Social, Organizational and Legal Determinants of the Profession of Peer Support Workers in Europe

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European Standards for Peer Support Workers in Mental Health

Social, Organizational and Legal Determinants of the Profession of Peer Support Workers in Europe

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Contents

PART II

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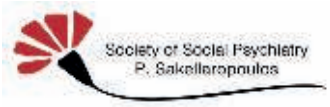

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Introduction

Mental health is part of public health and as such it is a common good. Therefore, protecting it lies in everyone's interest and is the duty of public authorities. Fulfilling this duty requires state structures to mobilise more and more resources. The global pandemic caused by the SARS-CoV-2 virus has further exacerbated these pressures, highlighting growing social needs in the field of medical and therapeutic care. This situation prompts a discourse on the challenges and opportunities facing national mental health systems, which is connected with tapping into the potential of peer support workers.

This publication, which wants to be a voice in this discussion, is based on the experience gained during the implementation of the international Erasmus+ project "European Profile for Peer-worker." A peer worker, or peer support worker, is a person who has lived through a mental crisis and wishes to share their experience with other people in a similar situation. Such a person can act as an educator, guide and intermediary between those in need and those providing professional help. The authenticity of their experience and the ability to share it can provide considerable support in the processes of recovery, rehabilitation and social inclusion. Employing a peer support worker by an organisation which offers the broadly understood mental health protection brings benefits in the form of greater flexibility of services and improved efficiency of work with the service user, but it also poses significant challenges for the employer. These challenges are the subject of this publication.

This book presents various aspects of the functioning of peer support workers in healthcare and social welfare systems in selected European countries, including the roles that can be performed by them in contemporary organisations. It addresses issues such as the competences and qualifications of peer supporters and the legal changes needed to recognise this informal role as a profession. Among its co-authors are representatives of the public, private and social sectors, both practitioners and academics. The study out-

lines the current state of work on the introduction of the profession of peer support worker in national organisational structures and presents selected results of scientific research from the literature on the subject, including in the field of psychology, law, health sciences and management. It is divided into two parts – Part I covers scientific studies and ideas for systemic solutions, while Part II describes selected results of the project "European Profile for Peer-worker," which provides the practical and intellectual background for the entire publication.

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PART I

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A presentation of the current situation of peer-support services in Greece and factors delaying their introduction in the community-based mental health services

ABSTRACT
The peer support model and the inclusion of peer support workers in the workforce of Community Mental Health Services are closely linked to the recovery model and have been a continuously growing trend in mental health services internationally. Some European countries have already adopted the model, including peer support positions within mental health organisations. This has not been the case in Greece. An effort will be made to examine the current situation concerning mental health and the peer support model in order to shed some light on the factors that may have delayed the adoption and implementation of the model.

KEYWORDS: peer support model, mental health services, recovery model, peer support workers, Greece

1. Introduction

Modern mental healthcare worldwide is closely linked to, if not identified as, high quality community-based mental health care. The ongoing discussion among European professional, scientists and peer experts has led to six basic principles "that serve as a foundation for a national, regional and local model of integrated mental health care." These principles include: 1) the protection of human rights; 2) a public health focus; 3) the support of service users in their recovery journey; 4) the use of effective interventions based on evidence and client goals; 5) the promotion of a wide network of support in the community; and 6) the use of peer expertise in service design and delivery [Keet et al. 2019, p. 4].

The peer support model has been a continuously growing trend in recovery-oriented mental health services internationally. The inclusion of peer

support workers (PSWs) in the workforce of addiction and mental healthcare (MH) services is strongly supported in current literature, as its benefits are clearly recognised within multiple levels of activity, by emphasising non-hierarchical relationships and a sharing of lived experience around emotional distress [Adame, Leitner 2008, pp. 150–155; Ibrahim et al. 2020, pp. 290–291]. As Solomon [2004, p. 393] mentioned, "social emotional support, frequently coupled with instrumental support, is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change." The positive impact is noticed both on the recipients and providers of MH services [Shalaby, Agyapong 2020, pp. 5–7]. The peer support model seems to be even more promising in terms of far-reaching benefits, such as the reduction of self-stigma [Corrigan et al. 2013, p. 4; Shepherd, Repper 2017, p. 610], as well as organisational and cultural change towards a recovery-oriented approach within mental health organisations [Pollitt et al., 2012, p. 28]. Research evidence also suggests that peer support models are effective in reducing psychiatric readmission [Ibrahim et al. 2020, p. 291; Shepherd, Repper 2017, p. 595]. In Europe, peer knowledge has been increasingly recognised as a domain of expertise, as shown in international and European policy documents and strategies of European service providers. Keet et al. [2019, p. 7] refer to peer knowledge as "a third domain of expertise, in addition to scientific evidence and practical knowledge and skills." However, this is not always seen in mental health practice as "only few peer experts are paid."

On the other hand, worries that peer support may be negatively influenced by the medical model have also been expressed. Research in countries with important experience in the implementation of the model highlights that PSWs are not always provided with adequate resources or support, and are sometimes mistreated. The organisation and implementation of peer support seems to be a challenging case, with some professionals describing peer support colleagues as extra workload. Stakeholders, on the other hand, are "unwilling to integrate it into existing practice or unable to make sense of the information required to operationalize it effectively" [Kemp, Henderson 2012, p. 339]. Some of the predominant obstacles in the way of peer support work implementation are: cultural impediments, poor organisational arrangements and inadequate overarching mental health policies**.** Therefore, Ibrahim et al. [2020, p. 291] have pointed out that PSW implementation has a good chance of successful implementation in MH settings which recognise lived experience as a helpful resource for others. The presence of PSWs in the service supports that change by reducing "within the service" stigma, such as "us-and-them" distinctions. The benefits of the PSW model as well as the presence of PSWs as members of multi-disciplinary teams or special advisors can influence the way other treatments and interventions are provided.

In this chapter we will present the current situation concerning peer support model/work in mental healthcare services in Greece. Moreover, we will attempt to shed some light on the factors that seem to delay the adoption and implementation of the model in Greece.

2. The evolution of mental health care in Greece

The historical evolution of psychiatric care in Greece can be divided into three extended periods [Madianos 2020, p. 26]. The founding of the first public mental hospitals in the country, in the late 19th century, signalled the asylum period. They were the prevalent type of care in the public sector until the early 1980s. A transitional period followed, which resulted largely from the European Economic Community's intervention and led to the beginning of the MH system reform. The launching of the National Mental Health Plan in 1997 and the introduction of new legislation in May 1999 (Law 2716/99) marked the beginning of the third period of psychiatric reform [Madianos 2020, pp. 27–28].

The objectives of Psychargos, a ten-year National Mental Health plan approved by the European Union in 1997, mainly focused on "the deinstitutionalisation of the remaining long-stay in-patients and the closure of public mental hospitals. It also aimed to introduce mental health legislation that would secure the sectorisation of the mental healthcare system (having the same team responsible for in-patient and out-patient care in a particular catchment area), further development of community-based mental health and rehabilitation services, the launching of psychiatric departments in general hospitals, as well as providing specialised services for children, adolescents and the elderly. Finally, detailed guarantees and procedures for the protection of patients' rights were established" [Madianos 2020, pp. 27–28]. Two years later, Law 2716/99 paved the way for a profound and inclusive policy on mental health. It introduced the sectorisation of the country, protected the human rights of the mentally ill and stressed the importance of developing a network of primary mental health services that would extend over the country. By 2002, the whole country was sectorised, with a revision in 2015 into seven health regions and 37 sectors [Madianos 2020, p. 28].

During the abovementioned period (1997–2001), infrastructure was significantly improved and long-stay patients were transferred to alternative, community-based housing services. Moreover, the staff employed in community services was trained accordingly. Psychargos II, the second phase of the National Mental Health Plan, lasted from 2001 to 2010 and contributed to the closure of six public psychiatric hospitals. University departments, non-governmental organisations and others implemented this second phase of the project, in the context of which hundreds of in-patients had the chance to

start a new life, living in the community, close to their homes. Society of Social Psychiatry with professor Panagiotis Sakellaropoulos played a significant role in that period of psychiatric reform. Furthermore, 23 new community mental health centres, 53 out-patient clinics and 28 psychiatric departments in general hospitals were instituted. The remaining three hospitals have been serving as acute care units linked to consecutive sectors**.**

3. Evaluation of the Greek mental health reform

The operation of the designed services and the evaluation of these significant changes in the Greek mental health system revealed that the reform was not comprehensive. As Madianos et al. mentioned [2014, p. 46], Greece's catchmenting, long after the scientific design of the reform, was not fully implemented on the basis of epidemiological data (providing 58 instead of 94 sectors). The pressure of the Leros Asylum scandal was massive (a total of four thousand psychiatric patients were transferred to this institution from the 1960s to the 1980s, living in inhumane conditions, without basic infrastructure, medical and nursing staff). Pressure came mostly from the European Commission and a group of Greek experts. The continuity of care is seriously hindered, even nowadays, because the system has not been designed accordingly. The existing community mental health centres do not operate on a 24-hour basis, nor are they connected to the Emergency Medical System. The role of the community (local authorities, resources, families and relatives of patients, human rights activists) is absent from the legislation and delivery of care levels [Giannakopoulos, Anagnostopoulos 2016, p. 327; Madianos et al. 2014, p. 46]. Stylianidis et al. [2016, p. 399] add the following obstacles to the evaluation attempts: a) the fact that evaluation is not an element of the system; b) the lack of a common record keeping system; c) the lack of common outcome criteria; d) the lack of therapeutic intervention standardisation.

Some of the most important benefits of extensive evaluation, in both outpatient and hospital units, are: a) tracing problems within the existing healthcare practices; b) contribution to the development of effective ways to promote service quality; and c) respect for human rights, so that the users' independence is promoted, their dignity and their right to self-determination/ self-identification is protected [Stylianidis et al. 2016, p. 401].

4. The socio-economic crisis in Greece and its effects on mental healthcare

The socioeconomic crisis in Greece (lasting since 2008) and the underfunding of the mental health services network has escalated the pre-existing structural problems [Stylianidis et al. 2016, p. 405]. As a result, all stakehold-

ers (patients, families, administrators, mental health professionals, the community) have been experiencing extreme frustration, while the needs for mental healthcare have been steadily increasing.

This intense institutional and professional insecurity "caused a series of chain reactions at all operating levels of mental health services, such as residential care, family and community intervention, as well as in personnel responsible for the scientific, administrative and ethical functioning of the units," who struggled to avoid the return to asylum function [Stylianidis et al. 2016, p. 406].

The innovative culture that social and community psychiatry principles aimed to introduce and promote has been "put in ice." The main focus of all kinds of support has been to decrease uncertainty and counteract negative feelings. Poor resources and economic strain in the mental health field still remain, as other emergencies arise (COVID-19 pandemic). Quality of mental healthcare, anti-stigma interventions, psychosocial variables (e.g. professional devaluation) that lead to occupational fatigue and burnout syndrome come in second place.

The findings of a qualitative research study conducted by Stylianidis, Navridis et al. [2016, p. 410], concerning the kinds of defence mechanisms that mental health staff use to counter this crisis, showed that they idealise the institutions they work for and overinvest in their jobs. An overprotective attitude towards the patients emerges as a side effect of those mechanisms and paradoxically leads to the patients' chronic dependence rather than empowerment and autonomy. Another significant issue is that these defence mechanisms are related to, and perhaps enhance, the aforementioned neo-institutionalisation phenomena in community mental health units.

Psychargos III (2011–2020) covered mental health units and actions prioritising the "Protection of mentally ill patient rights and advocacy for their mental health, and the promotion of self-representation of mental health service users and their families." Patients' associations and the Association of Families for Mental Health became members of the National Federation of Persons with Disabilities (ESAMEA). The latter implemented a project in 2011–2014 entitled "Empowerment of Collective Expression and Advocacy for Persons with Mental Disability." It "included organising local meetings in over 20 areas in Greece, for the purpose of informing the service users on the ways of organising and defending their rights and educating trainers on objectives such as empowerment, advocacy, support in organising associations and, finally, user training in the corresponding subjects. ESAMEA's actions promote the users' systematic information, in line with the Convention on the Rights of Persons with Disabilities" [Chondros et al. 2016, p. 444].

5. Current situation in Greece

The professional role of a peer support worker does not exist in Greece yet. As it has been explained, the psychiatric reform process has faced numerous socio-economic problems in the last decade. The mental healthcare staff seem unprotected against the threat of burnout, while service users experience their own struggle against stigma, lack of information and resources.

Relevant peer-support education is also non-existent. The only possibility for someone interested in performing this role is to move abroad and enrol in a recovery course outside Greece. None of the educational levels following secondary education have any offer for individuals interested in becoming peer support workers.

Therefore, Greece seems to have a long way to go before introducing the PSW position in mental health settings. The majority of mental health organisations in Greece (public or NGOs) have not yet adopted a recovery-oriented approach, which is the conceptual framework within which the peer-work model can evolve. Things seem to be at very early stages, with only few professionals and organisations having been inspired by the recovery model and interested in facilitating the introduction of this professional role within their practice. At the same time, in the context of the Psychargos programme, recovery is not explicitly mentioned as a priority of the mental health policy in Greece.

The Society of Social Psychiatry P. Sakellaropoulos is an organisation with keen interest in developing the PSW role within its services and one of the project partners of the Erasmus+ programme "European Profile for Peer-worker," along with Grone (Germany), GGZ Noord Holland Noord and Cordaan (The Netherlands), Cedu (Poland), Sorlandet Sykehus (Norway). Considerable hope has been invested in this programme, as it is going to produce basic materials concerning the implementation of the role, such as a glossary of basic peer-support terms, a qualifications curriculum, national and European guidelines for the implementation strategy.

6. Examples of "peer support" initiatives in Greece

Despite the difficulties, inadequacies and constraints, some positive initiatives have also been developed. These include anti-stigma campaigns, associations of mental health service users and federations of users' families and relatives, as well as Greek representatives of the Hearing Voices network. Some NGOs have recognised the importance of including PSWs as a kind of mentors or trainers that support the adaptation of other users to employment (this is the case in so-called limited liability social cooperatives), or accompany them in social integration. Support can be provided on a voluntary basis or as paid work, which is the case in social cooperatives.

Particularly in the field of substance-dependent individuals, KETHEA (Therapy Centre for Dependent Individuals) seems to be the leading organisation as far as peer support is concerned. It has established the Certification Board for Alcohol and Drug Counsellors and Prevention Specialists in collaboration with the International Certification & Reciprocity Consortium (IC&RC), a non-profit consortium of boards that credential drug counsellors, clinical supervisors, prevention specialists, professionals who deal with co-existing disorders, and certified criminal justice addictions professionals. The Board examines applications and provides credentials for professionals living and working in Greece, Cyprus, Malta and Bulgaria in accordance with international standards and the particular cultural conditions in each country.

Moreover, the Aristotle University of Thessaloniki (School of Psychology) in cooperation with the Greek Organisation against Drugs (OKANA) implements the Self-help Promotion Programme which, among other activities, educates and sensitises ex-users and local communities to the importance of self-help and mutual help practices. Self-Help Promotion Programmes of the Aristotle University of Thessaloniki are the only state proposal in the country that places the idea of self-help at the heart of its intervention methodology in order to address and prevent addiction and other psychosocial disorders and health problems.

In another field of work, there are breast cancer survivors' associations, such as Alma Zois, which use the term "peer supporter." Specifically, they are implementing the programme "Reach to Recovery," which is based on voluntary peer work (volunteers offer psychological support within the anti-cancer hospitals to women who have recently been mastectomised).

In the mental health field, the Society of Social Psychiatry P. Sakellaropoulos and many non-governmental organisations, self-representation and self-advocacy groups refer to the term "self-help groups / self-support." Recovery model-oriented organisations seem to be particularly interested in the peer support worker roles, but they face the structural deficiencies mentioned above. Moreover, since 2017, an annual three-day nationwide seminar for the promotion of empowerment, self-help and peer-support has been organised by Aftoekprosopisi, a Greek organisation for recipients of mental health services, in collaboration with the Society of Social Psychiatry P. Sakellaropoulos.

A reasonable question emerges about why things have been delayed so much in a country that has been reforming its psychiatric and community services for over 30 years. Why is the PSW profession still "invisible" in Greece? Unfortunately, there exists no research concerning peer-support in the Greek mental health field.

7. Factors influencing the introduction of peer support workers into the workforce

In search of relevant references in international research, certain factors have been traced as influencing the introduction of PSWs into the workforce. According to Ibrahim et al. [2020], the main factors impacting on the introduction of the position are: 1) organisational culture; 2) PSW's training; 3) PSW's role definition; 4) staff willingness and ability to work with PSWs; 5) resource availability; 6) financial arrangements; 7) support for PSW's well-being; 8) PSW's access to a peer network. There are also common myths and misperceptions about PSWs, such as being subversive, "anti-psychiatry" and "anti-medication," or making staff worried about "saying the wrong thing" [Shepherd, Repper 2017, p. 604].

There is limited research concerning the effectiveness and cost-effectiveness of the model. However, Shepherd and Repper [2017, p. 595] inform that:

> a) In no study has the employment of peer support workers been found to result in worse health outcomes compared with those not receiving the service. Most commonly the inclusion of peers in the workforce produces the same or better results across a range of outcomes. b) The inclusion of peer support workers tends to produce specific improvements in patients' feelings of empowerment, self-esteem and confidence. This is usually associated with increased service satisfaction. c) In both cross-sectional and longitudinal studies, patients receiving peer support have shown improvements in community integration and social functioning. In some studies, they also bring about improvements in self-reported quality of life measures, although here the findings are mixed. d) In a number of studies when patients are in frequent contact with peer support workers, their stability in employment, education and training has also been shown to increase.

There is fairly strong evidence that the inclusion of PSWs in the workforce, alongside other traditional mental health experts, may have significant benefits in terms of increasing feelings of empowerment and social inclusion both for those receiving the service and for those delivering it. Furthermore, there is some evidence that the introduction of peers into the workforce may be highly cost-effective [Trachtenberg et al. 2013, p. 6] and provide benefits for the organisations in which they operate in terms of inspiring a more positive, "recovery-oriented" approach. Of course, these benefits do not happen automatically. They require proper implementation and there is still considerable variability in what kind of support is provided. This lack of standardisation undoubtedly accounts for some of the variability in outcomes.

Based on the work of Ibrahim et al. [2020, pp. 285–293] and the influences that may affect the application of the peer support model, it is interesting to see how these influences may be present in the Greek reality. Stigma and pro-

fessional exhaustion phenomena seem to shape the atmosphere concerning an organisation's readiness (connected with the organisational culture and staff willingness) to design and apply peer support-related practices. Recovery model applications presuppose the display of hope and optimism. According to the CHIME model, hope and optimism are included in the five main dimensions of recovery [Leamy et al. 2011, p. 451]. It is not about encouraging unrealistic expectations, but positive expectations and positive psychology (emphasising the individual's personal potential/inner strengths) are more likely to lead to improvement and progress than low expectations that may serve as a "self-fulfilling prophecy." In the following paragraphs we will examine 1) the situation concerning the stigmatising reality in Greek society and health settings; 2) burnout syndrome in mental health professionals; 3) questions about resilient mental health practice.

8. Stigma among general population and health staff in Greece

Tzouvara et al. [2016, pp. 1–14] conducted an important review of research concerning stigma in Greece. According to their findings,

> mental illness stigma is consistently present in the Greek society, in moderate and high proportions, particularly in terms of social discrimination and restrictiveness, social distance and authoritarianism. […] The review also identified some evidence of benevolence and, in particular, some positivity towards "social care." It can therefore be interpreted that Greeks do hold at least some concern for people with mental illness but that any such sympathy and desire for their wellbeing are unlikely to translate into positive behavioral outcomes [Tzouvara et al. 2016, p. 11].

Arvaniti et al. [2009, p. 658] found clear and striking levels of stigma among healthcare professionals. As far as this chapter is concerned, this is particularly worrying given that (a) their work brings them into contact with people with mental illness; (b) they hold key roles towards helping such individuals achieve successful integration into society; (c) holding negative attitudes jeopardises the quality of care; and (d) it may discourage people with mental illnesses from using their services [Tzouvara et. al. 2016, p. 12]. This is the case not only in Greece. As Sunkel has pointed out,

> In low- and middle-income countries, myths and misperceptions are still attached to mental health conditions – perceiving people as violent, mad, lazy, incapable of positively contributing to society and the economy. Stigma and discrimination impact on the entire recovery process and affect those who struggle with mental health to become empowered. For some countries today it is still unimaginable that someone with a mental health condition can in fact be meaningfully employed, let alone employed within the mental health workforce [Sunkel 2012, p. 201].

9. Burnout syndrome in mental health professionals in Greece

The results of research conducted by Sofology et al. [2019, p. 4] suggest that emotional exhaustion in mental health professionals in Greece is strongly connected with the duration of their working experience. This means that emotional exhaustion may compound over time, increasing in intensity the longer a clinician has been in the role.

At this point, it is important to mention that exhaustion is not something that is simply experienced. It prompts actions to distance oneself emotionally and cognitively from one's work, presumably as a way to cope with work overload [Schaubroeck, Jones 2000, pp. 179–181]. While feeling emotional exhaustion, a professional may attempt to cope with it by detaching him- or herself from others and developing a depersonalised response to them. This highlights the importance for mental health institutions or community mental health centres to provide complementary strategies to combat the phenomenon in even the most experienced clinicians and provide tools to help them cope with exhaustion. Although it is evident from the literature that burnout is more common among professionals in other health settings [Tzouvara et al. 2016, pp. 10–11], Sofology et al. [2019, p. 6] commented in an interesting way on the quality of emotional experiences that mental health staff have. Strong emotional feelings may often be provoked by many professional interactions among health and social service practitioners. Consequently, these strong feelings may be a significant factor leading to poor quality of services. Additionally, it has been determined that strong feelings could be caused by schizophrenic or psychotic populations. The higher the percentage of schizophrenics in the patient population, the less job satisfaction staff members expressed [Sofology et al. 2019, p. 6]. The literature review reveals that professionals in settings with more schizophrenics liked their work less, were less likely to view their job situation as the ideal one, and were less aware of what their goals were in their everyday work [Glasberg et al. 2008, p. 249].

As far as the personnel of psychiatric hospitals and institutions is concerned, they are particularly exposed to stress factors related to the nature of care they provide and the general organisational framework of the Greek psychiatric institutions. Specifically, staff who have close, face-to-face interactions with patients and those with longer job tenure in mental health were found more likely to develop burnout [Bougea et al. 2016, p. 296].

Fatigue is one of the most common symptoms that healthcare professionals experience. Lack of harmony in the daily routine has been associated with higher scores of fatigue on relevant scales. Healthcare professionals, and specifically nurses in Greece, who work in shifts, display higher levels of anxiety, depression and fatigue than those who work under a standard-

ised schedule [Tzeletopoulou et al. 2018, p. 248]. Tzeletopouloy et al. [2018, p. 248] have also found a strong connection between fatigued mental health professionals, depression and the tendency to develop aggressive behaviours towards service users, coworkers, an organisation's administrative or managing bodies.

10. Questions about resilient practice

Panagopoulou and Montgomery [2019, p. 112] mentioned that "we need to move the focus away from a physician-centric approach towards one that asks what we can do in the modern healthcare setting to enhance the ability of health professionals to thrive. In other words, it is time to shift our gaze from the burned-out physician to the resilient health care organisation." Today, prevalent research evidence around the factors associated with burnout indicates that burnout "is an organisational rather than individual problem, rooted in issues related to the working environment and organisational culture" [Panagopoulou, Montgomery 2019]. Although burnout, characterised by exhaustion, cynicism and inefficacy, is experienced by individuals, it is worth bearing in mind that it is a shared experience that occurs in response to common job stressors, which means it should be viewed and resolved as a systemic problem, not simply as an individual one.

11. Conclusion

In the current situation in Greece, many complex needs and actions are required to make the national mental healthcare system more efficient. Mental healthcare and treatment require innovative actions to formulate mental health policies that would be less focused on biomedical aspects and closer to a holistic and more person-centred model. Clearly, despite the evidence of the peer support model value and benefits, there is still significant resistance among stakeholders/policymakers/governments to incorporate peer support work in mental health strategic plans, policies and service delivery.

From the service users' point of view, poor access to education and inadequate information are contributing factors that result in worse mental health and human rights literacy. This adds up to a number of pre-existing problems and disadvantages for the people with lived experience, who are often struggling with serious social and economic inequalities.

The greatest challenge for us, as mental health professionals, is to retain our extroversion and try to confront the feelings of disappointment and inefficacy caused by a continuously incomplete or fragmentary "reform" through synergies, innovations and networking with stakeholders and persons who do not belong to the narrow field of mental health.

