start for organsations that have little or no experience with using experiential expertise, but it cannot replace the growth process that must take place within the organisation. Start small with a few experts by experience and together develop a progressive insight into the next steps using the competency profile, curriculum and other products from this project.

The implementation of the recovery vision, including the use of experiential expertise, starts at the bottom of the organisation, at the level of the client, and works upwards, but it cannot exist without support from above.

Bottom-up:

1. Experiential experts contribute to the development of documents about the vison on recovery, recovery-oriented care and the use of peer support.
2. Experiential experts participate in self-help groups, develop and deliver recovery and empowerment courses to clients.
3. Experiential experts train employees in recovery-oriented thinking and working.
4. Experiential experts (and clients) contribute their experiential knowledge to all kinds of projects.

Top-down:

1. The organisation creates support among employees for working with experts by experience (emphasising added value).

2. The organisation educates managers on how to support experiential experts in the team (training is provided by instructors who have this expertise themselves).
3. The organisation facilitates the training, deployment and support of experts by experience in the organisation.

Remember: We can plan everything to the best of our ability, but the reality will always turn out to be unpredicatable.

3.2 Recommendations from representatives of business organisations

In spite of the high employment rate of EX-IN recovery supporters in a wide variety of social enterprises as well as outpatient and inpatient settings, there is no permanent employment in free economy.

We received information from three men from Bad Kreuznach, Berlin and Bremen. They were:

• An honorary position/volunteer with the local authority in Bad Kreuznach

• A permanent position in a project of FOCUS Bremen, a further education provider of the IzsR Initiative for Social Rehabilitation

• A freelancer, Berlin, German Depression Aid / German Railways AG

The fact that the last-mentioned project was awarded the anti-stigma prize of the DGPPN (German Society for Psychiatry and Psychotherapy) says a lot about the reputation of such projects in psychiatric circles and associations.

However, this does not mean that the topic of mental illness and work and study has been accepted as part of our society. There is insufficient attention to peer support in our society and work fields other than the psychosocial sector, as the following suggests:

The response rate to the questionnaire was low. Despite the involvement of associations such as EX-IN Deutschland e. V. , which present themselves as authorities in the area of training of peer supporters and recovery companions and their networking, we received few answers.

From the company PGIB, which explicitly presents itself as an organiser of training for peer supporters/ recovery companions in companies, we did not receive any answers within three months, despite several inquiries about the training of experts by commercial enterprises, so that the success of their further training is not verifiable for us.

Conclusion

EX-IN further training has become very important in the psychosocial context over the last 15 years. Nevertheless, what is missing is a connection with free-market enterprises beyond the need-oriented fields of work. This may be because of the training facilities, which are largely associated with outpatient and inpatient psychiatric mechanisms, or are operated directly by institutions, not infrequently for their former patients.

Independent further education institutions that train PSWs are rather the exception. In addition, due to a relatively high demand for graduates in the area in question, we know that further training opportunities are insufficient, specifically for the very complex field of peer work in companies.

Particularly in areas of work that are not needs-oriented there will be other challenges and areas of tension for recovery/peer supporters. It should be emphasised that networking and organisation in the interest of this professional group is essential.

Recommendation for assigning and placing peer/recovery supporters in companies

It is too early to make recommendations regarding the assignment of peer/recovery supporters, as the research results have not been fully analysed yet. Peer supporters in companies could provide specialist training, for which a curriculum could be written.

The fields of work in the free economy are much more heterogeneous than the fields in which PSWs have been working up to now. From an experiential point of view, many PSWs are familiar with all the fields of work in the psychiatric field.

In addition to the competencies of the interviewed persons, which were acquired during EX-IN training and through previous work experience, there are still some possibilities to gain more security in their role, for example by completing one or more internships in companies, if the field of work seems attractive.

Here are a few topical fields that could be covered during the training:

- Models of peer support in companies, practical examples, possibilities and variations
- How to find and get in touch with companies that are interested in PSWs and how to create an interest in their profession within the companies
- PSW’s profile in the company, what form of work/employment suits their skills
- Knowledge about different interests existing within companies, dealing with specific interests at different levels of work
- Levels of communication in companies

- Inter-professional work
- Responsibilities and support in integration procedures, placement activities
- Advantages/disadvantages of the severely disabled status
- Areas of responsibility, consultation and communication at various management levels and with personnel managers
- Personnel acquisition, recruitment
- Mediation between peer supporters and other personnel
- Knowing, assessing and being able to inquire about disturbance patterns and impairments
- Antistigmatisation
- Networking
- Project development
- Public relations
- Generating funding
- Empowering supervisors/recruiters to address background,
- Recognising disabilities that have to be compensated, preparing a survey of support needs
- Promoting an open approach - provide protection against excessive openness
- Consultation and communication between peer supporters and other personnel
- Dealing with bullying in the workplace
- Conveying recovery-oriented attitudes
- Rediscovering resources
- Support after the inpatient stay
- Online consultations
- Internship support
- Vocational guidance
- Suicide prevention
- Job coaching

Some of these competencies are already available after the EX-IN training, but can be deepened in the advanced and specialised modules; others would have to be achieved separately.