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Jörn Petersen

Experiences with the implementation of the EX-IN peer support worker in psychiatric services in Germany

ABSTRACT:
This paper describes the results of a science-based model of implementation of the peer support approach in psychiatric organisations in Bremen in 2017. The results from that time are compared in hindsight with the international literature and new practical recommendations are derived from them. Based on the German situation, the experiences can be transferred to international contexts. The central approach is to develop theory from practice, which in turn should directly serve practice: What questions arise when implementing the peer support approach and what can help to constructively solve problems and issues that arise? The aim is to develop psychiatric support services that are community-oriented and person-centred, promote recovery and empowerment.

KEYWORDS:
peer support, empowerment, recovery, participation, experts by experience, involving peers, mental health

1. Introduction

In the last years, peer support has become an important approach in psychiatric services. It is a catalyst of change, which can help to improve the effectiveness of services. A model of psychiatry in which the doctor tells the patient what to do, how to live and what to think is no longer valid. Therefore, many providers of psychiatric services want to involve peer support workers (PSWs) in their organisations as a step towards recovery. In our experience, there are important advantages to involving PSWs, although things might go wrong if certain issues are not considered. This article reflects on these issues and insights on the basis of projects and practical experience, which are then compared with publications.

2. What is peer support?

In mental health services, we often see that support is not accepted by service users, because there is no connection between the world of experience of the service users and the expectations and help offered by the providers. There is a missing link [Utschakowski 2013, p. 17]. Peer support workers can fill in this gap.[1] As Mead [2003, p. 1] explains, peer support is

> a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain.

It occurs when people share common concerns and draw on their own experiences to offer emotional and practical support to help each other move forward [Repper 2013, p. 4]. This is the essence of recovery-focused practice.

Originally, peer support was an individual, unstructured and informal mutual relation between peers, unpaid and based on self-help. The idea of using peers as assistants in treatment dates back to at least the 18th century in France [Pelletier, Davidson, 2015]. Modern foundations were laid by the Alcoholics Anonymous movement in the USA in the early 1920. Much later, in the 1980s, the recovery movement – a form of informal, mutual and collective resistance against coercion and control in psychiatry – inspired change in the mental health system. Over the last 25 years, peer support has become both a role and a paid position. However, it is a profession whose standards are difficult to define, as it is based on an individual perspective and lived experience. By definition, standards have to describe certain scopes of individual role perception. Although other professional roles in psychiatry, such as mental health practitioners, psychologists, nurses and social workers, also have individual competences and ways of connecting to patients depending on their personal background and experience, they have clearly defined roles and methods, techniques and decision-making authority.

3. Peer support training (EX-IN)

The EX-IN peer support course is intended to convey contents while working out, reflecting on and positively rating individual experience. In Germany

[1] In this article, the terms "peer support worker" is used in the meaning of a certified *EX-IN Genesungsbegleiter*, i.e. a peer support worker who has completed the most widespread form of peer support training in Germany – EXperienced INvolvement (EX-IN). This form of vocational training, which is addressed to people with experience of crises, mental health problems and psychiatry, uses experiences as a resource on which a person-centered and recovery-oriented model of psychiatry is built. The training was developed in 2005-2007 by FOKUS and its partners as part of an international project funded by EU.

there are mandatory standards for the training of PSWs, which are monitored by the umbrella organisation EX-IN Germany. These standards were developed as a result of an EU project in 2005–2007. They include a 264-hour course covering topics such as health and well-being, recovery, empowerment, experience and participation, trialogue, self-exploration, advocacy, assessment, crisis intervention, counselling and accompaniment, teaching and learning, reflection on the individual learning process. In addition, participants prepare a written portfolio of their strengths, goals and plans, of their perception and understanding of the role. During the training period, they do two apprenticeships and receive supervision. As an important part of the training, they perform self-exploration to reflect on their recovery process, and at the end they give a presentation on their success in learning.

In one year, the participants go through an intensive process of reflecting on their own experience of illness and recovery, re-evaluating it, describing and thus making it accessible to others. This process takes place in large groups (15–25 participants), so that very different experiences and competences can be confronted. The exchange of individual experiences becomes a pool of collective experiential expertise. Jörg Utschakowski describes the genesis of "we-knowledge" as follows:

> At the beginning, there is always the individual experience of mental shock. This relates to the reactions of the environment, treatment and care in the psychiatric care system, coping with crises and the search for meaning. However, having had such an experience does not automatically entail understanding or knowing something. During the EX-IN course, knowledge is created through reflection, i.e. by looking at, describing and classifying experience. This level is called I-knowledge and is initially something personal. […] We-knowledge first arises during the EX-IN course through the exchange of I-knowledge. Regardless of individual symptoms and diagnosis, the participants can almost always draw on common experiences. These include experiences with stigmatisation and self-stigmatisation, feelings of shame and guilt, certain steps in the empowerment process, and much more [Utschakowski 2015, p. 38f].

During the year of training, the participants become acquainted with recovery- and empowerment-oriented concepts and use them to create their own profile. On the one hand, this is based on the collectively developed we-knowledge, but on the other hand, it remains deeply subjective, because PSWs bring with them their previous professional and personal experiences, including the experience of illness and different paths that led them to recovery.

Examples:

> 1) Martin, a peer support worker, has three children and was a football coach for a long time. In addition, his deep faith in God is an important source of strength for him. He worked as a power plant mechanic and went through psychoses as a young man. He was stigmatised in his job and involuntarily

retired. His path to recovery is closely linked to his faith and his family involvement. At the same time, it was crucial for him to free himself from the judgements of others. His skills as a PSW are complemented by his experience as a football coach.

2) Ursula, a peer support worker, studied for over ten years, graduating in education and theatre studies. During her studies, she suffered from psychoses several times and was also compulsorily committed to inpatient psychiatric treatment and compulsorily treated several times. Her motivation to work as a PSW is based on two foundations: the strong feeling that her compulsory treatments were wrong and that no one should be forced to go through such an experience, and her discovery of bodywork and Asian martial arts, which she practices intensively. It keeps her stable and gives her grounding and strength. She therefore wants to show others how to cope with mental conditions in alternative ways, not only through medication.

3) Charly has no school-leaving qualifications. He worked as a warehouse helper for over twenty years until he could no longer keep his job because of his alcohol addiction. Now he works as a PSW in an addiction ward. His approachable manner, simple language and clear morals in interpersonal matters, which are essentially based on his experience of collegial solidarity among the warehouse clerk helpers, are the foundations of his attitude as a PSW in contact with the patients.

The EX-IN training content requires the PSW to develop their own profile as part of the portfolio. The content combines their personal and professional experience, core competencies, experience of illness and recovery, and their plans and goals. The profile is necessarily subjective. Therefore, processes of role-finding and institutional placement can only succeed if this subjectivity is acknowledged and maintained.

4. Inclusion of peer support workers in mental health organisations

"Our experience with the ImROC[2] programme has led us to the conclusion that the widespread introduction of people with lived experience of mental health problems into the mental health workforce is probably the single most important factor contributing to changes towards more recovery-oriented services" [Repper 2013, p. 1]. Clearly, understanding the idea of recovery can lead to peer support. The rationale for employing PSWs is not to help them, save money, or follow the latest fashion, but to strengthen the idea of recovery and empowerment. Angelika Lacroix, head of nursing in Bremerhaven, described it with the following words:

[2] **ImROC** – Implementing Recovery through Organisational Change, a government-funded organisation for the transformation of mental health services in the UK, led by Dr Julie Repper.

> There was a lack of ideas how to model relations with the patients at eye level, to treat them as humans and people with experiences rather than carriers of symptoms and mad persons to be handled with social distance. In the vocational training in the 1990s there were no topics like recovery or community-based therapy. So changing the institution towards a more recovery-focused place – the colleagues did not know how to set this up. This is the core idea behind implementing peer support [Utschakowski et al. 2016, p. 201f].

PSWs often work as "trailblazers" holding positions in organisations where no PSWs had worked before. As a result, the organisations, the staff and the PSWs are entering a new territory together. This requires the willingness to learn new things, accept uncertainties and change structures to incorporate the new professional group. Our experience has shown that the introduction of the new role goes particularly well when the organisation has prepared itself and receives support if necessary. It should not be the responsibility of PSWs to repeatedly explain what EX-IN is and what the role entails – external experts should impart this knowledge and explain the related processes. The criteria for the successful inclusion of PSWs include a participatory culture of the organisation (towards its own employees) that promotes self-empowerment among the service users. Under such circumstances, the PSW can make a difference by supporting the recovery and empowerment processes of the service users [Utschakowski 2015, p. 22].

In their systematic literature review, Ibrahim et al. [2019, pp. 289–290] identified twelve categories that can positively or negatively influence the introduction of PSW into mental health workforce, eight of which are important criteria for success. They include: 1) organisational culture; 2) PSW training; 3) PSW role definition; 4) staff willingness and ability to work with PSWs; 5) resource availability; 6) financial arrangements; 7) support for PSW well-being; 8) PSW access to a peer network. In order to use these influences as facilitators instead of barriers, it is important to develop a plan of implementation. Repper [2013, p. 2] describes four phases of developing peer worker posts:

1. Preparation: preparing the organisation, preparing the teams, defining roles, common myths and misconceptions, preparing the peer workers (training and work placement opportunities), developing job descriptions and person specifications.
2. Recruitment: advertising, benefits advice, applications, interviews, occupational health, CRB checks, supporting people who are not offered posts.
3. Employing peer workers: selecting placements, induction/orientation, supervision and support, maintaining wellbeing.
4. Ongoing development of the role: career pathways, training opportunities, wider system change.

5. Experiences from Bremen 2017–today

The following sections describe the phases of introducing PSWs into mental health workforce during a project that was carried out in Bremen in 2017, showing both the aspects of success as well as the reasons for obstacles. In Bremen, PSWs were introduced into five organisations in 2017 as part of a model project funded by the health authority and carried out by FOKUS[3] through workshops, coaching and evaluation. In a pilot project financed by the Senator for Health, Science and Consumer Protection of the State of Bremen, eleven PSW posts, each one involving 20 hours of work per week, were fully financed for one year; the only condition was that the participating organisations would continue to employ the PSW for at least another year at their own expense. Funding was provided to five different institutions in the state of Bremen, both in Bremen and Bremerhaven: inpatient and outpatient, from the areas of reintegration assistance and services financed by the health insurance fund. As part of this project, FOKUS (also financed from the abovementioned model funds) was able to offer the following support activities:

- preparatory talks with the management,
- initial assessment of needs (support of the organisations in the selection of suitable employees),
- kick-off workshop with the managers of all organisations,
- five workshops with staff, managers and PSWs in the individual organisations, but also with all organisations involved in the project,
- joint inter-institutional supervision of all PSWs,
- on-site job coaching,
- evaluation through focus group interviews with staff and PSWs at the beginning and at the end of the project period.

FOKUS worked both directly with the individual organisations and with all organisations together, holding workshops to promote networking and exchange of experiences among the project partners.

5.1 Preparation of the organisation

In organisations planning to employ PSWs, there are usually different voices that contradict or complement each other; there are hopes and support, fears, prejudices and resistance. Discussing these openly, agreeing on ways forward and taking concerns seriously are important first steps. Employing a PSW is a business decision.

[3] FOKUS is a center of participation and education, part of an initiative for social rehabilitation in Bremen, offering EX-IN training, empowerment college, counseling, organisational development, supervision and further training for psychiatric workers.

Work with the leadership in advance

In this phase, it is crucially important that the leaders take this step seriously and make a clear decision about:

- Do we want PSWs at all?
- Why do we want PSWs?
- What are we prepared to do to ensure the success of the process?
- What framework do we provide?

These questions should first be clarified within the leadership. There may be conflicts and difficult situations in the process of recruiting PSWs, for which the leadership should take responsibility in advance to maximise the likelihood of the success of the process and actively face problems as they arise.

As far as the model project in the state of Bremen is considered, this meant that one of the first steps was to personally visit all managers of the organisations that wanted to employ PSWs. The managers were asked about their motivation to employ PSWs and their willingness to participate in the accompanying activities. These interviews revealed very different needs and varying degrees of willingness to participate in the accompanying measures. External consultants have no possibility of influencing organisational decisions. As the project progressed, it became apparent that not all of the organisations had the desire to engage in the change process. This was achieved in an exemplary way with one organisation in particular, referred to as Hospital A. In this psychiatric hospital, the procedure was first agreed upon in principle during a discussion with the medical director. The top management of the hospital fully supported the process and the goals of the project. Hospital A, as the only participating organisation, booked information lectures for the senior staff in advance. As a result, FOKUS was able to give two lectures to doctors, psychologists and nursing staff about EX-IN training and recovery principles.

Work with the teams in advance

Working on prejudices and reservations, but also dealing with expectations and hopes in the multi-professional teams, is another important step. This is where myths appear that need to be addressed. Repper [2013, p. 7ff] lists some of the most common ones:

Myth #1 - Peer support is just a way of saving money.

Myth #2 - PSWs will be too fragile, they are likely to "break down" at work.

Myth #3 - PSWs cannot be expected to conform to usual standards of confidentiality.

Myth #4 - There is no difference between PSWs and other staff who have personal experience of mental health problems.

Myth #5 - The presence of PSWs will make staff worried about "saying the wrong thing."

Myth #6 - The only way to be sure of getting a job these days is to say you have a mental health problem.

Myth #7 - PSWs get to do all the nice things – talking to patients, taking them out, going home with them; the rest of us have to do the boring admin stuff, give medications, hand out meals, make beds etc.

Myth #8 - PSWs don't know the difference between friendships and working relationships.

Myth #9 - PSWs will be subversive, they will be "anti-psychiatry" and "anti-medication."

Myth #10 - PSWs will take up so much time that traditional staff roles will be made much harder, not easier.

Leaders of the PSW inclusion process will have to find answers to these myths. At the same time, unrealistically inflated expectations, such as "everything will be better with a PSW" or "finally we have someone for those cases where we can't think of anything else," should be dealt with. Once these concerns and prejudices have been expressed and – as far as possible – dispelled, the next phase can begin. With the team, a list of PSWs' tasks can be outlined, including the necessary training and induction. In this phase, a provisional task profile should be developed, leaving room for individual role perception. A contact person should also be appointed to answer questions and attend regular reflection meetings.[4]

Recovery-oriented culture

According to Dr Thomas Ihde-Scholl (Chief Physician, Psychiatric Services, Interlaken, Switzerland), the inclusion of PSWs can be fruitful only in institutions where recovery and empowerment orientation as well as person-centredness are already present. Otherwise, the gap between the affected persons, peers and the institution is too wide. Peers are trialogical bridge builders, important links between the affected persons, relatives and professionals. But if the gap is too wide, even a peer cannot build bridges [Ihde-Scholl 2014, p. 5].

Therefore, it is advisable to combine the process of introducing PSWs with a reorientation from content-related work towards more recovery and empowerment orientation as well as person-centredness. But what constitutes a recovery-oriented culture? Lacroix [2017] lists the following aspects:

- at the beginning of treatment, the emphasis is on diaogue rather than immediate change,
- the organisation should ensure that patients' rights are consistently respected,
- patients' needs take on a different meaning ("other-knowing"),
- more attention is given to subjective feelings and opinions (search for needs-based and doable solutions),
- individuality is more appreciated,

[4] It is recommended to prepare to discuss and find answers to all these myths in advance in the management teams. But if there is no time to find your own answers, Julie Repper addresses these myths in the IMROC resource: https://imroc.org/wp-content/uploads/2016/09/7-Peer-Support-Workers-a-practical-guide-to-implementation.pdf (pp. 7-9).

- "normal" is promoted more, the focus is no longer on "sick."

Recovery orientation means the search for individual solutions instead of following therapeutic programmes. It means consistent orientation towards the person's goals, the strengthening of the will to take control of one's own life again, wherever it shows itself: Having hope and communicating it, having respect and showing it, having a resource-oriented view and seeing and naming abilities in patients [cf. Lacroix 2017].

During the pilot project in Bremen, this work was successful above all with Hospital A. There, the wishes and ideas associated with the recruitment of PSWs were worked out with two wards. Task profiles and PSW profiles were developed. One ward, working according to the DBT (dialectical behavioural therapy) programme with people suffering from borderline personality disorders, had special requirements: The staff wanted a PSW who knew this disorder from personal experience and identified themselves with the DBT approach. They hoped that such a staff member would bring a more person-centred, experience-based orientation to their work. As a special requirement, it was emphasised that it would be important for the PSW to be able to adhere to binding team agreements in order to prevent splitting processes. Such a candidate could be found. During the interview, expectations were directly named and clarified. The PSW has now been working on the ward for three years and has completed further training as a DBT peer coach. This example demonstrates that it is crucially important to match the PSW with the right post in order to increase the impact of peer support. Therefore, the goals, ideas and tasks need to be defined before employment begins.

5.2 Cross-organisational workshops

Another component of the project was workshops held throughout the duration of the project with PSWs, trainers, managers and team colleagues. These workshops were not attended by all organisations to the same extent. Below is a description of the topics covered during the workshops.

1. Workshop I: Kick-off workshop for leaders

Wolfgang Monheimius, head of Malteser-Johanniter-Johanneshaus gemeinnützige GmbH, a hospital for mentally ill people in Siegburg, spoke about the successful inclusion of PSWs in his organisation as well as the associated stumbling blocks. In his lecture, he emphasised the necessity of deciding in favour of employing PSWs by the managers so that the changes triggered by the new employees' perspective will be considered at the decision-making level. In subsequent workshops, ideas on key topics were exchanged by the participating managers.

2. Workshop II: Recovery-orientation in different settings

Gwen Schulz, EX-In Counsellor in Hamburg, gave a keynote speech on her professional approach. Afterwards, the participants worked in small

groups on the following questions: Group 1: When would I be satisfied with the mental health care in my organisation? What are my criteria for success? What situations make me satisfied in contact with service users? Group 2: Where do we already work in a recovery-oriented way in our institution? What would I like to change? Where do I think PSWs can integrate well in our facility and contribute to our recovery orientation? Group 3: What can I contribute to the creation of structural and conceptual framework that would strengthen the position of PSWs in my institution? What framework do I need for my work with PSWs?

3. Workshop III: Empowerment and person-centredness in different settings

In this workshop, PSWs from the Bremerhaven Reinkenheide Clinic gave short presentations about their approach, areas of work and understanding of their role. Afterwards, there was the possibility to further work on the topics of empowerment orientation and person-centredness.

4. Workshop IV: Job description and task profiles

The aim of the workshop was to produce clear job descriptions and task profiles that would provide PSWs and other staff members with information as to which tasks can/cannot be taken on by PSWs. During the discussion, questions were analysed from different perspectives and experiences were exchanged.

In the actual work with PSW, there may emerge questions that have not been anticipated. Utschakowski et al. [2016, p. 217ff] provide the following example: Can or should PSWs have access to the patient file? This question was discussed at length and no unambiguous conclusions were reached. Two attitudes crystallised: 1) Access to nursing documentation should be possible; medical documentation should not be accessible. Justification: If PSWs are not involved in the day-to-day business, they don't know enough to have a say. However: a certain level of trust is necessary for the PSW to handle it reasonably; 2) PSWs should not have access to patient records on the grounds it could weaken the patients' trust in the peer. During the Bremen model project, another option emerged: Wolfgang Monheimius reported on the possibility of PSWs supplementing the documentation with their own comments, which are deliberately set off by colour and throw a different perspective on what is happening, thus enriching the professional discourse. The organisation represented by Mr Monheimius also uses this possibility in assistance planning. Utschakowski [2015, p. 46] lists the following possible tasks of PSWs:

First level: In contact with service users

- "light at the end of the tunnel" model,
- convincing, cheerleading,
- practical support,
- speaking the same language,
- understanding/explaining the impact of the mental disorder to the patient,

- reducing the fear of obstacles,
- providing emotional support,
- staying in touch
- inclusion, integration in the community.

  Second level: In contact with colleagues
- interpreting,
- bridging function.

  Third level: In contact with the organisation
- individualisation of support,
- impulse for quality assurance,
- contributing and presenting experiential knowledge in training.

5. Workshop V: Evaluation of the model project

For this workshop, each organisation participating in the project gave a short presentation on the following issues:

- In which area are PSWs employed?
- How have PSWs integrated into the organisation (guidance, team, supervision, etc.)?
- What tasks have PSWs taken on?
- Were there any changes in the PSW task profiles over the course of the project? If so, why?
- What is PSWs' special expertise and where is it best demonstrated?
- Did PSWs provide conceptual impulses for the organisation?

During the workshop, successes and problems connected with the inclusion of PSWs were discussed and recommendations were exchanged about what needs to be done in the future.

5.3 Other elements of the model project

Supervisions of PSWs by an inter-organisational group

PSW supervision is a good tool to:

- promote the development and maintenance of role clarity,
- stimulate discussion on the further development of resource- and recovery-oriented peer methods,
- support the exchange of experiences by PSWs,
- promote job satisfaction,
- further develop competences in the area of professional relationships with colleagues and "professional closeness" with the service users.

Individual coaching in the workplace

PSW coaching did not take place in all organisations. It was a good opportunity to provide PSWs with more support in the induction phase, especially in the case of organisations in which it was a new position, and to use external expert knowledge for this purpose. The contents of the coaching talks were based on the following topics:

- managing relationships with service users, colleagues/team,
- self-image,
- reflecting on PSW's role in the team and organisation,
- supporting PSWs to follow the framework regulations in the workplace,
- dealing with closeness and maintaining boundaries,
- developing communication skills based on case studies.

5.4 Evaluation of the project

To evaluate the project, a combination of questionnaires and focus group interviews was used. Each organisation received a questionnaire to record their experience and future plans concerning PSWs. Changes in the staff's attitudes and perceptions as well as their specific experiences of cooperation with PSWs during the project were recorded during the second focus group interview towards the end of the project.

Research results indicate that the quality of care improves by involving PSWs, which is confirmed by the literature [Chinman et al. 2014]. More recovery-, empowerment- and person-oriented care can be achieved if PSWs are not treated as helpers of the nurses, but are seen, involved, appreciated and paid for their special, experience-led perspective as team members with unique expertise. The results of the evaluation showed that the cross-institutional settings had a quality-enhancing effect. The project also offered the possibility to discuss role assignment (by professionals/leaders) and role perception (by PSWs) in a cross-institutional setting. This enabled the staff members to exchange ideas, hear suggestions from other institutions, question their own actions and reflect on their own perspectives. Thanks to the chosen format of workshops, coaching and supervision, PSWs received support in the particularly difficult phase of "entering the profession." This format enabled PSWs to reflect on their perception of their own role during discussion with other PSWs, during individual counselling and during meetings with professionals from different institutions who addressed their concerns.

The evaluation of the project led to the identification of different role models and tasks depending on the employing organisation. The differences had serious effects on the PSWs' self-image. The first two role models described below became clear in the Bremen model project. The third role model exists in various other places in Germany:

1. In the first model, PSWs are primarily tasked with representing the interests of the service users. Advocacy, independence and partiality are the main characteristics of their work, which does not develop within the framework of cooperation in the treatment team, but together with the other PSWs, as indicated by the following comments:
   - *...no professional can tell me, "you do it this way or that way." Otherwise I would have trained as a nurse or nurse practitioner or something like*

that. My tasks are different... I follow... or go with the patient the way he wants to go, or the way that is right for him. And I don't care what the professional thinks. They may have a different idea of what is good for the patient, but then they have nothing to say about it... nothing. Of course, I try to steer them on the right track in a diplomatic, tactical way, so to speak. So far I have succeeded. Once I am left alone with the patient. [118ff_Team4]

- *I find it very reassuring for me when a doctor or even a psychologist asks me: "Man...can you maybe, are you maybe a bit closer?" Of course I am closer... of course...* [218ff_Team4]
- *our job is to represent the patient, I accompany them, and that can also mean throwing myself over with all the professionals.* [188_Team4]

2. In the second model, the PSW enriches the multidisciplinary teams with their specific competences and experiential knowledge, which brings changes to the cooperation and improves the quality of treatment/care.
   - *I also see myself as a complement in my professional field, a bit of a luxury, because other professional groups create and maintain the structure here, without them it wouldn't work, it wouldn't work and I or we can also move around in it.* [248ff_Team5]
   - *I find it enriching, so I find it not competitive, but complementary.* [369ff_Team5]
   - *I take part in the morning round, which takes place on the floor or in the day clinic, I alternate that sometimes and it is also used. Once as a bearer of hope, I bring my experience across... also as an interpreter between professionals and peers. As an advocate less, we already have other people… that has already happened.* [46_Team3]
   - *Well, EX-IN has different possibilities, i.e. leisure activities* [...] *and there are also different focal points of individual EX-INers. But I have mainly worked together with B. and very closely, also with a client whom we accompany together... so a tandem between reference care and EX-IN / recovery support.* [175ff_Team1]

3. In the third model, the PSW offers an independent service that is not integrated into the processes, concepts, work organisation and cooperation of the teams. Thus, this role perception offers an independent special approach, complementary to the conventional treatment (comparable with painting therapy on another ward, etc.). From FOKUS's point of view, this role concept loses an important function: the PSW has little influence on the culture of the institution because they are not part of the team and the organisational culture.

5.5. Recommendations for practice

From FOKUS's standpoint, on the basis of practical results from the implemented project, recommendations for the successful introduction of PSWs into institutions include the following:

1. Clarity of leadership in the process, preferably upfront

   The introduction of a new occupational group is a corporate decision that will inevitably have an impact on the existing system. This must be considered in advance.

2. Preparation of the organisation, culture-building measures

   PSWs can only develop their special expertise if they are seen and heard as experts. This works better in an organisational culture that is recovery- and empowerment- oriented, in which the various professional groups are used to, and cultivate, multi-professional cooperation in their appreciation of diversity. This ought to be promoted by a management that values the expertise of all professional groups equally and supports their impact on the organisation.

3. Support of information and processes by experts who are familiar with the contents of PSW training and ways of their introduction into the organisation

   PSWs' approach, language and perspectives are different from the traditional psychiatric approach. It is therefore helpful for the organisation to buy in the PSW expertise (e.g. through PSW trainers). This is often not appreciated by organisations. The implementation of the PSW approach is a task that the PSW movement is increasingly focusing on.

   Especially in organisations that are new to the PSW approach, a situation sometimes arises that the new employee – often a newcomer to the field – has to explain to the superiors/managers what their tasks and integration into the organisation should look like. This almost inevitably leads to excessive demands.

4. Supportive staff members who are interested in working with PSWs and contributing to the process

   Ambassadors, mentors, patrons, catalysts help to make the introduction process smoother. It helps if they perform this function not only informally, but have been designated by the leadership, and this is accepted by the other team members.

5. Clear tasks, competences and work processes help PSWs considerably (job description, what are my tasks, what am I allowed to do, where do I get my clients from, who is allowed to give me work assignments, are my views interesting for my colleagues, etc.)

   It is also important to be clear about how much change/uncertainty, feedback/questioning we want to allow. Lack of clarity leads to conflicts and frustration. The management/supervisors must be clear about which tasks they

want to assign to PSWs (group work in tandem, independent group work, counselling in tandem or independently, open contact, participation in treatment/rehabilitation, etc.). PSWs can be "agents of change" (Everett M. Rogers), as they bring a different/new perspective. However, they can easily be overloaded with expectations, or be thwarted and frustrated. This needs to be reflected on and considered.

6. Young professionals need support, especially in new fields, especially if they are the first of their kind in an organisation
7. Networking and cross-institutional exchange in a cooperative atmosphere helps, e.g. through self-organised PSW meetings and professional (cross-institutional) supervision

The challenges, problems and issues that need to be addressed are quite comparable in different organisations. Nevertheless, organisations come up with different answers. Sharing and encouraging each other, offering feedback and space for reflection can be very helpful, according to the experience gained in the project.

8. Which orientation should it be?

The role played by PSWs in the organisation should be worked out in advance. Some of the possibilities are as follows:

- agents of change to initiate/accelerate internal processes,
- staff members in a multi-professional team with experience perspective and expertise,
- staff members with special expertise who offer an independent service in addition to/parallel to/independently from the others,
- advocacy, independence and partiality are the main characteristics of peer work, which does not develop within the framework of cooperation in the treatment team, but together with the other recovery facilitators.

9. Normalisation

Employment relationships in which PSWs are employed under a contract of employment (1st labour market, regularly financed) are the same as those that apply to other employees. It is important to clearly communicate this in the attitude and in contracts. "Special needs will be taken into account" can be a formulation that leaves room for individuality, restrictions and needs due to disabilities, illnesses and special situations without stigmatising from the outset. The employment of PSWs can help to make the work processes in the organisation/team more health-oriented.

6. Outlook – perspectives at national and European level

In order to secure the position of PSWs in the long term and achieve adequate payment for their services, one goal is the recognition of the PSW professional profile by the state. Professional standards are necessary for this. This has advantages, but also involves risks.

So far, EX-IN Germany has followed an important principle: the course participants can be people who are able to work and whose goal is to develop a professional perspective, as well as people who are not able to work and whose goal with the course is to achieve more participation. This broad range of people in very different life situations and with different competencies is an important prerequisite for the learning laboratory of the course, for the development of we-knowledge and for experiential learning from the course dynamics. If the courses were attended only by "highly motivated, able to work, completely symptom-free, stable participants" (which is unrealistic, since PSWs are never completely symptom-free), who are just waiting to take on a role in psychiatric care, we would be considerably limiting the diversity and consequently quality of learning. The perspective of self-help, anti-psychiatry, low-threshold and collective search for solutions in the face of difficult course dynamics and personal crises would then no longer apply to the same extent as before.

There is also a risk with regard to role definition. State recognition necessarily implies standardisation. The portfolio of PSW training so far has allowed participants to find an individual role based on their experience, their recovery knowledge acquired in life and their we-knowledge acquired during the course. This profile is individual and subjective. Professional standardisation could focus more on the acquisition of retrievable knowledge and the use of specific methods. This would mean that a core value of the course would be lost: the person-centredness of the profile. This must be preserved at all costs, even at the expense of professional recognition!

So far, the different social classifications (able to work, seeking, partially incapacitated, fully incapacitated) have not been an obstacle to accessing PSW roles in Germany. In the author's view, this should remain the case. The benefits of this development come down to the following:

1. Professional recognition provides an opportunity for pay scale classification.
2. An opportunity arises to charge for activities that accompany recovery, thereby creating more jobs.
3. Professional recognition can open up career options and opportunities for advancement in other ways. This is an important issue for the future. Many PSWs have high educational qualifications, are able to work on high level issues and do not receive adequate remuneration for their services. Therefore, we need further development of career paths. On the one hand, they should reflect the principle of "payment according to assumption of responsibility and performance of tasks more than according to professional qualification," on the other hand, there is also a need for educational and further training options, such as course/studies for PSWs, etc.

4. State recognition of PSWs will bring empowerment and lift the status of the fifth wheel on the wagon from them. Along with better pay, this is a major step towards empowerment.

In Germany, an important step was the foundation of a federal association for PSWs with binding training standards (EX-IN Deutschland e.V.) It was a way of formalising the social movement, which provided lobbying power and rejuvenated energy. Largely thanks to this, it has been possible to define and monitor binding standards in Germany. There is currently only one nationally recognised further training course to become a PSW. At the European level, an umbrella organisation should be created to promote professional recognition and to bring together the energy of the national associations. This could create further synergy effects and a new power of representation. At the same time, adapting to international standards always means losing some of the national traditions and giving them up in favour of international standards. In this context, it is important to take national traditions and cultural conditions into account. Here is an example: In the German-speaking area (Germany, Austria, Switzerland), it was relatively easy to transfer the course contents, since the professional exchange is intensive anyway and the German-language discourse is cross-border. When transferring the PSW experience to Poland, it became apparent that the cultural barriers and the development of the psychiatric landscape are very different (e.g. the importance and presence of religion, the non-existence of self-help associations, the strong power of inpatient psychiatry and the underdevelopment of outpatient and social psychiatric services, etc.). A lot of cultural adaptation work would have to be done in order to make the approach transferrable. European standards must therefore take regional specificity into account.

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The possibility of using the potential of the peer support worker in the Polish system of social welfare and social employment

ABSTRACT
In the Polish legal system, the concept of introducing the role of the peer support worker is in the testing phase. Peer support has been primarily associated with psychiatric care, which is part of health care. Nevertheless, peer support workers' potential can also be used in other areas of support in which it is desirable to draw on the skills and knowledge of experts by experience. One of such areas is social assistance, where peer support worker could oversee the treatment process of persons with mental disorders, support them in dealing with everyday matters, maintaining contacts with the environment, gaining professional qualifications and even taking up employment. Moreover, they could become members of teams of therapists and other specialists working in support centres and sheltered housing. Their involvement in providing social benefits could be an important element of support in the processes of recovery and social inclusion of persons in difficult life situations. It would be a valuable contribution to the existing traditional methods of working with clients, decreasing the burden on social workers in those areas where specialist knowledge and qualifications are not indispensable.

KEYWORDS: peer support worker, social welfare, social employment, social recovery

1. Introduction

The position of the peer support worker (PSW; also known as peer expert, peer worker, recovery assistant, recovery companion, expert by experience, experiential expert) was introduced into the Polish legal system in 2019 and assigned the role of a companion in the recovery process. This person shares their lived experience of having survived a mental crisis with people who are currently going through a similarly difficult situation in life. Peer support has been closely associated with the psychiatric care system, and thus the health system. Importantly, however, support for persons with mental disorders in Poland is provided under two separate systems: health care and social welfare. The current regulations associate peer support with the functioning of Mental Health Centres, without the possibility of introducing it into social welfare institutions. The aim of this paper is therefore to assess the potential of using peer support in the social welfare system taking into account the beneficiaries' needs. The possibility of involving experts by experience in processes that support recovery from long-term unemployment will also be considered.

2. Social assistance for persons with mental disorders

The concept of systemic use of peer support is rooted in helping people with mental disorders. Although they are one of many groups of recipients of social benefits, it is them who should be the focus of attention when assessing the possibility of involving PSWs in the social welfare system. Using their services in other areas could only be considered in later stages.

Providing treatment and care for persons with mental health problems is part of the health system. Social welfare institutions play a supporting role here, although they are important from the point of view of the social functioning of these persons. These organisations are tasked with preventing the social exclusion of persons with mental disorders, undertaking activities for their empowerment, integration with the environment, professional activation, and support for their families.

Article 2(1) of the Act on Social Assistance[1] defines this form of help as an institution of national welfare aimed at enabling individuals and families to overcome difficult life situations that they could not overcome using their own powers, resources and skills. There are various causes of difficult life situations, such as mental illness, intellectual disability, alcohol addiction, drug addiction, unemployment, homelessness, or general helplessness. Crisis situations are often caused by mental disorders and social maladjustment. The social welfare system supports individuals and families in their efforts to

[1] Act of 12 March 2004 on Social Assistance (consolidated text: Journal of Laws of 2020, item 1876, as amended).

meet their vital needs, enabling them to live in conditions that preserve human dignity. Another task of social welfare is to prevent difficult life situations by taking actions aimed at the empowerment of individuals and families and their integration with the environment [Sierpowska 2020, pp. 32–38].

Persons suffering from mental problems have the right to social benefits on general terms, after meeting certain conditions, but they are also entitled to special kinds of benefits addressed exclusively or primarily to this group. These solutions are intended to satisfy their basic living needs and develop their ability to function independently in society. Most of the benefits combine both of these features, which seems extremely important in the case of this social group.

The benefits addressed to persons with mental disorders include specialist care services. They are adapted to the specific needs resulting from a given type of disease or disability, and provided by people with specialist professional preparation [Bronowski, Sawicka 2010]. Their scope exceeds typical care and hygiene services and includes teaching and developing skills that are indispensable for independent life, such as the ability to meet basic life needs and function in society; instilling motivation to be active, seek treatment and rehabilitation; providing self-care training and training in social skills; and offering support, including in the form of daily life assistance. It also involves assistance in dealing with crisis situations, facilitating access to education and culture, counselling, coordination of activities of other social services provided to the family of a person who receives help in the form of specialised services, fostering positive relations between the supported person and significant others, cooperation with the family, assistance in dealing with official matters, support and assistance in finding employment, advice in money management. Moreover, these services include nursing, which consists in supporting the treatment process by arranging and monitoring the dates of medical appointments, diagnostic tests, assistance in buying or ordering drugs and medicaments, monitoring the intake of drugs and observing possible side effects. Finally, the services in question involve physical rehabilitation and improvement of disturbed bodily functions (cooperation with specialists in the field of psychological, pedagogical, educational and therapeutic support aimed at multidirectional activation of the supported person) and housing assistance.[2]

Another form of assistance that supports people with mental disorders in their living environment is the possibility of accommodation in sheltered housing [Krajewska 2020; Maciejko 2009, pp. 371–374]. A sheltered flat is a form of social assistance that prepares the residents living there under the

[2] Regulation of the Minister of Social Policy of 22 September 2005 on specialist care services (Journal of Laws 2005, no. 189, item 1598, as amended).

supervision of specialists to lead an independent life, or supports these people in their daily functioning [Article 53(2) of the Act on Social Assistance]. This form of help is addressed to people who are otherwise unprepared to lead an independent life in society using their own skills and resourcefulness. Their lack of independence may be due to mental disorders – people with such disorders are among the target beneficiaries of this form of help. Accommodation in sheltered housing involves a combination of various forms of assistance. Usually, at the beginning, it includes round-the-clock care, which gradually evolves into emergency support and ultimately leads to achieving independence. The overriding purpose of accommodation in sheltered housing is to make the resident independent. One of the principles of living in a sheltered flat is to provide limited access to care and well-being services, which is intended to encourage the beneficiary to seek solutions on their own, be active, look for sources of income and think creatively. At the same time, this form of assistance is associated with access to qualified personnel providing not only care and well-being services, but also advice and guidance in dealing with everyday matters [Maciejko, Zaborniak 2008, pp. 260–263]. For people with mental disorders who do not need to be placed in 24-hour care facilities, this form of support is a chance for independent functioning in an inclusive community.

Other forms of social assistance available to people with mental disorders include social work and specialist counselling. Social work is intended to improve the functioning of individuals and families in their social environment by developing or stimulating their activeness and independence in life. Social work can be done on the basis of a social contract and is independent of income. Counselling is provided to individuals or families in difficult situations or in need of support in solving their life problems, regardless of their income. The law permits different forms of this assistance, including psychological and family counselling. The former is based on the processes of diagnosis, prevention and therapy, whereas the latter focuses on challenges connected with the functioning of the family, such as caring for a disabled person, as well as family therapy [Nitecki 2013, pp. 369–372].

It is worth noting that the beneficiaries of social work and counselling may be families whose members include persons with mental disorders. This is extremely important, because it is a form of reducing the burden on relatives who may struggle to provide care to the family member who needs it; the psychological aspect of such support is equally important. The abovementioned social services provided to people with mental disorders and their families may take the form of motivating them to start or continue treatment and maintain cooperation with a doctor; involving the family in the treatment process, or educating them about the symptoms of relapse; encouraging them to use the services of support centres; or taking steps connected

with issuing a compulsory treatment order or incapacitation of a person with mental disorders [Wachowska 2013, p. 105; Podgórska-Jachnik, Pietras 2014, p. 117 et seq.].

The benefits discussed above are forms of providing assistance in the beneficiary's environment. Apart from them, there are in-house (institutional) benefits provided by social assistance units, such as support centres. It is an umbrella category for various social institutions, one of them being community self-help homes (*środowiskowe domy samopomocy*) for people with mental disorders. These institutions are addressed to people who, due to the impairment of certain bodily functions or adaptive abilities, need help to be able to live in a family and social environment. In particular, such assistance is intended to increase the beneficiary's resourcefulness, ability to live independently, and social integration. Community self-help homes provide services as part of individual or group self-care exercises and social skills training, consisting in learning, developing or maintaining skills needed in everyday activities and social life.

The services of community self-help homes can be used by chronically mentally ill persons, mentally retarded persons, and persons with other chronic mental disorders.[3] They include in particular: everyday life training, training in interpersonal skills and problem solving, training in the ability to spend free time, psychological counselling, assistance in dealing with official matters, assistance in accessing health services, providing the necessary care, physiotherapy, round-the-clock meals for participants admitted for round-the-clock stay, as well as other services preparing for occupational therapy workshops or employment, including sheltered work in an adapted workplace.

Persons with mental disorders who are unable to function independently in society are provided with accommodation in care homes (*dom pomocy społecznej*). These facilities provide services connected with assisted living, nursing care, different forms of support and education; they also provide access to health care, but they are not an alternative to professional healthcare units. The primary task of a care home is to provide care and support, not treatment. Specialised care homes are dedicated for persons with (chronic) mental disorders, intellectual disabilities, as well as for intellectually disabled children and adolescents. In these facilities there are therapeutic and care teams whose task is to determine the residents' individual needs and develop personalised support plans for them. The latter are prepared in agreement with the residents, provided their health allows it and they are ready to participate in the programme. There are also 24-hour care homes for persons

[3] Cf. Regulation of the Minister of Labour and Social Policy of 9 December 2010 on community self-help homes (consolidated text, Journal of Laws of 2020, item 249).

addicted to alcohol, i.e. persons who may display symptoms of mental disorders. Contrary to other types of care homes, accommodation in these facilities is always temporary.

To conclude this brief review of the available forms of social assistance addressed to persons with mental disorders, it is immediately noticeable that they are dominated by services connected with providing support and assistance, intended to enable the beneficiaries to function in their environment. Round-the-clock care is treated as a last resort provided to persons who are otherwise unable to live an independent life. The vast majority of benefits have an inclusive role, preventing social exclusion of the beneficiaries. Some of them support the process of treating persons with mental disorders. Effective community assistance may prevent further hospitalisations or isolation in closed institutions. Assistance provided to families caring for members with mental disorders brings similar results. Although the involvement of the family provides significant relief for public institutions, also in the purely financial sense, unfortunately it is not properly appreciated yet.

3. Peer support workers in the social welfare system, with particular emphasis on supporting persons with mental disorders

Providing assistance connected with mental disorders is typically associated with healthcare services and healthcare units specialised in this area. Perceived in this way, assistance is tantamount to treatment, but not every beneficiary requires it. Providing health services to persons with mental disorders is often treated as a last resort, not least due to the attitude of the interested parties and their relatives, who may prefer not to notice the problem, try to downplay its effects or hide it from the environment. Most people who suffer from mental disorders and do not require specialist treatment or hospitalisation manage to function in their own environment, independently or with the support of their families, but such disorders often lead to difficult life situations and problems that cannot be overcome without assistance. Therefore, it seems indisputable that the environment of a person with a mental disorder should have room for social services complementing the activities of healthcare institutions.

The role of social assistance and services provided in the beneficiary's environment can be considered in three contexts. Firstly, it can constitute sufficient support for persons with mild disorders who do not require medical attention, but only help in their daily functioning. Secondly, it may support the treatment process, including support for the beneficiary's family. Thirdly, social assistance may be more needed after the end of psychiatric treatment, when it should be primarily aimed at counteracting the social exclusion of the service user. All the indicated areas have room for peer support workers

who could support the beneficiary in overcoming crises accompanying the process of recovery and regaining social competences.

The Polish system of social assistance distinguishes between the services of accompaniment, support and assistance. It is worth mentioning in this context the professions of family assistant and disabled person's assistant. However, both roles require qualifications and education, not first-hand experience of a crisis. The introduction of the role of peer support worker would therefore constitute a new element in the system. However, this role would have to be viewed not only in the context of participation in the recovery process. The profession in question would have to align with the goals and needs of the social assistance system, and thus take into account the social aspect connected with the performance of various roles. It is worth adding that this aspect is also emphasised in the treatment and recovery process. It is noted in the literature that "the effectiveness of physical and mental recovery is measured by the success of social recovery. A recovered patient is a person who is well adapted to living in society" [Sokołowska 2011, p. 123]. Attention is given in this process to the role played by those who have experienced the disease themselves, as they are most knowledgeable about it and best able to define the expectations connected with recovery [Brown, Rempfer, Hamera, 2008, pp. 23–26].

The PSWs' potential could be used in community work. Currently, a leading role in this area is played by social workers and family assistants. Persons performing these professions penetrate the environment, make a preliminary diagnosis of problems and needs, and work with the individual or family affected by a crisis. They also recognise the symptoms of mental disorders and social dysfunctions, provide support or contact details to specialised help centres. However, persons seeking social assistance or the help of a family assistant or social worker are not always aware, or ready to admit, that the source of their problems lies in mental disorders. Contact with someone who has been in a similar situation, and who has managed to overcome the crisis using various solutions offered by the system, including the help of specialists, may prove invaluable. In the case of individuals struggling with mental health problems who are unable to overcome the barriers connected with diagnosing them, talking to a PSW may become a breakthrough in changing their attitudes.

PSWs can also assist social workers in the process of providing social benefits. When performing specialist care services, they can offer advice and support in the area of teaching or developing skills needed for independent living, overcoming fears, and functioning in society. Their experience in overcoming adversities will motivate the beneficiaries to make the effort to find treatment or therapy and be more active. PSWs can accompany them in everyday life activities, help to build positive relations with the environment,

deal with official matters or help to run a household. They can therefore assist social workers in the performance of specialist care services, or take over some of their tasks. In particular, the aim is to include PSWs in the range of care services that do not require specialised qualifications.

Another area where PSWs could be used is work with the so-called multi-problem families. Such families are usually characterised by helplessness in running a household and parental neglect; they are affected by unemployment and poverty, and all these problems are often compounded by alcoholism. The work of a family assistant or social worker is focused on persuading the addicted person to start treatment, which may determine the success or failure of working with the family; however, reducing alcohol consumption and long-term sobriety is already a satisfactory result. At this stage, the involvement of a PSW could prove very helpful. When working with a family in a crisis resulting from multiple, varied problems, it is recommended to create separate teams in which individual members assume different roles, e.g. taking the client's side or noticing their mistakes [Bozacka, Rynkowska 2014, p. 147; Krasiejko 2011, pp. 156–163]. It is these teams that could take on a person who has already overcome the addiction. This person may not only share their experience and encourage change, but also help the social worker to define the client's needs and strengths and involve them in setting goals. In the case of a relapse, a PSW seems to be better able to provide support than a social worker. The PSW's past failures and present perseverance could contribute to realising that relapse is a normal and temporary state of recovery, not an irreversible failure.

Counselling is another area of social assistance in which PSWs can be involved. Their experience and skills could be used to complement the advice given by specialists. Meeting with a PSW could be part of individual or group therapy or psychoeducation. The possibility of including them in therapeutic teams working with people in crisis, conducting classes in support centres for people with mental disorders, in care homes for people addicted to alcohol, crisis intervention centres, shelters for the homeless and other social assistance units should be considered. At the same time, it should be emphasised that there is a considerable demand for such services, not only among people struggling with mental problems. People who have experienced a crisis caused by domestic violence, rejection by significant others (e.g. single young mothers), addiction, homelessness, long-term unemployment are capable of helping those who are currently undergoing such crises. A person in crisis often loses the willpower to change their situation, lacks motivation and faith that overcoming the difficulties is possible, faces stigmatisation and rejection. Malaise, discouragement, and isolation aggravate the crisis. Contact with a person who has had a similar experience and managed to overcome it could be a poignant and authentic experience. In such situations, a PSW per-

forming the role of an educator and guide can achieve more than a qualified worker. The possibility of establishing less formal contacts should be noticed here, which may in turn trigger greater openness of the service user [Debyser et al. 2019, p. 561]. A PSW can often be the first representative of the support and assistance system with whom the person in crisis may be able to establish genuine contact. Therefore, a PSW assumes the role of a non-professional specialist in crisis intervention and social inclusion.

The project "Expert by Experience," implemented by the Municipal Social Welfare Centre in Gdynia in 2016–2018, is an inspirational and informative example of the possibility of including PSWs in the social welfare system. This initiative enabled the project participants – peer support workers – to:

- develop and evaluate individual reintegration paths and initiate new forms of support for the beneficiaries of social assistance;
- search for additional sources of finance to satisfy the vital needs of people benefiting from social assistance;
- support the work of the disabled person's counsellor;
- participate in support group meetings;
- provide services connected with career counselling;
- provide services connected with participation in the labour market, such as supporting the service user in the process of professional activation, searching for employment, preparing for an interview, taking up and maintaining employment [Florianowicz 2018, p. 66].

To sum up this part of considerations, it should be noted that the social welfare system not only offers the chance to use PSWs' potential, but also needs it. Their presence could contribute to the processes of recovery and social inclusion of persons in difficult life situations. PSWs could provide individual support and participate in the development of social networks, foster a sense of responsibility in the beneficiaries and strengthen their ability to cope with problems [Bronowski, Chotkowska 2016, p. 16; Scheyett, Diehl, p. 435 et seq.; Utschakowski 2007]. It seems that PSWs can be assigned one more function in the system – a kind of intermediary between the service user and the social worker. As people with first-hand experience, they demonstrate a greater ability to understand individual problems and needs, which can enrich the existing traditional methods of working with the user and at the same time contribute to reducing the distance between the user and social worker.

At this point, one more benefit of involving PSWs in the system is noticeable – to the system itself. Apart from the support provided to persons in a crisis, PSW services could expand the existing, traditional methods of working with the community, introduce more flexibility, modernity and the so-called element of closeness. Peer support can strengthen streetwork and interventional forms of help, which cannot otherwise develop due to the rigid organisational framework. Its potential should be noticed in the creation and

implementation of programmes aimed at social and professional activation, the integration of the local community, support for social groups, including those at risk of marginalisation and social exclusion. There is room for PSWs in the processes of teaching persons who leave various social institutions how to live independently; they can also provide support for those trying to overcome homelessness, return to the labour market or regain their educational potential.

Peer support could provide a counterbalance to the routine and bureaucratised social work and favour the introduction of social innovations, including innovative methods of social support. Marek Rymsza notes that "the development of social work is based on the constant modification and adaptation of direct work with the client to the changing circumstances. Without innovation, social work would not only fail to develop, but even 'collapse,' becoming overburdened by routine and stereotypical perception of the users." New methods of work and new professions, including various forms of peer support, are part of the development of social work that lead to its greater appreciation by society [Rymsza 2013, pp. 25–26].