It is recommended that, wherever possible, PSWs with basic training be also employed by companies in the free economy. Special attention should be paid to ensuring that they can primarily focus on the employees that need support, and that they can be involved in prevention activities depending on the employees' ability and level of independence. The fact that this requires time, which at first seems to reduce productivity, is probably compensated for by other factors. One aspect that should not be underestimated is that employees no longer have to hide their mental illnesses and can therefore participate in working life as

complete persons. Employees should be given the opportunity to specialise while they are still working.

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4. Selected conclusions from the conducted survey and analyses of the project team

As part of the project "**European Profile for Peer Workers**," four teams from Germany, the Netherlands, Norway and Poland conducted research on the professional position and role of peer support workers (PSWs) in selected professional teams. The respondents represented not only different geographies, but also various institutions and places of employment: hospitals and health care centres, governmental and non-governmental organisations, social welfare organisations as well as businesses, including various types of enterprises providing broadly understood social services, social and mental support services and therapy. All this means that representatives of this profession can be found in a broad spectrum of organisations, which results in a wealth of experiences and observations about medicine- and management-related issues. Although it may seem that such diversity and wide scope of issues will prevent the possibility of formulating universal recommendations, the key to solving this methodological problem is the concept of "diversity management."

The problems and postulates expressed by respondents in the submitted questionnaires and by researchers in expert analyses confirm the conclusions of numerous empirical studies on diversity management, which present recommendations concerning organisations' efforts and solutions based on diversity management. In the literature as well as in the surveys under consideration, the following key issues often appear:

- the benefits of implementing the concept of diversity management,
- revenues and costs associated with diversity management,
- the scope of policies implemented by the organisation,
- the functioning of diverse teams in the organisation,
- communication in diverse project teams,
- diversity management in the face of demographic challenges,
- the level of knowledge of the managerial staff, including future managers (doctors, nurses, psychiatrists and psychologists, social workers and other persons involved in the processes of patient recovery) not only in the professional area, e.g. health care, but also with reference to diversity, discrimination and diversity management in the organisation.[1]

[1] *Global Diversity and Inclusion. Fostering Innovation Through a Diverse Workforce*, Forbes Insight 2013.

The members of the project team – research authors – have prepared a number of postulates about what institutions, companies and organisations can do to create a work environment which is conducive to employing peer supporters. Their analysis confirms that irrespective of the exact solutions adopted by a given country, it is crucial to introduce systemic changes when deciding to introduce the profession. In addition, leaders and managers must be willing and determined to overcome the existing canons of behaviour in their organisations. A similar attitude should be displayed by members of the therapeutic teams, including peer supporters. Moreover, as postulated by researchers, managers should be educated and trained in the field of knowledge about the recovery of people with mental disorders, which will enable them to better understand diversity of persons and cultures, thus contributing to the improvement of organisational effectiveness.

The concept of diversity management is derived from the term "biodiversity"[2] and closely connected with other scientific disciplines, such as economics, psychology, philosophy, sociology and medicine. Therefore, it is worth bearing in mind that approaching diversity mainly through racial, ethnic and gender differences is a misunderstanding. In fact, diversity is part and parcel of working in the contemporary organisation – we have diverse human resources, diverse organisational cultures, diverse teams, different disease entities and different pathways to recovery – treatment processes.

By analysing the postulates voiced by the respondents and researchers regarding the peer supporter's position, role, rules of cooperation and communication styles, it is easy to identify paradigms that can be translated into recommendations in the context of diversity management:

1. The paradigm of assimilation (discrimination and justice), based on the recognition that discrimination and stigmatisation are wrong and that equality, fair treatment and legal compliance are of paramount importance. In this area, there were signals regarding peer support workers' problems with employment, access to training, participation in projects, exceptional treatment, bureaucratic procedures (especially troublesome for PSWs), excessive number of control processes, lack of individual approach, unfair treatment, e.g. during periodic evaluations, task assignment.
2. The paradigm of differentiation (access and credibility) – entities and organisations adopting the concept of diversity management gain the opportunity to secure a

[2] Litvin D, 1997. The Discourse of Diversity: From Biology to Management, *Organisation* 4(2): 187–209; Litvin D, 2006. Diversity. Making Space for Better Case. In Konrad AM, Prasad P, Pringle JK (ed.), *Handbook of Workplace Diversity*. London: Sage, pp. 75–94.

competitive advantage. For institutions focusing on the patients' well-being, recovery, support, and the effectiveness of therapy, it is worth emphasising that employing PSWs increases the likelihood of coming up with novel treatment methods and a different approach to recovery. This paradigm has resulted in the emergence of new professional opportunities for PSW groups (solutions devised in the Netherlands and Norway confirm the development of organisations that use the skills and experiences of their employees, including those related to illness and crisis).