4. The peer supporter's role in state aid in the form of social employment

Social employment institutions create a local system of social support for persons in a difficult life situation, including those with mental disorders. Their main goal is professional activation, inclusion and integration of the beneficiaries. The legal framework for these institutions is laid down in the Act on Social Employment.[4] Arguably, the social aspect of this form of employment prevails over the economic one. In the case of social employment, work is perceived not only as a source of income, but primarily as an activity serving therapeutic or recovery purposes [Mierzejewski 2003, p. 202]. The idea is closely connected with social assistance. It is rooted in fundamental human rights, above all in the right to a dignified life. The state ought to provide social employment to persons who cannot find employment on the free market by themselves, but are able to work and therefore do not have to rely on public benefits. Social employment is aimed in particular at persons who are:

- homeless, following an individual programme of overcoming homelessness,
- addicted to alcohol, drugs or other intoxicants,
- mentally ill,
- unemployed for a long time,
- ex-convicts experiencing difficulties in integrating with the environment,

[4] Act of 13 June 2003 on Social Employment (consolidated text: Journal of Laws of 2020, item 176).

- refugees, following an individual integration programme,
- disabled.

The intention behind the Act on Social Employment is an attempt to counteract and reduce the effects of social exclusion. The act is addressed to individuals who are most at risk of social exclusion and, due to their life situation, unable to meet their basic needs by themselves. These are persons who find themselves in a situation that causes poverty and makes their participation in professional, social and family life difficult or impossible. Importantly, the beneficiaries of assistance in the form of social employment include people with mental disorders as well as addicts. Before using this form of assistance, alcohol addicts are obliged to have completed a psychotherapy programme in an alcohol rehab clinic, whereas those addicted to drugs and intoxicants – a therapeutic programme in a health care facility.

The aim of social employment is not only to find a job for the beneficiary; rather, it is about a sequence of various activities, including therapeutic ones, which ultimately leads to securing a job for them [Piątek 2003, p. 197]. This form of employment is provided by social integration centres, social integration clubs, and in the form of supported employment. Crucially, despite its name, social employment does not always entail entering into an employment relationship under the Labour Code, although it is ultimately oriented at this goal.

The first form of social employment relies on the services of social integration centres, which are involved in professional and social reintegration. They conduct reintegration meetings aimed at instilling the desired attitudes in participants, e.g. the ability to be actively involved in the life of the local community, fulfil social roles in the place of work or residence, or regain (acquire) the ability to independently perform work on the labour market. As part of social employment programmes, the centres provide services connected with learning professional skills, apprenticeship and retraining. They teach the ability to plan life, rationally manage one's budget, and show different possibilities of obtaining income through employment or business activity.

Persons at risk of social exclusion may be referred to a social integration centre at their own request or following the recommendation of various institutions (social assistance units, county labour offices, non-governmental organisations). The application is reviewed by a social worker employed at a social assistance centre responsible for the area where the beneficiary resides or stays. Before issuing the opinion, the worker conducts interviews with members of the beneficiary's community. Furthermore, in order to be accepted by the centre, the beneficiary has to sign an individual social employment programme. The document specifies the scope and forms of reintegration, types of psychophysical skills necessary to take up employment, and methods of acquiring them. Discontinuation of the programme results in the

termination of assistance – it may happen in the event of non-compliance with the provisions of the programme or failure to attend the meetings. As part of the programme, the participant receives a cash integration benefit and health insurance coverage.

The second type of social employment is supported employment. It may take the form of performing socially useful work, being placed at a workplace, or receiving assistance in setting up a business or a social cooperative. Persons covered by social employment are eligible for vocational, psychological and social counselling. Founders of cooperatives are additionally provided with support in the form of partial coverage of the costs of legal assistance, consultations and advice. Supported employment is offered under an individual social employment programme or a social contract.

The third form of social employment are social integration clubs. They organise therapeutic, employment-related and self-help activities for persons at risk of social exclusion. In particular, they provide legal counselling and self-help activities in the field of employment, housing and social matters. The clubs also offer temporary employment programmes aimed at preparing the beneficiary to find a permanent job or work under civil law contracts. Participation in social integration clubs is voluntary.

As outlined above, social employment is a complex process comprising various forms of assistance: theoretical and practical meetings, counselling and therapy, performing work, receiving benefits. Apart from helping to independently function on the labour market, it is oriented at social integration and improvement of the economic situation of the person threatened or affected by exclusion. In the individual dimension, social employment develops the beneficiary's personality and improves their self-esteem. Importantly, for many people who have remained outside the labour market for a long time, social employment is the only possibility of professional activation. Due to mental and psychological barriers, such persons are often unable to overcome the fears and anxiety connected with taking up a job; on the other hand, due to their dysfunctions, many employers are unwilling to enter into an employment relationship with them. Social employment thus offers an opportunity to overcome these obstacles and combat stereotypes.

The effectiveness of the process of regaining social and professional competences could be improved by the involvement of peer support workers. Meetings with them could be part of the programmes offered by social integration centres. A PSW's presence is likely to provide valuable support in initiating self-help activities by sharing information, counteracting the beneficiary's sense of alienation, and promoting the idea of mutual support of people in need of help. Social employment is a more advanced form of support than social assistance as it requires greater involvement due to the very fact of having to leave home, establish contacts with the environment, and finally start

work. The PSW's role in this process resembles that of a guide improving the mental well-being of the supported person, helping them to overcome fear, apathy and doubt. A person who has managed to come out of isolation is a credible role model who can help to overcome the fear of establishing social relationships, teach how to coexist with other people, and build trust in oneself and others. The adoption of a dignity-based approach, which contributes to the development of a sense of self-esteem and equality, is also important. Initial contacts with the therapist and peer support worker may well be the first step on the way to changing one's life by regaining the ability to coexist in a group, fulfil responsibilities, participate in, and cooperate with, society at large.

5. Summary

The concept behind support for people with mental disorders in Poland is based on two types of assistance. This dichotomous division results from the assessment of the beneficiary's ability to live independently. Depending on the conclusion, the offered support takes the form of providing care or assistance. In the first case, public institutions assume the responsibility for satisfying the basic existential needs of people with mental disorders; in the second case, support takes the form of advising, accompanying, activating and increasing independence. Since the available forms of assistance are characterised by considerable variety and flexibility, it is possible to adjust it to the individual needs of the beneficiary. This flexible approach has a great potential to incorporate peer support workers, who could provide support in overcoming everyday problems, supervise the treatment process, help in establishing and maintaining contacts with the environment, managing the budget, caring for a disabled family member, acquiring professional qualifications or taking up a job, including social employment, which is a kind of therapy.

It would be difficult to overestimate the PSW's role in the system of social welfare and social employment. This is mainly due to the authenticity of their experience and the non-routine approach to helping. First-hand experience of a crisis changes the perception of other people's existential problems. On the other hand, a PSW appears as a credible role model demonstrating the possibility of overcoming a difficult existential situation and providing inspiration to work on oneself. The PSW's attitude is the result of successful implementation of a strategy of self-improvement, rejecting stigmatisation and stereotypes.

Including PSWs in the social welfare system is treated as an experiment. The literature recognises the benefits of using the knowledge and experience of people affected by a mental health crisis in the social welfare system. Their ability to better themselves is important when involving them as experts by experience in teams of therapists and other specialists working in support

centres and sheltered housing schemes. As noted by Zuzanna Neuve-Église, the cooperation of social workers with PSWs is part of the so-called solution-focused approach to social work with persons with mental disorders, who are thus motivated to make changes in their own lives, and then in the lives of other people experiencing mental crises [Neuve-Église 2018, p. 237]. The author emphasises that "cooperation of experts by experience with social workers can take place on two levels – through activities in the field of psychoeducation and counselling, and by enhancing social workers' ability to support and accompany their charges in difficult moments. This allows social workers to better understand the importance of the sick person's own experience and transform this resource into a motivation leading to change" [Neuve-Église 2018, pp. 237–238]. Using the PSW's potential also brings benefits to the social welfare system by enriching the methods of community work, placing strong emphasis on its humanisation and empowerment, shortening the distance between the person offering support and its recipient, providing relief to social services in those areas where having scientific knowledge and specialised qualifications is not essential.

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Teaching prerequisites for recognising the professional qualification of peer support workers in Germany

ABSTRACT:
This article is intended to answer the question about how the current peer support curriculum should be adapted in order to facilitate the recognition of the professional qualification of peer support worker with the EX-IN training. Firstly, there is a digression into the experience-based learning theory on which EX-IN courses are based; secondly, there are experience reports from EX-IN Mecklenburg-Vorpommern e. V., LebensART Münster and EX-IN Thüringen e. V. presenting some determinants influencing the abovementioned issue. Thirdly, proposals for topics to be included into the present EX-IN curriculum are listed, before a research design from Grone Bildungszentrum gGmbH with its associated partner LebensART Münster is introduced to identify topics to be added to the curriculum. The evaluation of this research project is beyond the scope of this essay. This will be done after finishing the ERASMUS+ project "Strategic Partnerships within Vocational Training. European Profile for Peer Support Workers."

KEYWORDS:
modules, curriculum, professional qualification, peer support worker, vocational training, EX-IN

1. Introduction

The recognition of the profession of peer support worker (PSW) by organisations and institutions is still a challenge, although there is a wide range of publications recommending the introduction of this occupation [DGPPN 2018, pp. 72–90; DGPPN 2019, pp. 238–239; Speck, Steinhardt 2018, p. 64]. While some countries in Europe, e.g. the United Kingdom, Norway and Finland, have gained experience in using this profession, this field of activity is relatively new in Germany, especially in the federal state of Mecklenburg-Western Pomerania.

EX-IN (Experienced-Involvement), a synonym for peer support work for mentally ill or disabled persons, was introduced by the Leonardo da Vinci Educational Programme "Experienced-Involvement" in Germany, among other places. On the German side, FOKUS / Initiative for Social Rehabilitation in Bremen and the Hamburg-Eppendorf University Medical Centre participated in this project from 2005 to 2007, and a training programme for perspective PSWs was developed. Other participating countries were England, the Netherlands, Norway, Poland, Slovenia and Sweden.

Internationally, there are numerous studies [Davidson et al. 2006, pp. 443–450; Hardiman et al. 2005, pp. 105–122; Felton et al. 1995, pp. 1037–1044] confirming that employing PSWs in socio-psychiatric institutions leads to the following positive effects for the patients and clients:

- more empowerment,
- better development of social networks,
- more social activities,
- more assumption of responsibility,
- better coping and problem-solving capability and,
- more hope [van Haaster, p. 5].

Alongside the scientific validation of the benefits of peer support in institutions, Tönnes [2017, pp. 134–135] in a review of peer support and EX-IN training describes the advantages of this new profession with the following words:

> To support people on their paths to recovery, experts on recovery and on developing coping strategies are needed. Professionals with relevant training in this field can assist in the recovery processes, but the main work is to be done by the affected persons themselves. In most cases, recovery processes last many years. Persons who have managed to recover, gained resilience and lead a satisfying life despite, with or because of their mental illnesses could be role models. Attention should be paid to the fact that there are different, individual ways to the recovery processes. Therefore, it is advisable to train people with first-hand experience of recovery to familiarise them with different other paths to recovery, diverse forms of psychological disorders and different coping strategies in a structured way. EX-IN is such a form of such a training [which provides] the basis for the profession of "expert by experience in healthcare" or "peer supporter." The development of the programme was promoted by the advancement made by the recovery movement in the USA and Great Britain. Supported by professionals and scientists researching recovery processes, the perspectives of persons affected by a mental health crisis have increasingly gained importance.

The first training course carried out by Fokus Bremen and the Hamburg-Eppendorf University Medical Centre took place in 2008–2009. Gradually, other EX-IN training sites were established in in Cologne, Münster, Bielefeld,

Stuttgart, Kiel/Neumünster in Germany, and in Bern in Switzerland. But it took three more years until EX-IN Deutschland e. V. was founded in 2011. Currently, there are 32 EX-IN training sites within the German speaking areas in Europe.

Due to the relatively long involvement of other EX-IN sites in the implementation of peer support, it is difficult to compare their achievements with the ones in Mecklenburg-Western Pomerania. One of the reasons for it is German federalism – each federal state has its own regulations, which additionally complicates the process of introducing peer support across Germany. This fact has various consequences for the profession, which will be discussed later.

Founded in 2017, EX-IN Mecklenburg-Vorpommern e. V. is not a scientific institution. Nonetheless, this registered association has gathered experience in identifying the determinants influencing the introduction of peer support in institutions and organisations. The aim of this article is to analyse how the training programme is to be adapted in order to facilitate the employability of peer support workers. Although there is scarce literature on the subject to substantiate the experience of EX-IN Mecklenburg-Vorpommern e. V., some information on how to modify the training programme is provided by other model projects in Germany. However, since it is based on individual experiences from just a few PSWs, it does not meet the criteria for scientific validity. Further research ought to be conducted in order to establish which topics should be added to the current EX-IN curriculum.

The experience of introducing the profession of peer support worker to the labour market has been shared by LebensART and EX-IN Thüringen e. V. (Thuringia). This has demonstrated that there is more than just one approach to achieve this goal. However, before discussing these experiences in the context of German regulations, let us digress into the experience-based learning theory on which EX-IN courses are based. After that, we will present proposals concerning the topics that could be included in the training programme and how perspective PSWs can benefit from another, more traditional teaching approach. Finally, an Erasmus+ programme aimed to verify the information provided by in-work PSWs regarding the extension of the EX-IN curriculum will be introduced.

2. Experience-based learning theory

The experience-based learning theory was introduced by Kolb [1984, p. 38] and is defined as "the process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping and transforming experience." It consists of four elements arranged as a cycle:

1. concrete experience
2. reflective observation
3. abstract conceptualisation
4. active experimentation

In general, the participant first names his/her experience in response to a question. Afterwards, the experience is reflected on, for example by means of a structured interview, and conclusions are drawn influencing his/her further behaviour. Then the cycle starts again by experimenting with the newly acquired behaviour.

The learning process during an EX-IN course is similar to the experience-based learning theory. After the second step, the participants exchange their individual experiences, then share and summarise their conclusions. As a result, all participants profit not only from their own expertise, but also from that of others. This learning theory combines cognitive elements with affective ones.

For this teaching and learning approach, a special setting has to be created. According to Kirk and Thomas [2003], the criteria for this setting that are most relevant for EX-IN courses include:

- The goal of experience-based learning involves something personally significant or meaningful to the students.
- Students should be personally engaged.
- Reflective thoughts and opportunities for students to write or discuss their experiences should be ongoing throughout the process.
- The whole person is involved, meaning not just their intellect but also their senses, their feelings and personalities.
- The students should be recognised for prior learning they bring into the process.
- Teachers need to establish a sense of trust, respect, openness, and concern for the well-being of students.

Additionally, the educational achievements of experience-based learning are superior to traditional classroom assignments. This is due to the facts listed below:

- "Experiential learning is a **powerful teaching tool**. While classroom lectures primarily address the cognitive domain, experiential learning involves the whole student: their cognitive, affective and physical domains" [Oxendine et al. 2004, pp. 259–265]. The result is that students can relate to the subject matter in a way that is meaningful to their own lives.
- Experience-based projects offer **a change of pace** from traditional classroom assignments and facilitate learning for students with a variety of learning styles [Millenbah et al., 2004, unpaginated]. Students that struggle with writing papers may find themselves re-engaged in the course with the help of a project that draws on their own experiences. Even students

who are high achievers in traditional assignments often appreciate an original format.

- Experience-based projects can help **bring the students and the teacher closer together**. Because they are sharing aspects of their own actions and decisions, there is a personal element to this type of learning [Kirk, 2003].

Critics of that teaching approach point out that "learning includes goals, purposes, intentions, choice and decision-making, and it is not at all clear where these elements fit into the learning cycle [Rogers 1996, p. 110]. The results are based solely on the way learners rate themselves. It does not rate learning style preferences through standards or behaviour, as some other personal style inventories do, and it only gives relative strengths within the individual learner, not in relation to others [Kelly 1997].

Harrie van Haaster, a representative of the Netherlands project partner in the Leonardo da Vinci Educational Programme, further developed this learning approach and adapted it to make it applicable for the EX-IN courses. The participants in EX-IN training, by reflecting on and exchanging their first-hand individual experiences, gain a wider knowledge on what could be helpful for clients or patients. Solutions that have worked out for the PSW will not necessarily help others. Thus, a wider repertoire of assisting attitudes and methods will contribute to a more individualised approach in peer support work.

3. Experience report of Mecklenburg-Vorpommern e. V.

The following section outlines an overview of the challenges faced by EX-IN Mecklenburg-Vorpommern e. V. in introducing the profession of peer support worker. Due to German federalism, each federal state has its own regulations, hence the differences in achievements and experiences gained by different EX-IN associations within Germany. However, in 2018 EX-IN Mecklenburg-Vorpommern e. V. implemented a pilot project called "Genesungsbegleitung M-V" [peer support in Mecklenburg-Western Pomerania], financed by the Ministry of Economy, Labour and Health of Mecklenburg-Western Pomerania. As a result, it became possible to adopt a structured approach to achieve the project objectives, i.e. training prospective PSWs and introducing the profession in Mecklenburg-Western Pomerania while respecting the perspective of persons concerned in education and training.

In 2012 and 2014, the first EX-IN courses were held in Rostock, but they did not result in the hoped-for impact on the labour market. Although PSWs were willing to work after finishing their training, they could not find employment due to different reasons, mainly connected with the novelty of the profession and financial considerations. Before the third course started in 2019,

the necessary prerequisites for introducing the position of PSW to the labour market had to be created. Thus, EX-IN Mecklenburg-Vorpommern e. V. held meetings with the community psychiatric network in each region of Mecklenburg-Western Pomerania to acquaint mental health professionals with the profession. The same approach was applied to psychiatric institutions and providers of services connected with integration assistance. The association also established contact with employers willing to employ PSWs. Some of them had a clear vision concerning the tasks that could be potentially fulfilled by PSWs, while others were unsure how to introduce PSWs to their organisations. To receive a better understanding of the duties taken on by the new profession, the project team developed job specifications for the diverse activities of PSWs.

The second obstacle – securing financial means for employing PSWs – has not been overcome yet. Not all employers are able to refinance the positions. Psychiatric institutions can employ PSWs and pay their salaries from their nursing budgets. In contrast, providers of integration assistance have no additional budgets to employ them, so they can only be involved on a limited scale. Therefore, the aim of the model project was, and still is, to include PSWs into the legal framework of regulations for providers of integration assistance in Mecklenburg-Western Pomerania [cf. Mecklenburg-Vorpommern 2019]. As each federal state has its own regulations for providers of integration assistance, each regional EX-IN association is tasked with convincing the negotiating partners to include the profession of PSW in the regulatory framework. Moreover, EX-IN Mecklenburg-Vorpommern e. V. is in regular contact with the Ministry of Social Affairs to negotiate the introduction of PSW into the institutional regulations for providers of integration assistance. So far, these negotiations have been unsuccessful.

One obstacle connected with the abovementioned issues is that PSWs are not recognised as qualified employees (specialists) due to their relatively short training programme. To be a qualified employee in Germany, one has to successfully complete a full-time apprenticeship lasting at least two years. Therefore, the initial step is to start the negotiating process by arguing that PSWs are semiskilled workers – employees who have finished full-time training lasting from three months up to almost two years. However, semiskilled workers are underpaid and have difficulties in finding appropriate employment. This illustrates the necessity of extending the current EX-IN curriculum so that PSWs are no longer semiskilled workers. An outline of an Erasmus+ project concentrating on topics which should be included in the current EX-IN curriculum is given later.

After finishing the course, EX-IN Mecklenburg-Vorpommern e. V. offers inter- and supervisions to PSWs, during which they can reflect on their experiences at work and find solutions to problems they were unable to discuss in their teams. The encouragement provided by other peer supporters in in-

ter- and supervisions is sometimes seen as more beneficial than that offered by other professionals. Additionally, PSWs and their employers, provided the former agreed to it, are asked about training needs. After the evaluation of their responses, it is decided whether EX-IN Mecklenburg-Vorpommern e. V. can provide the training by itself or whether an external educational institute should be involved.

4. Experience report of LebensART

After the first courses in North Rhine-Westphalia, in 2015 the two regional councils in charge of psychiatry investigated the assignment of PSWs. In a project of the Westphalia-Lippe regional council, eight PSWs were engaged in four psychiatric hospitals. Since 2016, PSWs have been employed in all psychiatric hospitals managed by the regional council of Rhineland. As of 2021, about 70 PSWs are working in psychiatric hospitals managed by both regional councils. This progress is accredited to LebensART, a further training institution founded in 2010. Commissioned by the Rhineland authorities, LebensART organised the first EX-IN course in Cologne, followed by a conference in Münster, networking and establishing Münster as another EX-IN site. Additionally, LebensART supported the development of EX-IN Bielefeld and EX-IN Siegen. Even after EX-IN Deutschland e. V. was founded, the training to become an EX-IN trainer was essential for the dissemination of peer work and networking.

At the same time, LebensART decided to train its own EX-IN trainers. As an independent further education provider, LebensART has been awarding an internal certificate since 2010, so to have the courses certified by EX-IN Deutschland Verein was not expedient for LebensART. These courses are based on the curriculum and teaching/learning approach developed during the Erasmus programme from 2005 to 2007. The trainer tandem consists of a peer support worker and a trainer with a qualification in the socio-psychiatric field. Three quarters of PSWs in North Rhine Westphalia have been trained at LebensART – 350 out of about 500 persons. Twenty-five courses have been conducted, including online ones. The recipe for this success was, first of all, broad cooperation and mutual support of the EX-IN players, followed by high quality of the training, good contact between the trainers and participants, a sound network and a flexible handling of requirements.

Since 2013, the EX-IN courses at LebensART have been AZAV-certified. The advantage of this certificate for the participants in that the course fees can be paid by employment agencies.

Five LebensART sites have been established in North Rhine Westphalia, Cologne, Münster, Bochum Wuppertal and Essen since 2014. Cologne and Münster are permanent sites. Besides LebensART, there is EX-IN North Rhine Westphalia e. V., founded in 2012 to organise and represent PSWs

as well as to disseminate the idea of peer support in this region. Almost all PSWs who are members of that association were trained by LebensART. Additionally, there exist regional groups of EX-IN in Bielefeld, Siegburg, Neuss and Siegen.

5. Experience report from EX-IN Thüringen e. V.

The philosophy of EX-IN Thüringen e. V. is that even mentally ill or disabled persons can perform meaningful work. This registered association offers the opportunity for persons affected by a crisis to integrate their individual wealth of life experience. At EX-IN Thüringen e. V., all employees gain professional and/or leadership experience before becoming peer support workers. The most common causes of mental disturbances are excessive stress, conflicts and mobbing in the workplace. The staff of EX-IN Thüringen e. V. experienced such crises at first hand and developed coping strategies with professional assistance, having confronted themselves with their illnesses and tried out new ways of life. After finishing the EX-IN course to become a PSW, they offer their employees the opportunity to integrate their personal wealth of experiences. All services are provided exclusively by qualified PSWs who are employed by this association and work in psychiatric hospitals (with whom they have agreements) or in counselling centres. This association is unique in Germany.

Other training programmes provided by EX-IN Thüringen e. V. are:

- EX-IN courses to become a peer support worker,
- EX-press-IN (trial and eligibility modules),
- EX-IN courses to become an EX-IN trainer,
- EX-fresh-IN (refresher modules for trained PSWs),
- EX-port-IN (further training for managers and human resources managers),
- EX-tra-IN (further training for PSWs within the scope of everyday assistance),
- EX-Kurs-IN, internally and externally, Internet for all,
- EX-ist-IN (upcycling).

The projects of EX-IN Thüringen include:

- "Where to go?" – recovery support in psychiatric hospitals
- recovery support in companies,
- services within the scope of everyday assistance,
- EUTB (complementary independent participation counselling) in whole Thuringia,
- space of possibilities (testing ideas).

EX-IN courses at EX-IN Thüringen e. V. are AZAV-certified.

6. Broadening the EX-IN curriculum

According to the literature, not only employers but also peer support workers themselves perceive a need to extend the current EX-IN curriculum [Palloks 2013, p. 83; Jahnke 2014, p. 27; Cramer et al. 2015, p. 13]. On the one hand, employers express concerns such as the fact that knowledge is primarily imparted to the participants by means of exchanging personal experiences rather than using learning methods, standards and facts. This aspect is often criticised by other external parties. PSWs, however, counterargue that this is their strength; they use their wealth of experiences to support people in need, adopting an approach that differs from what professionals in the respective fields do. Therefore, PSWs are valuable members of the therapeutic teams. On the other hand, PSWs themselves express a need for further training or education. Often, they do not feel prepared for the work they have to fulfil. Their practical training (at least 40 hours during the basic module and 80 hours during the advanced one) during the course does not alleviate their concerns.

According to the literature mentioned at the beginning of this chapter, topics to be included into the present curriculum are:

- integration into a multiprofessional team,
- basic socio-educational knowledge on developing and implementing empowerment strategies successfully,
- knowledge of psychiatry criticism,
- knowledge of side- as well as knock-on effects of psychotropic drugs,
- knowledge of social law,
- institutions teaching in the socio-psychiatric setting,
- profiling of perspective operational areas.

This leads to the question: How can these topics be included into the current curriculum? Three approaches are possible:

1. EX-IN Deutschland e. V. develops further training modules and offer lectures.
2. Separate modules in the further training "Fachkraft in the Sozialpsychiatrie" [social psychiatry specialist] are attended by participants after having finished their EX-IN courses, leading to a partial recognition of a professional qualification. The partial recognition of a professional qualification is mainly used when foreign citizens undertake work in Germany. The institutions responsible for recognising professional qualifications verify in what way the professional qualifications gained abroad are comparable with equivalent German professions [cf. Bundesministerium der Justiz 2011, p. 2515; Bundesministerium für Bildung und Forschung 2012, p. 17].
3. Combining the EX-IN course with some modules of the further training "Fachkraft in der Sozialpsychiatrie" to design a novel further training programme with its own training regulations, possibly offering a degree. At the end of the training, the participants would have to pass exams and

write a thesis, different to the ones of the perspective social psychiatry specialists.

Taking exams by the participants at the end of the present EX-IN courses would not be possible, as it is the exchange of experiences that is of paramount importance for the training, not the transfer of knowledge. It is not feasible to evaluate and grade experiences.

Offering a proposal for training regulations, as envisaged under point 3 above, is beyond the scope of this article. Instead, below is provided a list of topics of the training "Fachkraft in der Sozialpsychiatrie" that are also relevant for peer support workers.

1. Basic socio-educational knowledge
   - self- and external determinants
   - socio-educational methods
   - psychosocial scope of activities
2. Basic knowledge of psychology
3. Social psychiatry
   - history of psychiatry
   - cornerstones in therapy and care of persons being mentally ill or handicapped as well as of addicts
   - permanent care institutions
   - socio-psychiatric services
   - complementary assistance systems
   - employment promotion projects
   - support for relatives of addicts and persons who are mentally ill or disabled/self-help groups
4. Therapies and further assistance
   - family work
   - individual and group therapy
   - drug treatment, especially with psychotropic drugs
   - crisis intervention
5. Supervision and analysis of the practice
   - destabilisation of current behaviour patterns
   - developing and reflexion on one's own professional action
   - conversational skills
   - feedback to verbal and nonverbal behaviour
   - analysis of group- and interaction processes
   - analysis of the practice (self-awareness and practical examples)
6. Handling of stress and conflicts
   - conflicts
   - theories of stress
   - stress control and management in conjunction with dynamic group processes

- burn-out syndrome

7. Law
   - social law
   - social security law
   - selected areas of law: administrative law, family law, labour law, criminal law, liability law and secrecy
   - guardianship law, PsychKG (help and protective measures for mentally ill persons law).

Further training for PSWs is to be offered as an extra-occupational training. The advantages of this solution include the fact that EX-IN graduates can gain practical experience while being employed and, on the other hand, gradually broaden their knowledge by attending theoretical training sessions. Furthermore, the training "Fachkraft in der Sozialpsychiatrie" should consider the trialogue. Instead of including the perspective of the persons affected (in this case, of mentally ill or disabled persons) by engaging them as trainers, they become training participants, with a constant exchange of experiences, attitudes and opinions between those who are mentally ill and those who are not. The future social psychiatry specialists and PSWs learn how to work together in a multiprofessional team and how to integrate the different perspectives during their joint training. Extending the curriculum would also promote the negotiating process with ministries and external parties claiming that PSWs are not qualified employees. Furthermore, PSWs could receive higher income due to their extended training. It would be particularly important in the case of PSWs who are not eligible for disability benefits.

7. Research on qualification modules

As stated at the beginning, there are few experience reports on the topics to be included into the EX-IN curriculum. Hence, this data needs to be validated and further research is to be conducted. This was one of the aims of an international Erasmus+ programme "Strategic Partnerships within Vocational Training. European Profile for Peer Support Workers," conducted in 2019–2021 by organisations from Germany, Greece, the Netherlands, Norway and Poland. On the German side, the project partner was Grone Bildungszentrum gGmbH with its associated partner LebensART Münster. According to the German project partner's informational materials,

> The aim of the project is therefore to create Europe-wide working standards for peer support workers, for example a job description, entry requirements, competence profiles as well as placement in companies and therapy teams. These standards will form the basis for qualification modules in education and training for peer support workers in psycho-social work [Grone Bildungszentrum für Gesundheits- und Sozialberufe gGmbH, undated, p. 2].

One of the project goals was to develop qualification modules supporting PSWs' specialisation. In order to devise these modules, PSWs have been asked which additional knowledge they needed. In order to determine it, a questionnaire was sent out to all identified peer support workers in German-speaking countries in Europe (Germany, Austria and Switzerland). However, as the data collection and evaluation have not been finished yet, the results cannot be published in this paper.

8. Conclusions

In the past years, the need for an extended EX-IN curriculum has become obvious. The reasons for it are:

- to recognise PSWs as qualified employees, the curriculum has to be extended to be comparable with full-time vocational training lasting at least two years,
- PSWs themselves have expressed their need for an extended curriculum to be better prepared for their duties.

The literature on the subject contains some advice on topics that should be added into the existing EX-IN curriculum, but there has not been a systematic research in this area. This will be hopefully changed by the Erasmus+ programme "Strategic Partnerships within Vocational Training. European Profile for Peer Support Workers." One of the aims of this project is to develop modules to be added into the curriculum to promote the recognition of the professional qualification of peer support worker. A questionnaire was developed and sent out to PSWs in the German-speaking countries in Europe to identify topics for the additional modules. Since the questionnaires have not been evaluated yet, a proposal from EX-IN Mecklenburg-Vorpommern e. V. for topics to be included into the present EX-IN curriculum has been reproduced to solve the issues mentioned at the beginning.

To establish a nationwide EX-IN curriculum, it is necessary to devise additional modules with standards to be followed by all EX-IN sites. Furthermore, a special designation will have to be agreed upon to refer to peer support workers who have finished an EX-IN course, in contrast to PSWs who have not attended this training. A qualification, comparable with other professions and necessary for recognising the professional qualification of PSW, should be a prerequisite for being employed as a PSWs.

Although there are diverse determinants influencing the introduction of peer support in Germany, some EX-IN associations have developed their own approach in order to create employment opportunities for PSWs. These differ widely between EX-IN Thüringen e. V., LebensART Münster and EX-IN Mecklenburg-Vorpommern e. V. Each procedure has its own eligibility criteria, and none of them seems to be optimal. In the end, choosing different ways of introducing peer work may be the most successful approach.

A European EX-IN curriculum can be developed. However, as each country has its own vocational training act, it is questionable whether the procedures for recognising the professional qualifications of PSWs can be compared and whether a unified procedure can be developed. Especially in vocational training, there are many differences between European countries in terms of their willingness to acknowledge work experience without having completed formal apprenticeship.

It is to be shown whether the results of the Erasmus+ programme will persuade the decision-makers in Germany to acknowledge the peer support worker as a profession. As it is PSWs' experience of their illnesses/disability, not learning criteria, that is currently in the foreground during the training, it would be difficult to introduce final exams to issue degree certificates. Without a degree certificate, PSWs with an EX-IN training will be less likely to be recognised as qualified employees. Although grades are not always a good indicator of whether someone will fulfil their job duties properly, without them it is difficult to determine whether a given person is a well-trained PSW.

Although the first steps towards recognising the professional qualification of peer support worker have been made, there are still some questions to be answered. Hopefully, some of the answers will be provided by the research study described in this paper.

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Annex I

Questionnaire

The questions are directed to all peer support workers who have passed the further EX-IN training based on the curriculum developed in 2005–2007 and worked in this field. The content and the time of the training is therefore comparable. Please choose which organisation issued your certificate.

☐ EX-IN (Deutschland e. V.) certified
☐ EX-IN LebensART certified
☐ EX-IN Bern (Diploma of Advanced Studies)
☐ EX-IN Schweiz certified
☐ EX-IN Pro Menta Sana (Switzerland) certified
☐ EX-IN Austria certified
☐ another EX-IN site, e. g. Poland – please name the country and place

_____

What is the professional title on your certificate?

_____

Please choose the location of your EX-IN course:

☐ Bremen	☐ Wetzlar	☐ Braunschweig
☐ Hamburg	☐ Frankfurt	☐ Würzburg
☐ Berlin	☐ Kaufbeuren	☐ Bodensee
☐ Cologne	☐ Siegburg	☐ Bochum
☐ Stuttgart	☐ Siegen	☐ Regensburg
☐ Münster	☐ Alzey	☐ Nürnberg
☐ Bielefeld	☐ Essen	☐ Freiburg
☐ Kiel/Neumünster	☐ Wuppertal	☐ Heidelberg
☐ Rostock	☐ Neuss	☐ Kaiserslautern
☐ Erfurt	☐ Norden	☐ Halle
☐ München	☐ Oldenburg	☐ Dresden
☐ Marburg	☐ Hannover	☐ Göttingen

☐ another place:

_____

In which federal state are you working or did you work as a peer support worker?

_____

In case you have not been working in Germany, in which country are you employed?

_____

Since when have you been working as a peer support worker?

_____

In case you do not work as a peer support worker anymore, how long were you employed (please indicate the beginning and end of employment period)?

_____

Do other peer support workers work in the place where you are employed?
☐ yes
☐ no

How many peer support workers are employed alongside you?

_____

Please choose your field of work:

☐ hospital – psychiatry
☐ medical practice
☐ home treatment
☐ outpatient clinical setting
☐ integrated care
☐ socio-psychiatric service
☐ contact point / counselling service
☐ day care centre
☐ single supported living
☐ assisted accommodation
☐ freelancer
☐ forensic
☐ EUTB (complementary independent participation counselling)
☐ research
☐ advisor / consultant
☐ EX-IN trainer
☐ lecturer
☐ another working field:

_____

During your further EX-IN training, you attended the modules mentioned below. Please evaluate each module in terms of relevance and usefulness for your professional field.

	very applicable	applicable	slightly applicable
Salutogenesis	☐	☐	☐
Empowerment	☐	☐	☐
Experience and Participation	☐	☐	☐
Recovery	☐	☐	☐
Trialogue	☐	☐	☐
Self-Exploration	☐	☐	☐
Assessment	☐	☐	☐
Advise & Accompany	☐	☐	☐
Intercession	☐	☐	☐
Crisis Intervention	☐	☐	☐
Learning & Teaching / Research	☐	☐	☐
Portfolio Presentation	☐	☐	☐

Please describe briefly which themes concerning each module you would like to deepen during the further training.

Salutogenesis

_____

Empowerment

_____

Experience & Participation

_____

Recovery

_____

Trialogue

_____

Self-Exploration

_____

Assessment

_____

Advise & Accompany

_____

Intercession

_____

Crisis Intervention

_____

Learning & Teaching / Research

_____

Please name up to 10 concrete further training topics you find interesting, for example: Online counselling – how does it work? How to set up a recovery group?
Theme 1:

_____

Theme 2:

_____

Theme 3:

_____

Theme 4:

_____

Theme 5:

_____

Theme 6:

_____

Theme 7:

_____

Theme 8:

_____

Theme 9:

_____

Theme 10:

_____

How many hours did your practical training comprise during the basic and advanced modules? Please double check before ticking a box.
basic module
☐ 120 hours ☐ 100 hours ☐ 80 hours ☐ 60 hours ☐ 40 hours
advanced module
☐ 120 hours ☐ 100 hours ☐ 80 hours ☐ 60 hours ☐ 40 hours

☐ another duration, please state the total number of hours of your practical training.

_____

Please evaluate the duration of your practical training.
☐ The duration of the practical training was too long for me.
☐ The duration of the practical training was too short for me.
☐ The duration of the practical training was just right for me.

Please tick the box below which reflects your opinion on the duration of the practical training.
☐ A practical training, after finishing the basic module and lasting six months, with revision days would be appropriate.
☐ Several short practical trainings would be appropriate.
☐ The EX-IN further training could/should take place outside the workplace while working as a peer support worker.
☐ A probationary year would be reasonable.
Please name other possibilities for gaining practical experience as a peer supporter.

_____

Please choose how many additional days were offered to support the writing of your portfolio and for internship supervision.
☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ more

Please choose whether an instructed self-study was part of your course.
☐ yes
☐ no

Please choose whether writing a portfolio was part your course.
☐ yes
☐ no

Please choose whether an additional final paper was part of your course (apart from writing a portfolio).
☐ yes
☐ no

Please assess the hours you spent on the written assignments during the course.

_____

Pease state whether you passed the further training to become an EX-IN trainer.
☐ no
☐ Yes – and I did it for my own purposes / for myself.
☐ Yes – and I am working as a trainer now and then.
☐ Yes – and I am working as a trainer on a regular basis.

Please tick the topics you are interested in for your specialisation as a peer supporter.

☐ Interceder/ombudsman
☐ freelancer
☐ forensic
☐ addiction
☐ project development
☐ setting up an enterprise
☐ homelessness
☐ street working
☐ research
☐ quality management
☐ public relations
☐ guide for peer supporters during their practical training

☐ own suggestions:

_____

Integral parts in the work of and training of peer support workers are the exchange of experience with colleagues and the strengthening of the peer support workers` attitude within their positions at work. Please tick the box reflecting your opinion.
☐ intervision, in-house
☐ independent intervision
☐ supervision within a multiprofessional team
☐ supervision between colleagues, cross-institutional
☐ interchange in special groups within my registered association
☐ revision days for refreshing topics and attitudes

☐ joint training with colleagues representing other professions
☐ own suggestions:

_____

Please name suggestions and wishes contributing to the acknowledgement of peer support as a profession.

_____
_____
_____

Do you want to be informed about the results of this questionnaire and the further training modules to be developed?
☐ yes
☐ no

Please name your email address in order to be able to inform you.

_____

Thank you for your time and participation!

Franziska Streiber (b. 1981) has studied adult education and vocational training, psychology as well as English literature and culture. She has worked as a trainer, tutor, quality manager, research assistant, social education worker and integration pilot. Since May 2018 she has been employed as project manager of the model project "Genesungsbegleitung M-V" initiated by EX-IN Mecklenburg-Vorpommern e. V., eventually becoming a member of the board in this association. She is a relative of a person with mental illness.

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Using European Qualifications Framework level 5 to build a European competence model for peer support workers

ABSTRACT
Over the years, European education systems have developed completely independently of each other, with each of the European Community member states creating its own system of primary, secondary and higher education and adapting it to the needs of the local labour markets based on traditional historical models. For this reason, until the establishment of the common European Qualifications Framework, and the preceding definition of the Bologna Process rules for higher education, not only were there differences in the scope and duration of individual stages of education, but the recognition of qualifications obtained in one country by another country was problematic. The EC's efforts to unify the rules led to the development of the European Qualifications Framework, which in the next stage became the basis for building national qualifications frameworks in individual countries. This has offered the possibility of transferring competences across borders for the first time and became the basis for the free movement of professionals within the EC.
This text introduces the principles of mutual recognition of formal qualifications, the development of general, vocational and higher education systems, and the possibility of using these principles in the system of unifying qualifications in the health sector. The second part of the article presents the gap resulting from the failure to use European Qualifications Framework level 5, which – according to many experts on the European labour market – could provide the basis for comparing the qualifications of peer support workers, i.e. people with the experience of an illness, who may thus become part of a professional system of healthcare for patients – in this context, also for patients with mental disorders.
The last part of the text is devoted to the possibilities of permanent implementation of the peer-supporter profession into national education systems

(secondary, vocational or tertiary, without indicating preference for any one of them), taking into account the possibilities of European Qualifications Framework level 5, which are already used in some European countries. It has been pointed out that the permissible freedom of translating the European Qualifications Framework into national systems leaves the use or non-use of level 5 at the disposal of the system organisers. Thanks to this, Community member states can quite freely define the location of peer support competences in their education systems. Thus, today, with the emergence of political will but without the need for major legal changes, it has become possible to implement the peer support worker educational model in national education systems.

KEYWORDS:
European Qualifications Framework level 5, competences

1. Introduction

The European Qualifications Framework (EQF) is a tool that enables the unification of education levels (as well as the learning process and diplomas obtained in various European countries) in order to ensure freedom of movement and professional activity [Kapiszewska 2013]. This solution results from the Council Recommendation of 22 May 2017 "On the European Qualifications Framework for lifelong learning and repealing the Recommendation of the European Parliament and of the Council of 23 April 2008 on establishing the European Qualifications Framework for lifelong learning." The system based on a set of eight levels, corresponding to education from the level of primary education to the level of higher education, clarifies the recognition of diplomas and types of education. Within the EQF, however, there is one level that is not used by all European countries, which is level 5, situated between the level of secondary education and higher (tertiary) education.

This study will analyse problems related to the possibility of including the qualifications framework in European education systems as a level involving peer support workers (PSWs), recovery assistants, people with disease experience as participants in therapeutic teams in psychiatric care. Such a solution would enable the recognition of PSW competences by all European countries, thus applying the underlying principles of the EQF, and offer the chance to permanently include PSWs in therapeutic teams in European psychiatric care systems.

The purpose of this text is to discuss the possibilities of implementing EQF level 5 in national education systems in order to adapt it to the needs of PSWs as representatives of a new profession expected in the healthcare environment.

2. Mutual recognition of professional qualifications in Europe

The European Qualifications Framework is not Europe's only legal basis for the recognition of qualifications, but it is one of the pieces of the puzzle intended to ensure that professional qualifications can be compared. Various historical models based on different levels of education, as well as the lack of uniform rules in education before the era of European integration, were often the cause of difficulties in comparing the qualifications of European residents and immigrants intending to work in one of EC member states [Kwiek 2010]. A good example is the profession of a nurse, in which the requirements for obtaining certain professional degrees (bachelor of nursing, master of nursing) in Poland are regulated by a legal act of the rank of an ordinance [Satu et al. 2013], while in other countries (e.g. in Germany) by regulations at the level of federal states or regional governments, and yet in others – by regulations of the rank of a governmental act. Due to the fact that each of the EC countries organises the system of recognising qualifications differently, and it takes place at a different organisational level of the state system, it becomes all the more important to define uniform rules for the recognition of diplomas without the need for launching a special procedure of their recognition.

In Europe, there are also other instruments supporting the recognition of qualifications:

- Council Recommendation of 26 November 2018 on promoting automatic mutual recognition of higher education and training and upper secondary education and training qualifications as well as the results obtained during study periods abroad,
- Directive 2005/36/EC on the recognition of professional qualifications in the European Union, enabling professionals to move between countries and to practise their profession or provide services abroad,
- Lisbon Recognition Convention (an international agreement under the patronage of UNESCO and the Council of Europe that allows for academic recognition in Europe and beyond),
- The Bologna Process (description of education cycles for the European Higher Education Area).

Currently, in European countries there is a significant problem with the recognition of professional qualifications of immigrants from outside the European Union [López et al. 2019], in particular from the Middle East, Eastern Europe and Asia, where the education systems significantly differ from the organisational solutions adopted in Europe. As a consequence, professional diplomas obtained there are not easily comparable with European qualifications, which often leads to the inability to start the nostrification and diploma recognition procedure, e.g. in medical professions (doctor, nurse).

From the point of view of a person applying for recognition of qualifications in a country other than the one in which they obtained their diploma, the inability to compare qualifications may result in limitation or impossibility of mobility during studies (or vocational training), or resignation from establishing institutional cooperation between educational institutions. Currently, there are a number of mechanisms in the European Union that support international exchange in the field of vocational education, mainly under the Erasmus+ programme (the name of the programme is the acronym: *European Region Action Scheme for the Mobility of University Student*s). The programme offers the possibility of student exchange in order to complete part of the study cycle in another country, the exchange of academic teachers and study visits to improve the quality of teaching, implement new educational solutions, establish institutional cooperation between universities, organise intensive courses, including language courses, or participate in thematic networks of the programme dedicated to specific problems of the globalising Europe and the world [Tuncer Unver et al. 2021]. The mutual cooperation system is enabled by the European Credit Transfer System (ECTS), which gives the opportunity to complete a period of study at a foreign university.

The Erasmus+ programme offers similar solutions for the primary and secondary education system, as well as for vocational training and amateur youth sport in Europe. In addition, the programme also offers mobility and cooperation in adult learning, which – in the context of the aspects discussed in this section – can be used to strengthen the role of peer support workers in the healthcare systems of European countries.

3. European Qualifications Framework level 5 as an underdeveloped area for professional qualifications in Europe

In the description of each level, the European Qualifications Framework refers to three criteria: knowledge, skills, and responsibility with autonomy. Each of the eight levels shows separate criteria, the fulfilment of which is tantamount to the acquisition of qualifications marked with that level. For level 5, the description of knowledge is as follows: "extensive factual and theoretical expertise in a field of work or study and awareness of the limits of that knowledge." In the skills part: "a comprehensive range of cognitive and practical skills needed to creatively solve abstract problems," and in the responsibility and autonomy part: "management and supervision in work or study contexts subject to unpredictable changes, analysing and developing one's own and others' achievements." It is evident that the provided description is not detailed enough to allow for adopting a specific level of education (general, vocational or higher). It seems that this is why in Poland and in

some other European countries, the system of occupying specific levels of the qualifications frameworks has been applied not in the order of their appearance, but depending on external conditions or international comparisons. Therefore, presumably, the Polish secondary education system ends at level 4 (*matura* exam), and the subsequent higher education system starts at level 6 (bachelor's degree).

The description of the qualifications framework does not provide answers in which educational institutions particular types of diplomas should be obtained, which is understandable due to non-comparable educational systems in European countries. Another problem may be the national nomenclature of the schools themselves and an attempt to translate them into the English language, which may lead to a misunderstanding of their actual function in the national education system (e.g. high school, college, lifelong education school, vocational school, trade school, etc.).

Some European universities have decided to adopt EQF level 5 in such a way as to enable their students to obtain qualifications under the so-called "Bologna fast track," i.e. to award diplomas after completing accelerated vocational courses dedicated to the problems of narrow industries or professions. However, this solution did not bring the expected result, because in many countries (including Poland), due to the rigid legal position of universities in the higher education system (i.e. from EQF level 6 upwards), these universities' right to issue diplomas from outside their own organisational level was questioned. In academic discussions, it was repeatedly pointed out that the diplomas issued in such manner "go across" the existing educational systems and as such may not be recognised outside the country in which they were issued. In other words, in terms of the purpose for which EQF was created (e.g. mutual recognition in all EC states), such actions may turn out to be counter-effective and unjustified.

In Poland, the problem of applying EQF level 5 by universities is also the subject of observation and discussion. At the turn of 2019/2020, the Conference of Rectors of Academic Schools in Poland (KRASP), as an organisation gathering all large public universities in Poland, conducted a study identifying the possibility of becoming involved in a system of using EQF level 5 in higher education. The results of the study showed that most universities are not interested in taking advantage of this opportunity to develop their educational offer, and the main reason for this is the inadequate legal system, which, apart from the general description of the EQF, does not provide any answers to questions about the place of graduates of such studies in the system. Such a person would be someone between a secondary school graduate and a holder of a bachelor's (or engineering) degree. So far, Poland has not defined a place or profession for which such a level could be created. There are also no descriptions of how such a diploma would distinguish

a person from a graduate of vocational schools, industry schools, or lifelong education institutions.

The approach of Poland and other European countries to the training system in the area of EQF level 5 is not the only one that is represented in Europe, as several countries are working on enabling education and recognition of qualifications in local education systems. Already in 2014, CEDEFOP, the European Centre for the Development of Vocational Training, published a report identifying countries interested in benefiting from EQF level 5 and recognising such diplomas. These were: Belgium (in the Flanders region), Czech Republic, Denmark, Germany, Estonia, Ireland, France, Croatia, Lithuania, Latvia, Luxembourg, Malta, the Netherlands, Austria, Portugal, United Kingdom (at the time of the study, it was a member of the EC). In these countries, appropriate definitions and references for the EQF have been adopted and, for example, in France, it has been defined that qualifications at level 5 may be obtained by "staff normally engaged in work requiring a level of training equivalent to the Certificate of Completion of Professional Studies (BEP) or the Certificate of Professional Ability (CAP), and by assimilation also the certificate of completion of vocational training at level 1 for adults (CFPA)" [France. European Inventory on NQF 2016]. The description notes that "this level corresponds to the full qualification to perform a specific activity with the ability to use appropriate instruments and techniques. The activity is mainly concerned with executive work, which may be autonomous within the limits of the techniques used."