3. The integration paradigm (learning and efficiency) is a paradigm that connects diversity with work perspectives to the greatest extent because it relies on bringing together diversity and the actual work performance. This approach is based on the idea that integration should follow the principle that "we are all members of one team, along with our differences, not in spite of them." If properly used, the experience of an illness or mental crisis does not have to be an obstacle – it can broaden the individual's perspective on action, treatment and functioning. Today it is easy to imagine when a former patient offers advice, educates, supports and accompanies another person in recovery, but it would not be possible without learning, focusing on effects, exchanging experiences, controlling and changing management and treatment processes.[3]

What emerges from the research is a picture of an organisation open to cooperation with and employment of peer support workers. By analysing the respondents' statements it is possible to indicate the conditions required to successfully employ PSWs, to transform the organisation to be able to integrate different experts, including experts by experience. In order to systematically present these postulates, it is worth referring to the ones identified by Thomas and Ely[4]:

1. The leadership must understand that a diverse workforce will embody different perspectives and approaches to work, and must truly value variety of opinion and insight.
2. The leadership must recognise both the learning opportunities and the challenges that the expression of different perspectives presents for an organisation.

[3] Gross-Gołacka E, 2018. *Zarządzanie różnorodnością. W kierunku zróżnicowanych zasobów ludzkich w organizacji* [*Managing diversity. Towards diverse human resources in organisations*]. Warsaw: Difin, pp. 62–74.
[4] Thomas DA, Ely RJ, 1996. Managing Difference Matter: A New Paradigm for Managing Diversity, *Harvard Business Review* 74: 140–142.

3. The organisational culture must create an expectation of high standards of performance from everyone.
4. The organisational culture must stimulate personal development.
5. The organisational culture must encourage openness.
6. The culture must make workers feel valued.
7. The organisation must have a well-articulated and widely understood mission.
8. The organisation must have a relatively egalitarian, non-bureaucratic structure.

The above-mentioned conditions cover all the actions needed to respond to the demands of the respondents and researchers investigating the position and situation of peer support workers in the organisations of the project team members.

Thomas and Ely also list specific actions that must be undertaken by leaders and decision-makers to use the knowledge, skills and experience of diverse staff.[5] These postulates are reflected in the analysed questionnaires and in the project experts' recommendations. They include:

1. Looking for mental connections – PSWs frequently raise the importance of compassion, the special bond they have with the patients whom they accompany in their recovery, which makes it easier for the latter to open up to cooperation, apply the principles of open dialogue, and join the accompanying therapies.
2. Legitimating open discussion – according to both the literature on the subject and this research, managers are expected to give the green light to speak openly, share ideas, take co-responsibility for the processes leading to patients' recovery. Similarly, people who had experienced a crisis were encouraged to use their lived experience in organisations to build support for patients. Interestingly, these postulates appeared equally frequently among PSWs employed in medical institutions, in foundations, cooperatives, social work and care agencies.
3. Actively working against all forms of dominance and subordination – managers should act against dominance. Respect for diverse competencies, knowledge, taking into account one's role in the therapeutic, support or project team, brings not only organisational and cultural changes, but also accelerates the learning process of the entire organisation. Intolerance or presumed superiority decreases the efficiency and effectiveness of entire teams. The respondents often mentioned the mistrust of the medical personnel or team leaders when they made suggestions based on their own

[5] Ibid, p. 228.

experience, which significantly prolonged the team's learning process, patients' recovery, and the selection of appropriate therapies. Organisational effectiveness is a factor that should be particularly relevant in managing teams that include a person who has experienced a crisis situation.

4. Organisational trust should stay intact – managers and team leaders must ensure that the organisation is "safe" and that the employees are not afraid to be themselves. Of course, of paramount importance are the organisation's mission, goals, tasks, social responsibility, etc., but any type of innovation begins with openness to diversity. Wide-ranging discussion, openness to other people, joint commitment to look for solutions (in treatment and patient support) strengthen the team, providing the opportunity to increase broadly understood effectiveness.

Towards the end it is worth referring to the results of research on the role of peer support workers in various organisations, which confirm the existence of the glass ceiling phenomenon as well as other obstacles faced by these employees. The problem of resistance to various initiatives promoting greater use of experts by experience is not uncommon among leaders of organisations and patients' families. Similar scepticism is expressed by opponents of diversity in the workplace. According to D. Litvin, change and diverse approaches (including to the recovery process) can be threatening because they undermine social categories that are depicted as "obvious, natural and unchangeable."[6] The question of power and dominance, which characterises some medical professional, stands in the way to the implementation of pro-diversity mechanisms and PSW employment programmes, or, once they have been employed – makes it difficult for them to develop and influence the organisation.

[6] D. Litvin, *Discourse of Diversity …*, op. cit. p. 188.