The French education system also admits – which may turn out to be crucial in the case of PSWs – the recognition of qualifications obtained in the informal and non-formal system. It is a kind of standard in the EQF, but excludes the so-called "regulated professions" that are subject to other European systems of supervision over training and performance of the profession (e.g. doctors, architects, nurses, etc.).

In all countries where EQF level 5 is recognised and the relevant systems of recognition of these qualifications are in place, great attention is paid to the fact that it is a solution that fits into the perspective of lifelong learning, making it possible not only to return to work after a break, but even to pursue a different career than before. As discussed above, the French model is considered by CEDEFOP to be very well developed and among the best in Europe, largely thanks to its strong commitment to the personal development of the employee. Moreover, it is emphasised that despite efforts to adjust the applied solutions to the needs and capabilities of the candidates, the system requires constant development and adaptation to the changing conditions, including labour market conditions. It is becoming increasingly accepted that professional qualifications (including EQF level 5) should not be validated with a single certificate (e.g. a diploma), but rather should relate to a set of re-

newed and updated professional competences. Such a solution also functions at other levels of qualifications, although it is enforced to a varying intensity in different countries (e.g. systems of educational points in the medical profession, whose accumulation leads to obtaining professional qualifications). The French model – despite its adaptability to the needs of other European countries – also acknowledges the problem of mutual recognition of qualifications at level 5; therefore it is considered to be a solution dedicated mainly to people intending to perform a specific job in France.

Germany has a completely different experience with the use of EQF level 5 [Germany. European Inventory on NQF 2018]. As a rule, competences characteristic of this level have been defined, but the educational offer and the use of qualifications at this level are not common in this country. The Federal Ministry of Education and Research (BMBF - *Bundesministeriums für Bildung und Forschung*) in cooperation with the Federal Institute for Vocational Training (BMBF - *Bundesinstitut für Berufsbildung*), social partners and universities undertook to implement a project whose aim was to define the possibility of a common description of qualifications for specific professions, based on EQF level 5. As part of this project, two descriptions for the professions of IT specialist and car mechanic (*motor vehicle service technician*) were developed. The project proved that Qualifications Framework level 5 can be a good bridge between secondary and vocational education systems, but the implementation of these solutions requires broad cooperation involving different participants from different parts of the education system, employers, the labour market and, above all, legislators. So far, despite the creation of conditions for the recognition of these qualifications, interest appears to be moderately low. In addition, a study by the Association of German Chambers of Commerce and Industry proved that only 20% of companies associated in the Chamber had heard about the EQF, which is an increase in awareness by 6% compared to a similar survey conducted in 2014. 51% of the surveyed companies considered the adaptation of the national qualifications framework to the European system to be positive and important, and companies use it, among other things, when recruiting employees for individual job positions and adjusting their own professional development and promotion programmes. The German approach to adapting the EQF seems to prove its usefulness especially in the context of supporting human resource development (recruitment, internal development of employees), as well as its suitability for both large and smaller enterprises thanks to a system of mutual comparison and no need for additional activities to identify competences resulting from qualification certificates. Therefore, German companies are interested in adapting the EQF, but due to the limited possibilities of comparing level 5 qualifications, its use is currently limited. What the German and French approaches have in common is the internal nature of the applicable

regulations, defining the rules of applying the qualifications system rather for the internal labour market, but without excluding themselves from the common European market (provided that it accepts, among other things, the possibilities resulting from EQF level 5).

4. Possibilities of using European Qualifications Framework level 5 for the peer support worker profession in Europe

A peer support worker (PSW) is a person who, in addition to having certain individual qualifications (irrespective of whether they are humanistic, technical, general, medical or other), has had the experience of an illness [Chudzicka-Czupała and Zalewska-Łunkiewicz 2020]. This person, thanks to having overcome a crisis, understands the fears and behaviour of a patient who has been diagnosed with a disease, who expresses anxiety, sometimes fear, and is unable to cope with the diagnosis. From the patient's perspective, a PSW as a person with lived experience may be more trustworthy and credible than a doctor, nurse or therapist who knows the disease only from a professional point of view, but who has not experienced the pain or anxiety associated with it [Adams 2020]. Such experience means that a PSW can assist the patient in the process of recovery, support them in making decisions related to the therapy, and above all, answer numerous questions regarding not only the disease itself and its prognosis, but also the attitude of the family and society to the patient's situation.

The modern model of hiring employees in the health care system, as in any other industry, is based on two pillars: the qualification model and the competency model [Kesy 2008]. Of course, it is assumed that diplomas, certificates and other formal documents granting specific professional qualifications confirm the existence of the desired competences, resulting either from specific regulations (as in the case of regulated professions: doctor, nurse, pharmacist, etc.), industry regulations (similar to the German solutions) or from the description of the learning outcomes adopted by the educational institution or university issuing the document. However, among the professions for which a specific set of formal competences has been adopted, in practice there are many for which the expectations are defined by the employer. In health care, such positions include: medical assistant, dental assistant, patient guardian, public health assistant [Rosińczuk, Karniej 2020]. These professions are listed in numerous legal acts as jobs in healthcare organisations, but there is considerable freedom in terms of both formal and informal grounds for hiring them. In this sense, a PSW may be a member of the therapeutic team or patient care team, and this position may be described analogously to the above-mentioned positions. In the discussion there are doubts concerning the extent to which a PSW is a profession (which can be formally acquired),

and to what extent it is a performed job. For if the necessary condition for recognising a person as a PSW is the experience of the disease, it is difficult to assume the existence of a planned educational cycle for the position. One can, however, provide for the possibility of additional competence education, aimed at using the experience in patient care.

Currently, in Polish hospitals, the system of hiring employees performing basic activities in hospital departments is quite routine and assumes the existence of medical, nursing (or obstetrical in the case of gynaecology and obstetrics), rescue (in surgical, intensive care or emergency departments), care and nursing as well as auxiliary qualifications and/or training [Bugdol, Bugaj, Stańczyk 2012]. Additionally, some people are usually employed across departments, e.g. physiotherapists or nutritionists. Psychologists, occupational therapists, psychotherapists and others are employed in psychiatric wards. From this perspective, PSWs could be employed directly in hospital departments, hired to carry out therapeutic work not only in psychiatric departments, but also in oncology, internal medicine and paediatric departments (as support for both parents of children and elderly patients), as well as wherever there is a need for this type of service.

Currently, in the Polish healthcare system, the following barriers to the employment of PSWs in the public health system can be identified (the catalogue of barriers is much longer):

- failure to include the PSW in the package of guaranteed services in the field of hospital care as an employee required in the process of contracting medical services in a specific area,
- lack of separate financing for the PSW as a person providing health services or participating in the provision of such services,
- failure to define the PSW as a member of the therapeutic team, which prevents access to medical records, insurance under the healthcare organisation's policy,
- failure to define the competences and criteria for PSW employment, in terms of professional qualifications (completed level of education), type of illness experience, method of documenting this experience, the PSW's right to keep issues related to their disease secret,

From the point of view of the healthcare system manager, however, the most important are financial barriers, primarily the lack of funds for employing PSWs by healthcare organisations [Wysocka, Walkowiak 2013].

However, if the abovementioned barriers could be overcome or neutralised as a result of the political and organisational will of decision-makers, changes in the system of secondary and higher education should still be expected in order to:

- define the level of education at which a PSW could obtain professional qualifications under EQF level 5. In this sense, an interesting view seems

to be that it could be a common model for institutions from the level of both vocational and higher education, without creating additional levels in the educational system, but using the existing institutions (professional competence management based on the model of functional, procedural, not institutional),
- determine a PSW's professional qualifications, on the basis of either EQF level 5 diplomas (certificates) or other forms of gaining competences, including those resulting from external observation (e.g. supervision in psychotherapy) and employee evaluation,
- include PSWs in the catalogue of jobs in public healthcare entities, specifying their minimum qualifications (e.g. having at least secondary education) and allowing the employer to assess the competences and suitability for employment,
- include PSWs in the therapeutic team model while educating medical professionals and psychologists in order to prepare them for cooperation with PSWs and define competence boundaries.

From the point of view of the education system in Poland and Europe, such solutions could be based on EQF level 5. Unfortunately, due to a very different approach to recognising EQF level 5 qualifications in most European countries, and despite the formal possibility of non-existence of a system of cross-border transfer of these competences, it may turn out to be very difficult. The lack of limitations imposed by the system in those countries where it is very poorly developed (e.g. Germany), or does not exist at all (e.g. Poland), can be an advantage enabling mutual relations between the members of the therapeutic team and the organisation to be arranged in such a way that it can function properly. It would be somewhat more difficult to use this model in France, because it would require the modification and adaptation of existing solutions to the needs of PSWs. However, it would be beneficial from the point of view of European recognition of PSWs as full members of therapeutic teams in many medical specialties, not only in psychiatry.

5. Summary

The European Qualifications Framework is defined as a coherent vision and a unified set of descriptions, criteria and levels of education and training for national education systems in European countries. The discussion on these criteria and procedures for obtaining specific qualifications and recognising them abroad as part of international transfer constitutes a great challenge for all European countries. The development of both European and national adaptations of the EQF requires not only clear criteria, but above all very good cooperation of all stakeholders and all educational subsystems (primary education, secondary, tertiary, postgraduate and lifelong education institutions) to distinguish individual institutions and levels from each other.

One of the experiences of European studies on the inclusion of EQF level 5 in the integrated system in Poland is the proposal of the simultaneous involvement of institutions from different levels, namely secondary and tertiary, in the joint education of employees with intermediate qualifications. There are countries in Europe, such as Ireland, France or the Netherlands, which, thanks to very extensive recognition systems and large experience in recognising the effects of informal and non-formal qualifications, treat EQF level 5 qualifications as an introduction to university education. Such an approach cannot be applied universally, due to the existence of different levels and models of organising the educational system, as well as diverse legal conditions in individual countries (e.g. competence requirements for regulated professions in health care). However, under certain local conditions, EQF level 5 could undoubtedly become a tool for the professional development of employees also in those countries that have not yet fully integrated this level into their educational systems.

Peer support workers are a group of employees who, thanks to a very diverse general education (primary, secondary, vocational, higher), experience of various diseases, as well as general therapeutic competences that could be standardised (i.e. the ability to recognise the patient's needs, understanding the pathophysiology of diseases, conducting an interview, the ability to deal with life-threatening situations, dealing with medical records and the need to maintain professional secrecy, etc.), may become Poland's first profession recognised on the basis of EQF level 5. Such actions could certainly prove beneficial for the peer support workers themselves, as well as for patients, medical workers in the health sector and the entire healthcare system.

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A peer support worker as an active agent of organisational learning and an opportunity to benefit organisations by hiring diverse employees

ABSTRACT
The concept of diversity management is applicable in healthcare organisations not only because it creates an employee-friendly working environment and improves the image and reputation of the organisation, but primarily because it contributes to boosting the innovativeness and creativity of all employees. Openness to diverse employees, including peer support workers – people with the experience of a mental crisis who have the skills and knowledge to help others, is a chance for medical entities to come up with new therapeutic and organisational solutions that efficiently exploit the available resources. Contemporary theories of managing human capital, knowledge, change and recovery trigger a number of processes that may lead to new situations and new knowledge, individual and organisational learning, as well as corrections of the assessment and value systems. Teams of employees functioning in an environment that is conducive to diversity and welcoming of different competencies, experiences and multiculturalism increase the likelihood of improving strategically important aspects, such as lean and agile process management, knowledge growth, promotion of mental health protection and emergence of a creative atmosphere. Health services managers or team leaders must improve their employee management competences towards managing diverse teams, in which the employees' unique experiences and skills can contribute to the improvement of the efficiency of processes and entire organisations. An organisational culture that is open to peer support, self-development and organisational improvement may offer better opportunities for learning and changing in the face of a dynamic and complex reality.
KEYWORDS:
peer support, learning organisation, team learning, individual as agent of organisational learning, team leaders' competences, diversity management in health care, human and social capital

[Every organization] must be organized for the systematic abandonment of whatever is established, customary, familiar, and comfortable, whether that is a product, service, or process; a set of skills; human and social relationships; or the organization itself. […] The organization's function is to put knowledge to work—on tools, products, and processes; on the design of work; on knowledge itself. It is the nature of knowledge that it changes fast and that today's certainties always become tomorrow's absurdities."

Peter Drucker
Harvard Business Review,
"The New Society of Organizations," October, 1992

1. Introduction

Faced with demographic changes, cultural evolution and increasing competitiveness and complexity of the environment, healthcare organisations need access to diverse human resources in order to have a chance to keep up with the changes. Since the main subject of this article is connected with mental health, changes in the science of psychiatry cannot be ignored, as they have resulted not only in reducing the stigma of mental illness and better understanding of mental diseases, but also in revolutionising the terminology and categorisation of mental development disorders [Grzywa 2018, p. 211–219].

In 2009, G. Mulgan in the *Europe 2025* forecast predicted that ecology, globalisation and demography would shape the economy to the greatest extent [Mulgan 2009, pp. 69–77]. It seems that even the appearance of the SARS-CoV-2 virus has not fundamentally changed the catalogue of challenges faced by organisations today. Healthcare and social welfare organisations voice the need to increase employment in the sector, upgrade employees' skills and enable immigrants to take up employment. The situation is exacerbated by the growing number of problems connected with human mental health. The health system, like any other system, is unable to evolve quickly enough to fully meet the needs of patients.

According to the studies of the Polish Sociological Society on technology, digitisation, work and education during the pandemic [Pokojska 2021, pp. 17–21], the looming social problems are likely to strongly affect citizens' mental condition and determine the course of action. Data and forecasts on the mental health of Europeans show that mental disorders are already a serious and growing problem in the European Union, and the scale of the problem will continue to grow due to the impact of the SARS-CoV-2 virus. It is estimated that 164.8 million people in the European Union (38.2%) suffer

from mental health disorders each year. According to the report, the most frequent mental health disorders are anxiety disorders (14%), insomnia (7%), major depression (6.9%), somatoform (6.3%), alcohol and drug dependence (>4%), ADHD in the young (5%), and dementia (1-30%, depending on age). The study diagnoses that mental disorders have become the "core health challenge of the 21st century."

This article offers a preliminary analysis of the role fulfilled by peer support workers (PSWs) in a team of employees whose individual initiatives, based on the concept of "personal mastery," are crucial not only for supporting the treatment of patients and creating recovery programmes for them, but also for identifying and evaluating the extent to which organisational learning and diversity management methods have been used by the organisation.

Fortunately, it is a well established fact today that the inclusion of PSWs in teams of healthcare workers is key to a recovery-focused approach. PSWs facilitate contact between specialists and patients by creating a new space in which the latter can discuss their experiences connected with mental illness. Numerous studies have been devoted to PSWs' role in the medical community, their cooperation with mental health experts and therapeutic teams, as well as the principles of supervision and ethics in their work.

This article focuses on the PSWs' role in the workplace, be it a mental health centre, a psychiatric hospital, a mental health clinic, a foundation, or any other mental health facility. In the organisational context, the PSW's experience of specific events accompanying the processes of inpatient treatment and recovery from a mental crisis may contribute to direct and evaluate teamwork processes. This evaluation may in turn inspire managers of mental health institutions to change their concept of organisational management.

Many popular management techniques, tools and processes assume the homogeneity of teams. For this reason, they are no longer valid in the case of a culturally-diverse organisation. Organisations where diversity is considered a strategically important asset, where the cost of adapting management tools to new conditions is treated as an investment, owe their sustainable growth to openness to diversity. Although traditionalists may find it difficult to view diversity management in health care as an opportunity to build innovation and a competitive edge, it is worth emphasising that it is a tool for better communication, team cohesion, cooperation, closer interaction or even partnership between the team members, communities and stakeholders. Competitiveness in this context does not entail competition for the patient, but striving after a competitive advantage over other organisations, which results from the level of specialisation, professionalism of medical services, efficiency and effectiveness of operation. These factors have a direct impact on the methods of mental health treatment, processes of restoring mental well-being, but also dealing with overworking or overcoming a crisis.

The subject of mental well-being in particular refers to an interdisciplinary problem at the intersection of social and economic psychology as well as general psychology of health understood in a modern way. "Well-being plays an important role in the economic, social and mental functioning of man. Therefore, the interdisciplinary nature of this issue exceeds the scope of psychology itself, touching on important contemporary issues from the field of other social sciences" [Mirski 2009, p. 169]. Until recently, tangible assets were of strategic importance for the organisation; today, it is human capital that plays a special role in the structure of the organisation's resources and influences its social functioning.

There is an increasingly pronounced shift in economics today from purely material measures to social measures, which are considered equally or more important than the former and include categories such as life expectancy, human rights, democracy, civil liberties, mental health or health care. These concepts are connected with the issue of sustainable development, where non-economic factors are of paramount importance. Therefore, it is worth approaching welfare as a generalised concept of goods, including intangible goods [Mirski 2009, pp. 170–171]. An opportunity has presented itself to promote well-being while using tools that also contribute to diversity in mental health organisations.

2. The instrumental role of peer support workers in the struggle for the mental health of society

In preparation for, among other things, waves of deep crises affecting people performing their tasks in the "home office" mode, medical teams of mental health institutions must consciously and consistently draw on the PSW's experience of a crisis. The integration and cooperation of teams of mental health professionals – doctors, psychotherapists, psychologists, nurses, occupational therapists – with trained PSWs should be carried out in accordance with the concept of *diversity management* and the *theory of organisational learning*. To be more precise, PSWs, as persons who have experienced a mental health crisis and want to help patients undergoing psychiatric treatment by working in interdisciplinary therapeutic teams, not only contribute to overcoming the crisis, but, with the support of the organisation, are capable of becoming active agents of organisational learning. If organisations and institutions tasked with looking after mental health, in particular those financed from public funds which provide psychiatric care and treatment of addictions, want to become more effective and open to changes, they are likely to benefit from employing a diverse pool of workers.

The derived benefits may take the form of greater creativity, new recovery strategies for people after inpatient psychiatric treatment who are trying to return to participation in everyday social life, as well as improved financial

performance of the entire healthcare system. According to V. J. Friedman, "People who choose to act on [their] discoveries and experiences and to bring them to the attention of the organization assume the role of agents of organizational learning" [Friedman 2001, p. 412]. PSWs' reports collected as part of the project "European Profile for Peer Workers" (Grone, Erasmus+ project) as well as in other sources published on the Internet [Pawelec 2018], demonstrate their creativity, willingness to establish formalised cooperation and importance for organisations, despite having to overcome numerous limitations and obstacles; as Peter Senge concluded, "Without constraints there is no creating" [Senge 1990, p. 140]. At this point, it is worth recalling a similar idea, a model of acting against the well-established patterns of social functioning and limited resources, which echoes throughout the book *Life Without Limits: Inspiration for a Ridiculously Good Life* [Vujicic 2012]. The world-famous Nick Vujicic suffers from phocomelia, a rare condition that manifests itself in the absence of all four limbs. Nevertheless, this extraordinary man has overcome the unimaginable limitations imposed by his disability and leads an active social life, works as a motivational speaker, engages in charity and business activities, and successfully changes the approach to our resources and the resources of our organisations.

Processes launched by an individual may contribute to organisational learning by means of the so-called single loop, in which the activities of the organisation consist of individual actions [Zgrzywa-Ziemak, Kamiński 2009, p. 40]. By distinguishing between conceptual and operational learning, we adopt D. H. Kim's double-loop learning model [Kim 1993, p. 44], in which basic individual assumptions are incorporated into the organisational worldview (*Weltanschanung*).

Let us relate this to a situation in which an individual's *modus operandi* (e.g. recovery strategies) has proven effective and becomes the organisation's standard procedure. In this way, under certain conditions, this individual can change the existing model of supporting the recovery processes and contribute to the creation of a new one [Zgrzywa-Ziemak, Kamiński 2009 p. 41]. For instance, many PSWs emphasise the role of their hobby, interest or other activity as a "bait" – a tool that supports recovery by facilitating cooperation and establishing relationships. The most frequently mentioned activities include amateur sports and participation in sports events, the arts and social engagement, or the acquisition of highly specialised knowledge concerning, for example, tea brewing and drinking ceremonies, cooking, contemporary dance or painting. The use of these elements to initiate recovery not only contributes to the treatment process, but seems to translate into a peculiar "ability to heal" of those PSWs who are able to communicate information about their favourite pastime in a convincing and passionate way.

Interestingly, the tools for the dissemination and "externalisation" of individual mental models listed by D. H. Kim include group dialogue and collective reflection. These methods correspond to the Open Dialogue approach, which consists in therapeutic meetings attended by the service user together with a network of stakeholders, i.e. a group of people involved in the recovery process [Seikkula et al. 2006, pp. 214–228]. The conversation is led by a moderator – a member of the hospital team accompanied by the so-called reflecting team. A description of the theoretical assumptions of the team's functioning can be found in the literature [Andersen 1993, 1995]; however, it is worth introducing the seven principles of the Open Dialogue treatment method:

1. family – a social network in the centre of the therapeutic process; the appointed crisis teams are to organise the first therapeutic meeting as soon as possible;
2. members of the patient's social network, including persons from outside the family circle, are invited to the meeting;
3. treatment is flexibly adapted to the patient's needs, using therapy methods that are most appropriate for a given situation;
4. the person who receives the "request–need" becomes responsible for organising the therapy and treatment process, irrespective of where it takes place and how long it lasts;
5. guarantee of psychological continuity of therapeutic treatment;
6. promotion of a sense of security and trust among the network members, acceptance of uncertainty and crisis;
7. focus on generating dialogue, including in the area of enhancing the patient's potential [Kłapciński, Rymaszewska 2015, p. 1186].

It is worth repeating after the authors and promoters of the Open Dialogue method that pharmacotherapy is losing its primary role in favour of psychosocial interactions. However, as there are no prospective randomised comparative studies assessing the effectiveness of the method across various groups of patients, many practitioners are wary of using it. The same could be said about many popular modern methods used in psychosocial research [T. Witkowski 2019, p. 34]. As the author notices, the problem of the repeatability of studies came to the foreground after the publication of the results of the Many Labs 2 replication project by the American Psychological Association [Klein et al., 2019]. Over several years, an international team of nearly 200 psychologists tried to repeat a number of previously published studies and experiments from their field to see if they could obtain the same results. Despite their best efforts, the same results were achieved in only 14 of the 28 cases. Although the rate of variation may be somewhat shocking, these same researchers, by pointing to the complexity of contemporary social relationships, argue that in the long run the results of Many Labs 2 are "much more optimistic and hopeful."

This is the reason for the growing need for solutions that will not only improve the effectiveness of the current treatment methods, but also motivate the participants to self-develop and consequently provide an opportunity for organisational changes and new management models. P. M. Senge claims that individual learning is irrelevant for organisational learning; it is only team learning that can become a microcosm for learning throughout the organisation [Senge 1990, p. 237]. It therefore seems safe to assume that the PSW activates the potential of team learning by influencing the therapeutic team. It may be new knowledge or new competences, which, when properly used by skilled experts – other team members – will affect the effectiveness of the applied methods of treatment and therapies and consequently of the entire recovery processes.

We strive after new ways and models of recovery that would lead to positive outcomes for the supported people. For this reason, making every effort to improve the effectiveness of modern methods of mental recovery is both a duty and an opportunity for all participants in mental health organisations.

3. A peer support worker's role in the therapeutic team from the point of view of the philosophy of medicine

The aim of teaching philosophy to doctors is to enable them to learn the entire organisation and to perceive medicine from this perspective (including the inference mechanism based on making and refuting hypotheses) [Oksiak-Podborączyńska 2016, p. 13]. This is not a purely theoretical exercise, but a means of providing health professionals with a tool to improve their preventive and therapeutic efforts. The status of the discipline is reflected in its definition:

Philosophy of medicine is a science that considers medicine holistically; discusses its position in humanity, society, the state and medical schools; offers a glimpse of the entire history of medicine; presents the most general issues in the philosophy of biology; analyses methodological forms of medical thinking by listing and explaining logical errors made in medicine; draws those messages and views from psychology and metapsychics that are relevant for medicine in its entirety; discusses the principal values in medicine and formulates the general foundations of medical ethics [Szumowski 1948, p. 15].

Therefore, if a doctor or psychiatrist is able to exceed the routine patterns of managing a medical team and overcome the instrumental constraints of the profession, he or she is likely to improve the effectiveness of treatment according to various criteria of success. However, the appropriate attitude must first be instilled in the doctor. Managerial skills and the ability to influence people (and indirectly material and financial resources) are no less important

than specialist qualifications, because they not only provide tools that inspire action, but also turn the medical professional into a kind of integrating factor [Listwan 1995, p. 22]. Therefore, it is essential to educate medical professionals in human resource management as well as in philosophy and ethics.

What is important from the position of people supporting organisations on the way to higher effectiveness is the permanent inclusion of the PSW in the doctor's environment. In order to create the right conditions for effective treatment, it is worth using the help of people who are able to critically perceive the surrounding reality. In business, this method is commonly used by organisations to create innovation, gain a competitive advantage or increase market share. Companies are faced with an increasingly complex and dynamic environment. In order to successfully address new challenges and solve problems in an effective and innovative way, they establish teams (e.g. project teams, communities of practice) which work in a coordinated manner, but without hierarchical and functional structures. It is worth noting that groups in which collective learning takes place are not necessarily established by leaders. Such initiatives may emerge spontaneously and informally. Observations of relationships in therapeutic teams have shown that psychiatric nurses are often able to "use" a patient with experience in overcoming a specific crisis to help a person struggling with the same illness or crisis.

The experiences of socially-engaged PSWs, both described in the literature [Zalewska-Łunkiewicz, Chudzicka-Czupała 2018, pp. 573–583] and collected during the project, demonstrate their ability to make very insightful assessments of the functioning of the mental health system, in particular regarding insufficient information flow, overly routine procedures and excessive standardisation, which not only increase the cost of treatment, but also prolong the processes of recovering from a mental crisis. This is all the more reason to refer to Senge's concept of an individual as an agent of organisational learning. Involving PSWs and drawing on their ability to evaluate systemic actions taken in connection with a mental crisis and recovery not only show great potential for team learning, but also provide a chance to establish professional teams and organisations in which PSWs can successfully function.

In the area of business, organisations with a "growth mindset" (term proposed by psychologist Carol Dweck, 2017) use knowledge developed in teams comprising suppliers, customers and partners. Moreover, it has become common practice to implement processes that allow organisations to collect and aggregate the opinions of former employees or customers. "A pro-entrepreneurship culture should support diverse thinking and the courage to raise objections, even when all other team members disagree. Sometimes we are lucky that a person assumes the role of the devil's advocate in a natural way, but this is not common" [Motyl 2020, p. 225]. Hence the techniques supporting organisations in building diversity. The formal

introduction of an expert by experience into the therapeutic team seems to offer a response to this trend from the intersection of philosophy and psychology of business.

Judging by the attitudes of some psychiatrists, psychologists and mental health experts, it seems that they are unable to see the potential benefits of formal cooperation with a person who has experienced a mental illness or crisis. It is even more difficult for them to accept that the cooperation of a professional therapeutic team with a PSW may result in new knowledge and innovative organisational ideas that can potentially influence psychiatric treatment methods. Just like the competences of a surgeon have been enhanced and developed by advanced robotics, pioneered by the well-known da Vinci robot, psychiatrists and psychologists should welcome the prospect of using PSWs' knowledge and experience to improve the health and psychological well-being of their patients.

4. Individual development of peer support workers and organisational improvement

The insights obtained during the project show what skills are expected from PSWs by stakeholders interested in involving them in the recovery processes of people in a mental crisis. By observing dedicated PSWs one becomes aware of their "mastery," attention to detail and willingness to cooperate. Fellow team members often emphasise that PSWs are able to successfully manage not only their own recovery process, but also the tasks entrusted to them by their qualified colleagues. As P. M. Senge points out, "People with a high level of personal mastery live in a continual learning mode" [Senge 1990, p. 148]. Participants in formal (professional) relationships and forms of therapeutic work will use these relationships to search for new knowledge and skills contributing to the patient's recovery. The role of the organisation is to foster this development, whereas the task of the team leader – a psychiatrist or psychologist – is to manage it in such a way as to bring benefits to the organisation. The direction of development should therefore be correlated with organisational tasks and strategy. It is not unusual in business today that organisations follow the unique competences of their employees when designing their development strategies. It would be rhetorical to ask whether the same can apply to psychiatry and psychology. In the face of the soaring numbers of patients and an ever greater range of disorders, when mental health issues are as common as physical problems, is it not our duty to involve PSWs as agents of organisational learning? Also, the scale of the problem and the fact that doctors and therapists classify many attitudes, behaviours and states as disorders will result in the appearance of a large number of experts by experience on the labour market, who will specialise in concrete mental illnesses or crises and ways of overcoming them.

T. Witkowski points out that "mankind is attacked by ever new mental diseases that mutate like viruses. In 1952, the first Polish edition of the textbook *Diagnostic and Statistical Manual of Mental Disorders* [*Kryteria diagnostyczne zaburzeń psychicznych*, edited by Gałecki et al. 2018] distinguished only 106 disease entities and mental disorders. In 1968, in the second edition, there were 182 of them. The third one in 1980 brought a sharp increase in this number, to 265. But mental illnesses and disorders seemed to keep mutating, with 292 of them in the third supplemented edition in 1987. The fourth edition saw a slight increase to 297. A revised version from 2000 already contained as many disease entities as there are days in a year – 365. The most recent fifth edition distinguishes 374 mental disorders. In just 60 years, the number of mental disorders has increased more than three and a half times" [T. Witkowski, 2020, p. 18]. The psychologist further states that "the WHO estimates that over 350 million people in the world currently suffer from depression, which is almost 5% of the population. In most countries, the percentage of people suffering from depression varies between 8 and 12 percent. According to the same source, over a third of people worldwide will have met all diagnostic criteria for at least one mental disorder at some point in their lives. These data prove that we are faced with a pandemic of mental illnesses on a scale unprecedented in the history of mankind. For the sake of comparison, the Spanish flu, which was the largest pandemic in history, claimed 20-100 million victims, according to various estimates. Yet numbers illustrating the scale of mental disorders and diseases are constantly soaring" [T. Witkowski, 2020, pp. 18–20]. These numbers herald the failure of the mental health system, which is already struggling with a number of problems, as well as the increasing likelihood that everyone who has been diagnosed with a mental disorder and managed to overcome the crisis can soon become an expert by experience.

Doctors cooperating with PSWs highlight the problem of lack of motivation resulting, among other things, from the ineffectiveness of the applied systems of motivating the employees. Carrot-and-stick methods are a thing of the past. Contrary to managers' assumptions, financial remuneration does not ensure commitment to teamwork or performance to a satisfactory level. Organisations are looking for new forms of motivation. Those based on extrinsic motivation are being replaced by combinations of tools influencing intrinsic motivation. According to T. Tomaszewski, intrinsic motivation occurs when a person is treated as a "self-regulating and self-perfecting system, actively processing the received stimuli" [quoted after J. Szaban, 2003, p. 216].

S. Borkowska [2002 p. 78], T. Listwan [2010, p. 167], M. Armstrong [2007, p. 657] highlight the importance of the following factors in shaping the motivation of team members:

- willingness to do something that is important,
- doing work that brings joy, is interesting and professionally developing,

- a sense of responsibility for results due to being part of something big, important, new.

Therefore, the system of motivating PSWs as agents of organisational learning should be based on three components:

1. AUTONOMY – dictated by the experience of a mental illness or crisis,
2. MASTERY – contributing to the development of competences and self-improvement,
3. PURPOSE – a two-way learning process, of the PSW and organisation: the mental health organisation benefits from the PSW's ideas whereas the PSW can count on the help of the health organisation.

For many project participants (in Poland, participants in pilot programmes), being formally employed as a member of a therapeutic team was an elements confirming their success on the way to recovery and proof that weakness can become a source of advantage (unique competences). The very fact of finding formal employment by a person who has suffered a mental breakdown or undergone psychiatric hospitalisation can be a source of intrinsic motivation. The same beneficial role can be attributed to self-development programmes, cooperation and supervisions within a team, or being part of an organisation. All systemic solutions trigger a sense of responsibility. They typically require flexibility due to the type of mental disorder, the course of the treatment process or the characteristics of a particular mental condition, but the same is true of business organisations in which people with strategic competences and skills determine the work of project teams. Although special treatment and working conditions are required for such individuals to function effectively, the benefits received in return by the organisation exceed the costs (financial and organisational). The importance of remuneration systems is often emphasised. The influence exerted through tangible and intangible stimuli must be correlated with the achievement of goals (expressed, for example, as the number of supported persons, hours of work or implemented projects). Motivational systems supporting learning and acting to the benefit of the organisation must promote the acquisition of new skills and personal development: mastery, professionalisation, expertise. These tools contribute to specialisation, professional development and a sense of having a "career path" in the field of peer support. "Research suggests that the most important and effective element (…) of job evaluation is to set goals for the future" [West 2000, p. 139]. This concept is congruent with most therapy techniques.

Since mental crises affect people with different education and professional qualifications, it would be difficult to list a comprehensive set of professional competences required from a PSW. Therefore, the process of PSWs' professional development should involve skills that are crucial to learning in general, such as drawing on one's experience, managing information, developing a systemic view, functioning in a network of relationships, recognising de-

pendencies, formulating a vision, identifying and following the vision of others, jointly formulating questions, opinions and decisions. M. J. Marquardt [1995], P. M. Senge [1990], P. Robert, J. Simones [1995] also list recognising other people's views on the surrounding reality, taking and assessing risks, formulating and solving problems, being creative, communication skills, the ability to listen, engage in dialogue and discussion, team work, responsibility and leadership. Evidently, these are general rather than specialised competences, important from the point of view of cooperation with other members of the organisation and patients, significantly influencing the processes of organisational improvement.

Drawing on experience and the literature, establishing and developing a therapeutic team can be compared to a project team and presented from the following perspectives:

- as an element of project culture,
- organisational,
- psychosocial.

Within each of these perspectives it is possible to identify factors that adversely affect the team's performance, such as: incorrect team structure, inappropriate process of recruiting the team members, communication breakdowns, incorrect integration of the team members' work. This is worth bearing this in mind when recruiting a PSW to a team. Following J. D. Frame [2001, p. 75] it can be assumed that establishing a therapeutic team with a PSW as a potential agent of organisational learning should begin with the analysis of the so-called environment, i.e. the conditions in which the team will operate. The environment is created by the stakeholders who can influence the course of the patient's treatment and recovery – healthcare professionals, family, social workers, formal and informal support groups. The importance of teamwork ought to be emphasised, preferably rooted in the principles of organisational culture and taking into account hierarchy and subordination to the doctor, psychiatrist or psychologist.

The main role of organisational learning is not to keep creating new teams, but to identify and support informal groups and communities that already exist. Due to a wide range of experiences, this approach guarantees more effective cooperation and greater benefits for the organisation. It has been suggested that only a community that has been tested in this way can be institutionalised. A significant role in the process of selecting and sanctioning such teams is played by institutions supporting the healthcare system: foundations, associations, educational and training centres, which, following the principle of employee outsourcing, can delegate PSWs to work in health organisations in order to check and test various models of cooperation. Then, "in the face of shared problems or upsetting phenomena, knowledge may be reformulated and integrated by the community, potentially resulting in a new understanding of the

community and innovative ideas that will be readily available throughout the organisation" [Zgrzywa-Ziemak, R. Kamiński 2009, p. 57].

5. A peer support worker as an opportunity to manage diversity in mental health organisations

Diversity is a concept embedded in the philosophy of social justice and human rights, but it is often applied in business too. A review of selected international studies shows that diversity is considered a strategic issue, crucially important for organisations, because socio-economic heterogeneity in gender, age, ethnicity, religion, disability, health condition, etc. is an essential characteristic of human resources in any organisation and its environment [Gross-Gołacka 2018, p. 378]. Socio-economic changes, including those occurring in the workplace, have influenced the development of the concept of diversity management.

According to numerous definitions, diversity is generally said to mean acknowledging, understanding, accepting, valuing and celebrating differences between people with respect to age, class, ethnicity, gender, physical and mental ability, race, sexual orientation, spiritual orientation and public assistance status [Esty, Griffin, and Schorr-Hirsh, 1995, based on Mor Barak 2001, pp. 136–145]. It is also worth mentioning the definition of the International Labour Organisation, which in its Report for the World Day for Safety and Health at Work emphasises that diversity distinguishes those organisations that employ people of different nationalities, ethnicities, cultures, languages as well as workers with physical or mental disabilities [ILO, Report 2005]. Various definitions not only focus on diversity as a broad set of group characteristics, but also situate the individual characteristics (differences) of a team member in the context of collaboration and active participation in society.

R. Kandola and J. Fullerton stress the importance of proper management of diversity by executives, who must not only recognise diversity within the team, but also acknowledge that this feature allows the team to achieve the intended goals. This approach "is founded on the premise that harnessing these differences will create a productive environment in which everybody feels valued, where their talents are being fully utilised and in which organisational goals are met" [Kandola, Fullerton 1998, p. 8]. It should be noted that heterogeneity creates an environment that favours efficiency, understood in our case as the ability to produce effective treatment methods in psychiatry that support the recovery processes of patients in a mental crisis. If managed properly, diversity offers a chance for everyone in the team to feel appreciated and flourish.

Such a desirable vision of teams, organisations and stakeholders–environments can only be attained through the conscious inclusion of diversity management in the mission of healthcare organisations. As far as the formal employment of PSWs in therapeutic teams is considered, it is not only the

personnel policy that should be changed – new procedures for work performance will be needed, as well as adequate training and rigorous application of the principles of effective communication. It is impossible to involve PSWs in the mental healthcare system on a large scale without strong leadership and the strategic role of doctors in team-building processes, without the right organisational culture, education and monitoring of team learning.

Future projects and research on teamwork should focus on doctors' readiness to embrace processes connected with diversity management. It is uncertain whether this professional group can effectively activate the basic functions – planning, organising, controlling, improving and motivating – in the work of medical teams and organisations. Importantly, only a comprehensive approach to these areas offers a chance to develop an effective leadership model favouring the transition towards a learning and diverse organisation. K. Obłój lists the following characteristics and skills of change leaders:

- monitoring the environment,
- creating a mission,
- inspiring the employees,
- quick action [Obłój 2001, pp. 134–138].

Although the development of leadership qualities is often centred around the idea that "a leader is one who sees more than others see, who sees farther than others see, and who sees before others do" [LeRoy Eims 2016, p. 112], it does not guarantee success in practice. Without proper support in the form of an appropriate organisational culture, it is difficult for the leader to sustain change. This opportunity is offered by a culture that opens up to a variety of therapeutic teams and accepts PSWs' role as leaders in organisational learning. Diversity encourages creativity, which is why organisations must welcome various initiatives, ideas and activities of its members. It is said culture is the organisation's psyche, and this psyche is constantly receiving stimuli and reacting to them; only a person who is aware of it can influence organisational behaviour through self-reflection and personal experience [Block, Carter 1998]. The authors note that organisational atmosphere and culture are created by team leaders, both those appointed formally and those who perform this role unofficially. They influence organisational culture regardless of who the particular team members currently are. Certain patterns of behaviour, procedures and practices remain unchanged despite employee turnover or different team composition, which is why it is so important to develop organisational culture in a conscious manner, using tools such as mission, strategy, code of ethics, personnel management model, and plans such as career paths and employee development.

Open, effective communication is another important issue on the way to introducing the concept of diversity management. It provides an opportunity to discuss subjects connected with organisational diversity, but also focuses

on various forms of expressing relationships. Such communication must involve the collection of information from PSWs and patients, and take into account different ways of dealing with people with various mental disorders, for example:

- with patients with panic disorder,
- in psychosis,
- with psychoorganic disorders,
- with neurotic disorders,
- with personality disorders,
- with addicts,
- with mentally disabled people.

The variety of disease entities must be taken into account, because misunderstanding of a message can lead to different perspectives and misinterpretations of the same concepts. This is why it is so important to educate PSWs and familiarise them with mental illnesses that go beyond their experience and first-hand knowledge. Being aware of the different features and characteristics of diseases not only increases the clarity of communication, but also improves the understanding of how teams and healthcare organisations function. Moreover, it raises the awareness of the following barriers to effective communication:

- physical,
- linguistic,
- emotional,
- perceptual,
- connected with a lack of trust,
- connected with a lack of credibility.

The above-mentioned barriers highlight another important aspect of building diverse teams in healthcare facilities and involving PSWs: to develop organisational learning, one must focus on training and education. Building knowledge and raising awareness should highlight the significance of diversity, collective learning and sharing information. The literature [Rynes, Rozsen 2005, pp. 247–270; Kęsy 2014, pp. 107–124] mentions mentoring as the best training technique and a successful form of cooperation and education. Mentoring is an effective tool that can be used by medical personnel to influence PSWs; importantly, it is also a form of effective communication, education and cooperation with patients. This tool is compatible with an organisational culture that welcomes diversity and with the PSW's roles in the therapeutic team.

6. Summary

According to Anthony et al. [2002, p. 31], recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way to a satisfying, hopeful and full life despite the limita-

tions caused by the illness. Recovery is about finding new aspirations and ambitions in life that go beyond the adverse effects of mental illness. In other words, the negative aspects of the mental health system need to be overcome to come up with new solutions, inspirations, functions and roles for the new members of therapeutic teams – peer support workers.

Faced with a growing number of mental health problems and ever greater demand for treatment, mental health professionals are charged with a difficult task of developing more effective treatment methods, taking into account their consequences and impact on the patient's life. Peer support is a natural tool in the patient treatment processes. However, a new approach to managing healthcare organisations is needed in order to use peer support workers as agents of organisational learning capable of generating new knowledge and improving processes. Diversity management can unlock the potential of therapeutic teams by stimulating learning and a better understanding of recovery, which, despite its seemingly straightforward meaning, is a complex phenomenon in the context of mental health.

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Mental health as a public good: Implications for the transformation of psychiatric health services

ABSTRACT
This article is intended to present the recent paradigm shift in thinking about the mental health of individuals and entire populations, emphasising the importance of good mental health of society in creating the economic prosperity of countries around the world.
Particular attention is paid to the role of peer support workers (also known as peer workers, recovery assistants, EX-INs) in the transformation of psychiatric healthcare and improvement of the quality of services by promoting a person-centred approach. An important issue described in the article concerns training programmes for peer support workers preparing them to perform their role in therapeutic teams, among others. The article also discusses the Optimal Mix of Services for Mental Health, a model developed and recommended by the WHO, which not only indicates the direction of change for psychiatric care, but can also be used in the process of devising new training models for peer support workers.

KEYWORDS:
mental health, peer support workers, organisation of psychiatric health services

1. Introduction

In recent years, mental health has become a very important subject in public discourse and one of the top priorities of health policies for the European Union and other international organisations. Mental health has been recognised as a global public good. The deteriorating mental condition of individuals and entire communities has become a fact that is confirmed by

all countries without exception. The difficult situation in the area of mental health has been additionally exacerbated by the COVID-19 pandemic sweeping through the world. All of it has resulted in a significant acceleration and intensification of actions intended to improve mental health.

2. Global mental health as a paradigm of sustainable development

In September 2015, at the 70th Session of the United Nations General Assembly in New York (attended by 193 representatives of states, heads of government and civil society leaders), the 2030 Agenda for Sustainable Development was adopted.[1] It identifies 17 Sustainable Development Goals, each of which is accompanied by a set of targets that need to be implemented to ensure the successful achievement of particular goals. The agenda is an action plan for global change and transformation, which describes how the needs of the present generation can be met in a sustainable manner, respecting the environment and the needs of future generations.

Goal number 3 refers to the need to ensure healthy lives and "promote well-being for all at all ages." One of the tasks connected with the implementation of this goal is task 3.4, which says that by 2030 premature mortality from non-communicable diseases is to be reduced by one third through prevention and treatment as well as promotion of mental health and well-being.

The popular saying "there is no health without mental health" is widely known and remains valid. However, a new era begins, a new stage, and with it comes a new slogan: "there is no sustainable development without mental health." It is sustainable development that has become the goal for all countries and all policies, and emphasising the importance of mental health as an important element that guarantees economic, social and political success clearly shows how much importance is attached to it.

The UN agenda situates mental health at the very heart of sustainable development in all countries and communities, and for all people. Attaching so much importance to the mental health and well-being of societies calls for urgent and comprehensive actions by all stakeholders, at the international, national and community level.

The need for change in health care seems obvious, but focusing solely on this area is insufficient. All areas of social policy, education and the labour market need reform. Urgent action is required to protect mental health and prevent disorders, to increase the scope of services, improve early detection, treatment and recovery of people with mental illnesses.

[1] Resolution adopted by the General Assembly on 25 September 2015, *Transforming Our World: The 2030 Agenda for Sustainable Development*, A/RES/70/1.

According to the authors of a report on global mental health,[2] despite significant progress in research showing what can be done to prevent mental disorders, how to treat them and promote mental health, translating the findings into real, noticeable actions is very slow. The global burden of diseases attributable to mental disorders has increased in all countries due to major demographic, environmental and socio-political changes. An analysis of data from the World Health Organization [Bloom et al. 2011] shows that the global economic cost of mental illnesses will be around $16 trillion by 2030, i.e. one-third of all global spending on non-communicable diseases. As of 2017, the Social Insurance Institution in Poland allocated approximately PLN 6 billion to benefits connected with incapacity to work resulting from mental disorders.[3] The quality of mental health services is generally inferior to the quality of physical health services. Government investment and development aid in mental health remain too low. All of this results in a tremendous loss of human talent and potential, as well as preventable suffering experienced by people with mental disorders.

The UN committee for mental health recognises the opportunities offered by the Sustainable Development Goals to broaden the global mental health agenda, from reducing the gap in access to health services and treating people with mental disorders to improving the mental health of entire populations and reducing the share of mental disorders in the global burden of disease. These activities are also supported by the WHO Comprehensive Mental Health Action Plan 2013–2020, which envisions a world where "mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination."[4]

The agenda of the UN Mental Health Commission rests on four foundational pillars:

1. Mental health is a global public good, connected with sustainable development in all countries, irrespective of their socio-economic status, as all countries can be considered as developing countries in terms of mental health.
2. Mental health problems range from mild, time-limited suffering to chronic, progressive, and severely disabling conditions. The binary approach to

[2] The Lancet Commission on global mental health and sustainable development, The Lancet 392, October 2018.

[3] Statistical data of the Social Insurance Institution in Poland: Expenditure on social security benefits connected with incapacity to work in 2017; https://www.zus.pl/baza-wiedzy/statystyka/opracowania-tematyczne.

[4] Mental Health Action Plan 2013-2020, WHO, www.who.int.

diagnosing mental disorders, while useful in clinical practice, does not accurately reflect the diversity and complexity of mental health needs of individuals or populations.

3. Everyone's mental health is the unique product of social and environmental influences, particularly early in life, interacting with genetic, neurodevelopmental and psychological processes and influencing biological pathways in the brain.
4. Mental health is a fundamental human right for all people that requires a rights-based approach to protect the well-being of people with mental disorders and those at risk of poor mental health, and to create an environment that promotes mental health for all.

These excerpts from The Lancet Commission on global mental health and sustainable development clearly indicate the recognition of the importance of mental health and suggest the directions of development for mental health. Global mental health is becoming a paradigm for sustainable development. Bearing it in mind and in order to meet the expectations of people with mental disorders and their families, the Erasmus+ project "European Standards for Peer-workers" has been part of the action plan described both in the UN agenda and WHO documents.

One of the assumptions of the policy adopted in these documents is to include people with the experience of a mental crisis in the recovery process of those who are currently in a crisis situation, take their voice into account in the process of organising psychiatric care services, with the ultimate aim of enabling them to return to the labour market and fulfil their preferred social roles. However, all actions taken in this area must assume a perspective based on the following rights: the right to protection, the right to care, the right to dignity and the right to freedom.

It is also recommended that the process of organising psychiatric care should include new opportunities created by the involvement of trained non-specialised people, such as, for example, police officers, hairdressers, fitness trainers, who, as people with lived experience of a mental disorder, could contribute to therapeutic teams. It is important to build a psychiatric care system in which the expectations and needs of people with mental disorders are in the centre of attention. Therefore, a person-centred approach becomes crucial.

In order to improve the mental health of individuals and entire populations, a system of integrated health care should be organised in such a way that people's physical health is as important as their mental well-being. It is necessary to identify barriers and threats to mental health, raise the awareness of the importance of mental health for social and economic development, and pay attention to the promotion and protection of mental health in all sectors of the economy. Cross-sectoral actions should become a priority. These actions should focus on social and environmental determinants that

have a decisive impact on mental health at all stages of life of individuals and the entire population.

"We have evidence of the effectiveness of a community-based approach from countries that have applied it for a long time. In Poland, too, we want and need modern psychiatry, available to every Pole without having to wait many months to see a doctor or therapist, offered in a convenient location near one's place of residence, where help can be obtained quickly, comprehensively and in a way that is adapted to the individual situation of the patient and their family members, which is adequately financed and offers optimal working conditions for the staff" [Syc 2021, p. 3]. This vision of psychiatric care by editor Monika Anna Syc includes almost all the expectations of people with mental disorders and their families.

3. "Nothing about us without us," or towards the development of peer support

This slogan is much more than the expression of the expectations and needs of people with mental disorders concerning the mental health services. This is a call to transform psychiatric care towards a more community-based system, involving, among others, people with the experience of a mental crisis. Deinstitutionalisation of psychiatric care is one of the processes postulated by the WHO and other international organisations as a step towards building modern psychiatry and ensuring quality in psychiatric care. Thanks to dedicated funds allocated by the European Commission under the Knowledge Education Development Operational Programme (POWER), Community Mental Health Centres have been established in Poland, among other European countries, implementing the idea of deinstitutionalisation in practice. Moreover, some of the projects selected for implementation under the programme "Deinstitutionalisation of Services Provided to People with Mental Disorders and Diseases" were intended to train and employ persons with the experience of a mental crisis.

The regulation on a pilot programme in mental health centres, issued by Poland's Minister of Health in 2018,[5] indicated the possibility of employing people with a mental crisis experience as peer support workers (PSWs) in the newly opened centres. However, in the following year, the regulation was amended and the obligation to employ PSWs in the centres was introduced. To justify the amendment, the Ministry of Health stated that the previous formulation was insufficient to promote the employment of PSWs, adding that their employment in mental health centres should be the norm rather than exception.

[5] Regulation of the Minister of Health of 27 April 2018 on a pilot programme in mental health centres (Journal of Laws, items 852 and 1786).

In Poland, one of the organisations involved in the process of returning people with the experience of a mental crisis to the labour market is the Leonardo Foundation for the Support of Social Development. To ensure the highest quality of services provided by PSWs, their safety as well as the safety of patients and members of therapeutic teams, the Foundation has prepared a special 720-hour training course.[6] Developed as part of an EU project, the course also enabled the participants to undergo internships in public healthcare organisations. As a result, 61 PSWs were trained over two years; 24 of them work in Warsaw: in hospitals (Wolski and Bielański) and in the Community Mental Health Centre in Bielany. The Foundation has also applied to the Ministry of Health to recognise the profession of peer support worker, as have patient organisations. Importantly, these activities are also supported by psychiatrists.

Including the profession in the qualifications framework would provide a basis for employing PSWs also in other places where services for people with mental disorders are provided, e.g. in community self-help homes or service centres offering specialist care. Of course, these are not all the organisations where PSWs could find employment. As early as 2005, the WHO considered it recommendable to include "experts by experience" in the medical services sector, recognising that their active participation would significantly improve the quality of care. In response to strong demand for medical and therapeutic services provided to people with mental disorders, the "EXperienced-INvolvement" project was established in Europe. As part of this project, courses were offered to people with the experience of a mental crisis who had improved their health enough to be able to function independently. Ten years later, this course started to be offered in Poland.

The trend towards including people with the experience of a mental crisis in the recovery process is increasingly pronounced. This action is by all means beneficial, because it allows such people to return not only to the labour market, but also to the social roles they previously performed, restoring faith in their own abilities. On the other hand, it supports the work of the overburdened medical personnel.

The essence of the PSW profession is encapsulated in the statement that "[a PSW] can help a sick person realise that the life of absolutely every human being has meaning, which can never be lost – it is unconditional. It leads the sick person onto the path of searching for or achieving success in their difficult situation, i.e. in the disease, possibly enabling them to fully realise their human potential" [Kula 2021, pp. 4–5]. If just for this reason, it is worth

[6] The course has been developed according to a 12-module curriculum prepared in 2007 by an international partner group under the EU Leonardo da Vinci programme (https://psychiatrie-verlag.de/wp-content/uploads/2019/01/EX-IN-Curriculum_02.pdf).

making the effort to include PSWs in the process of recovery of people with mental disorders. Building social bonds is not about tolerating the presence of people with mental disorders, but about accepting them. However, it is worth remembering that a person after a mental crisis is not an expert until they reflect on their experience and confront it, until they have completed training that will enable them to use their full potential in working with other people with mental disorders.

The importance of peer support is stressed by psychiatrist Marek Balicki, former director of the Pilot Office of the National Mental Health Programme, who says that a PSW's support is an extremely valuable complement to the therapy and yields very good results. He emphasises that for a person in a crisis situation, the support of someone who has experienced a similar crisis, recovered and undergone training is very important. This form of support is effective in many places around the world.

This opinion is shared by virtually everyone, as is the condition that such people should receive appropriate training before taking up peer support work. The relevant training programmes are being developed by many countries and organisations, including the United Kingdom, Germany, the Netherlands, Canada, Australia, New Zealand, the United States, Singapore and Ireland, to name but a few.

Crucially, in addition to preparing PSWs to work in multidisciplinary teams, it is equally important to prepare professionals (psychologists, psychiatrists, therapists) to cooperate with people who have experienced a mental crisis in therapeutic teams. It is also necessary to raise the level of knowledge and awareness among the employers in healthcare organisations. Training programmes developed with the involvement of these three parties increase the likelihood of successful deployment of PSWs. Such a programme for employers has been prepared as part of the Erasmus+ Programme "European Standards for Peer supporter."

4. Peer support worker as a new profession

The overarching goal of all the actions described above is to include the profession of peer support worker in the qualifications framework, which will radically change the situation of people who have experienced a mental crisis on the labour market.

A peer support worker is a trained person who has experienced a mental crisis and is able to provide individual or group support to people with mental disorders in their recovery process to enable them to make decisions about their lives based on the principle of self-determination. Peer support work focuses on recovery, not disease, which means that the role of a PSW is not to make a diagnosis, provide advice or treatment. PSWs establish relationships with people with mental disorders, believe in their ability to improve their

health and well-being, give hope, motivate, and inspire positive behaviours supporting the recovery process.[7]

There are four basic principles necessary for a recovery-oriented service:

1. Service user's lived experience is central.
2. Co-creation of recovery-promoting services by all stakeholders, including: people using the support services, family, carers, medical staff.
3. Organisational commitment to the development of recovery-oriented mental health services.
4. Supporting recovery-oriented learning and recovery-oriented practice in all stakeholder groups [Health Service Executive 2017, p. 11].

These principles should be considered in the process of transforming mental health care towards a community-based model. In this model, services are offered as close as possible to the place where people with mental disorders live, work and study, and care includes all sectors providing health, social and educational services. Service users, their families and carers are involved in deciding about the manner, place and scope of the provided services.

5. Transformation of psychiatric care services, i.e. the WHO pyramid framework

The World Health Organization has developed a pyramid framework presenting the optimal mix of services recommended to all countries and psychiatric health systems. The basis of the pyramid rests on the cheapest and most needed mental health services (self-care and informal community care). At the top there are more expensive services required by a smaller percentage of mentally ill people (psychiatric hospitals, long-stay facilities and specialist services). To develop this combination of services, the WHO recommends that countries should reduce the number of psychiatric hospitals, relocate mental health services to general hospitals, develop community-based services, integrate mental health services into primary care, build informal community mental health services and finally promote self-care. Integrating mental health services into primary care is expected to provide a more holistic approach to health care, increase the likelihood of early detection and treatment of mental disorders, improve the accessibility of mental care and reduce the stigma associated with seeking this form of care. To ensure effective and high-quality mental health services, the integration of mental health care into primary care services must be accompanied by adequate resources and specialised education.

[7] For more information on PSWs' role in the recovery process, cf. Hendry P, Hill T, Rosenthal H, 2014. Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services. ACMHA: The College for Behavioral HealthLeadership and Optum; and Health Service Executive, 2017. The National Framework for Recovery in Mental Health. Dublin, HSE: Mental Health Division.

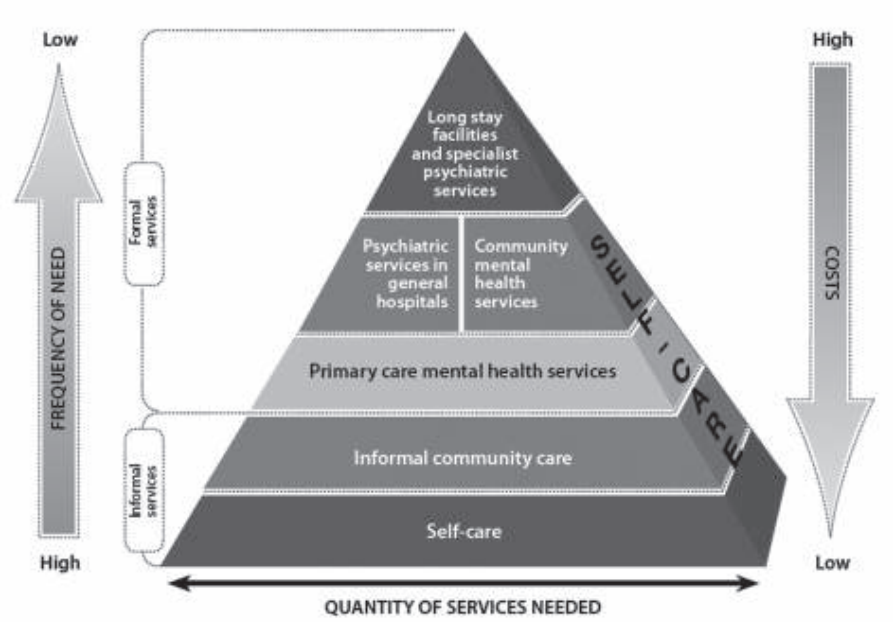

Fig. 1. WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health (source: The WHO MIND Project: Mental Improvement for Nations Development, Department of Mental Health & Substance Abuse, WHO Geneva).

At the bottom of the pyramid there are two informal levels of care and support offered to people with mental disorders. The first level is self-care, for which awareness and empowerment are of key importance. Most people are able to deal with their mental health problems by themselves or with the support of family and friends. The effectiveness of self-care is greatly influenced by formal healthcare support offered to people with disorders and their families. Formal healthcare organisations are the source of information on how to effectively deal with stress or how to take care of mental hygiene. They provide reliable information on factors contributing to good mental well-being and risk factors that have an adverse effect. They inform and teach families how to support people with mental disorders. Each subsequent level of the WHO pyramid framework should facilitate and develop self-care.

The second tier of informal care involves support services provided by the community, acting either collectively or individually. They can be friends, family, neighbours, religious leaders, social workers, and finally people with the experience of a mental crisis. Informal community care includes community-based services that are not part of the formal health and social care system, provided by, for example, traditional healers, professionals from other sectors such as teachers or police officers, NGOs, user and family associations, lay people. This tier can help prevent relapses among people who have

been discharged from hospital. Informal services are usually easily available and acceptable, as they are an integral part of the community. However, it is important to remember that mental health care should not be based solely on informal community care.

The subsequent levels of the pyramid are forms of formal care. The first is mental health care provided as part of primary health care. According to the WHO, it is the optimal level for ensuring that mental care is offered at a relatively low cost and integrates physical and mental health. The WHO specifies that this type of care is available, acceptable, sustainable and feasible. Basic services at this level include early detection, diagnosis and treatment of mental disorders, managing stable psychiatric patients, counselling for common mental disorders, referral to other levels of care if necessary, mental health promotion and preventive actions, particularly those that support the development of self-care. If mental health is integrated into primary care, access to these services is easier, mental disorders are detected and treated more often, and coexisting physical and mental health problems are addressed in a holistic manner.

The fourth level of the pyramid is specialised social services, including community care, day care, long-term care for chronic patients, assistance and family support in finding employment or housing, rehabilitation services, psychiatric wards in general hospitals, services in mental health clinics, mobile crisis teams, supervised therapy and inpatient services, services at home, and other support services. At this level, cooperation and coordination of activities with primary health care are crucial. Of course, not all community mental health centres will be able to provide all these services, but combining some of these elements according to individual needs and requirements is essential for effective mental health care. The WHO stresses that well-developed community mental health services are an essential part of any deinstitutionalisation programme and prevent unnecessary hospitalisation. What is worth noting is that persons receiving good community-based care have better physical and mental health and enjoy a higher quality of life.

Level 4 of the pyramid also includes services provided to people with mental disorders in general hospitals. For more serious (or recurring) mental problems, a short stay in hospital is often necessary. This solution is also beneficial for patients, because co-morbidities are better managed in psychiatric wards of general hospitals, where patients have access to many specialists. Moreover, since general hospitals carry less stigma compared to mental hospitals, access to psychiatric health services is improved. General hospitals can provide an accessible and acceptable form of round-the-clock medical care and supervision for people with acute mental disorders or in sudden crisis, in the same way that they manage acute physical conditions.

The last level of psychiatric health care in the WHO pyramid framework is highly specialised psychiatric care, which is required by the fewest number of people, but is the most expensive. This small group of patients with mental disorders require specialist care beyond that which can be provided in general hospitals. For example, people with treatment-resistant symptoms or complex disorders sometimes need to be referred to specialised centres for further testing and treatment. Some patients require constant care in specialist facilities due to very serious mental disorders, intellectual disability or the lack of family support. Forensic psychiatry is another type of specialist service that falls under this category. However, the need for referral to specialist and long-stay facilities is reduced when general hospitals employ highly specialised health professionals such as psychiatrists, psychologists and psychotherapists.

In the pyramid, the WHO deliberately uses the terms "long-stay facility" and "specialist services" in order not to identify these services with existing psychiatric hospitals. According to the WHO, psychiatric hospitals have a history of serious human rights abuses, poor clinical outcomes and inadequate rehabilitation programmes. They are costly, consuming a disproportionate share of all mental health expenditure. Of course, this opinion should not be generalised, because there are, and were, hospitals that did not violate human rights, had excellent clinical results and appropriate rehabilitation programmes. Nevertheless, the WHO recommends that psychiatric hospitals be closed down and replaced by general hospital services, community mental health services, and integrated primary care services. It should be remembered, however, that the implementation of this optimal model of integrated services will take many years and will not bring the same results in all countries. Nevertheless, this is the preferred direction in reforming mental health care systems.

From the point of view of improving the quality, efficiency and effectiveness of mental health services, it seems crucially important to develop an innovative model of cooperation and management of interdisciplinary and cross-sectoral teams coordinating the activities of entities providing health, social, educational and cultural services for people with mental disorders. Integrating the local community around activities for people with mental disorders and their families, the complementarity of health services and social assistance will contribute to increased knowledge about mental health and counter stereotypes about people with mental disorders [Mazur 2015, pp. 24–30].

To implement the idea of including people with mental disorders in the organisation of psychiatric services in a way that respects their needs, it is necessary to involve them at every level of the WHO pyramid. PSWs can constitute an important source of knowledge and support for people with

mental disorders and their families, but also for professionals. When designing training programmes for PSWs, the needs and opportunities arising at individual levels of the pyramid should be taken into account. PSWs involved in work on the first two tiers (informal community care) will require a different scope of knowledge and competence than those who will work in formal psychiatric facilities. It is an important and underestimated function of the WHO optimal mix of psychiatric services, and it should become a signpost for all countries developing training programmes for PSWs at different levels of the pyramid. These assumptions should also by considered in the qualifications framework.

In an analysis of PSW programmes developed and implemented in various European (and not only) countries, Charles et al. [2021] indicate the need to vary their training. The authors note that training programmes differ depending on the setting, local context and resources. Traditionally, peer support has been provided face to face, interventions took the form of group or individual meetings. However, as digital mental health interventions have become more common, the way mental health care is delivered is changing. Mutual peer support is increasingly offered through digital technologies.

6. Summary

Mental health is considered a public good and recognised as a crucial element of the sustainable development paradigm. This is one of the most important changes in thinking about mental health. The COVID-19 pandemic has additionally exacerbated the problem of the deteriorating mental health of individuals and entire societies. Meanwhile, the role of well-being has become increasingly important in economic development. Taken together, all these factors are likely to accelerate the transformation of psychiatric care systems towards a community-based care model. The WHO pyramid framework – the Optimal Mix of Services for Mental Health – seems to be helpful in these changes, as it clearly indicates how to organise psychiatric services in an optimal, effective and efficient manner. The recommended approach to the reorganisation of psychiatric care systems emphasises the necessity to meet all the needs of patients, including their social, professional and psychological needs. This means that people with first-hand experience of a mental crisis should be involved in designing the services. To be effective, mental health services should be driven by needs.

The WHO pyramid also constitutes the basis for training programmes for peer support workers. It should be included in the development and approval of a qualifications framework for the new profession of peer support worker.

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She is actively involved in promoting the idea of deinstitutionalisation of psychiatric care.

PART II

Anna Block

Introduction to the Project Products Presentation

The Erasmus+ project called "European Work Standards for Peer Support Workers" responds to the need to create uniform work standards for "recovery companions" – people who play an increasingly important role in the mental health care system by assisting the service user in 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 principle underlying this role: 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 relative novelty, the notion of peer support yields such promising results that in the near future it is very likely to become an important element of therapy in EU countries.

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 count on standardised job descriptions, uniform 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 constitute the basis for the education of persons willing to find employment as peer support workers.

This publication has been prepared under the guidance of project partner CEdu Sp. z o.o. by an international team of experts specialising in

peer support and the professional development of peer supporters. It is addressed to institutions that employ, or would like to employ, peer support workers and to members of therapeutic teams. Alongside valuable information about the position and employability of peer supporters in psychiatric and psycho-social care institutions, it contains a list of require competencies and a comprehensive glossary of important terms connected with peer support. Another element of the publication is the proposal for a training module on the work and role of peer supporter workers, which is addressed to team leaders and managers of psychiatric and psycho-social care institutions.

We hope that this publication will become a valuable guide for employers recruiting, or planning to recruit, peer supporters, and 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 competencies.

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

Erasmus+ Project "European Standards for Peer Support Workers in Mental Health"

Glossary for the peer supporter

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I. Introduction

The glossary used for the Erasmus+ project on peer support work and recovery consists of many terms and definitions that exist in the world of recovery and experiential expertise. Since these two concepts are important in our project, we start with an extensive description of each of them.

There are many different versions of the word experience expert: peer expert (EUCOMS), peer support worker, expert by experience, certified peer specialist, experiential expert, peer supporter, person with lived experience, survivor, peer worker, etc. For the needs of this project, the term "peer support worker" (PSW) has been chosen.

Recovery

Much literature can be found on the concept of recovery in psychiatry. Recovery is often seen as a multidimensional concept that includes clinical recovery and symptomatic recovery, social recovery and functional recovery, as well as personal/existential recovery [Whitley and Drake 2010]. In essence, it is ultimately about providing the client with the support and treatment that enables them to live the life they want, despite the psychological problem.

In addition to the different dimensions recognised at the beginning of the development of the concept of recovery, more recently it has been supplemented with attention to one's strengths (positive psychology) and self-direction (self-management, self-determination; Shepherd et al., 2008).

- Two important models for recovery are described by Andresen et al. [Andresen 2003, pp. 586–594] and by Leamy et al. [Leamy 2011, pp. 445–452; the so-called CHIME model]. Their main similarity is that recovery involves finding and keeping hope. Hope is the fuel for recovery. This is not about encouraging naive or unreal expectations. Having positive expectations and perspective is more likely to lead to improvement than low expectations, which can become a self-fulfilling prophecy.
- Rediscovering your own identity, in which having the mental disorder has a place, and in which there is a positive sense of self.
- Building a meaningful life, despite having a mental illness.
- Having control over the mental illness and over life itself; empowerment.

"Connectedness" can be added to these four aspects, which includes having supportive relationships, being part of society. Finally, recovery is understood as a process. Based on interviews with clients [Andresen et al., 2006, pp. 972–80], five stages of recovery were distinguished, the first stage being the so-called "moratorium" stage of hopelessness and the last stage being the stage of growth. These stages are not linear and clients differ in the degree to which they are willing/able to enter the recovery process; among other things because of the severity of the symptoms, the pain it takes to recognise that help is needed, previous negative experiences with care, (many) side effects of medication.

Experiential expertise or peer support expertise

Experiential expertise is the ability to make room for other people's recovery based on one's own experience of recovery. The knowledge gathered through reflection on one's own experiences and the experiences of partners, supplemented with knowledge from other sources, is used in a professional manner for the benefit of others. The development of experiential expertise starts with reflecting on your own experience of disruption and recovery. The knowledge of experience is broadened by exchanging experience with peers, consulting literature and further analysis/reflection.

The next step is experiential expertise. This is achieved by learning skills to use the experience knowledge professionally. There are various paths to achieve this.

Expert by experience / peer support worker

An experiential expert or peer support worker is someone who has knowledge of their own recovery process as well as of other people's and is able to facilitate recovery processes of others in an appropriate and professional way. The expert has developed the ability to use their own experiences with a disruptive disorder and overcoming it (recovery) in order to support others in finding or making room for their personal recovery process. It is crucial that peer support workers

- contribute the personal dimensions of recovery,
- use their own experience of stigmatisation and empowerment to promote a recovery-supportive (social) environment and recovery-supportive care.

The contribution to mental health care of peer support workers differs substantially from the contribution of regular mental health professionals.

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II. Glossary

No.	Definition	English	Dutch	German	Greek	Norwegian	Polish
1.	There are several dimensions of recovery within the recovery process. Mostly used are: • clinical/symptomatic recovery • functional recovery • social/personal recovery.	Dimensions of recovery	Dimensies van herstel	Dimensionen der Genesung / Erholung	Διαστάσεις της ανάρρωσης	Recovery nivåer	wymiary procesu zdrowienia
2.	We prefer to speak of people with a psychic vulnerability instead of calling them depressed or schizophrenic in order to state that people are more than just their diagnosis.	Psychic vulnerability	Psychische kwetsbaarheid	Psychische Verletzlichkeit	Ψυχική ευαλωτότητα	Psykisk sårbarhet	podatność na zaburzenia
3.	We prefer to speak of people with a sensibility to addiction instead of having an addiction to state that people are more than just their diagnosis.	Sensibility to addiction	Verslavings-gevoeligheid	Suchtneigung	Ευαισθησία/ τάση στην εξάρτηση	Forhøyet risiko til avhengighet	skłonność do uzależnień
4.	Knowledge of one's own recovery means having insight in the development / process of one's own recovery.	Knowledge of one's own recovery	Eigen herstelkennis	Wissen über die eigene Genesung	Επίγνωση της προσωπικής ανάρρωσης του ατόμου	Kunnskap om egen recovery	wiedza o własnym procesie zdrowienia
5.	Recovery momentum is a recognised significant moment within the recovery process where the process changed direction.	Recovery momentum	Herstelmoment of kantelmoment of ommekeermoment	Genesungsdynamik Wendepunkt	Σημείο καμπής στην ανάρρωση	Recovery momentum/ Gyllent øyeblikk	punkt zwrotny w procesie zdrowienia

6.	Recovery group assumes development of recovery by exchanging knowledge of what supported recovery and what did not.	Recovery group	Herstel in groepsverband of herstelwerkgroep	Genesungs-gruppe	Ομάδα εργασίας για την ανάρρωση/ Ομάδα ανάρρωσης	Recovery gruppe	grupa w procesie zdrowienia
7.	The process of recovery is the gradual, step-by-step development that is needed in order to strengthen recovery, gain inside knowledge of what is supportive or obstructive in your own recovery process.	Recovery process	Herstelproces	Genesungsproz-ess	Διαδικασία ανάρρωσης	Recovery prosess	proces zdrowienia
8.	When representatives of the idea behind the added value of recovery show activities leading to broader acknowledgment, credibility and application of recovery, we speak of recovery movement. This movement originally derives from movements of service users.	Recovery movement	Herstelbeweging	Genesungsbewe-gung	Κίνημα της ανάρρωσης	Recovery bevegelse	ruch na rzecz zdrowienia
9.	Recovery-oriented care consists of all forms of care that take into account various dimensions of recovery.	Recovery oriented care	Herstelondersteunende zorg	Genesungsorien-tierte Pflege	Φροντίδα προσανατολισμένη στην ανάρρωση	Recovery orientert helsetjeneste	opieka nastawiona na zdrowienie
10.	Recovery supporting means reinforcing, supporting and promoting the process of recovery.	Recovery supporting	Herstelbevorderend	Genesung unterstützend	Υποστηρικτικοί παράγοντες ανάρρωσης	Recovery støtte	sprzyjający zdrowieniu

11.	Recovery obstructing means obstructing and counteracting the process of recovery.	Recovery obstructing	Herstelbelem-merend	Genesung behindernd	Αναστολτικοί παράγοντες ανάρρωσης	Recovery hindring	utrudniający zdrowienie
12.	The Recovery Oriented Intake (ROI) has been developed from the idea that starting points for treatment in specialist mental health care must be shaped from the intake, so that intake and treatment are in line with each other and it becomes an ongoing process. The recovery-oriented intake is done with several people. In addition to the service user and the coordinating therapist, there is a second therapist (basic psychologist, social psychiatric nurse) and a peer support worker. This means that the three main sources of professional knowledge are available and that all dimensions of recovery can be applied. The main concepts for the ROI are: 1. Positive health 2. Recovery 3. Personal diagnostics	Recovery Oriented Intake (ROI)	Herstelondersteunende intake	Genesungsorientierte Aufnahme (ROI)	Intake στο πλαίσιο της ανάρρωσης	Recovery orientert innkomst/inntak	przyjęcie nastawione na zdrowienie

	4. Motivational interviewing 5. Supported decision making.						
13.	Clients receive a so-called "warm welcome" upon arrival, which means that a service user is assigned to a peer support worker. The peer support worker communicates with them in an accessible manner, invites them to the conversation room and arranges something to drink so that the service user feels comfortable. There they are joined by two other therapists as part of the recovery-oriented intake and the follow-up.	Warm welcome	Warme ontvangst	Herzliches Willkommen	«Ζεστή» υποδοχή	Åpen mottagelse	ciepłe przyjęcie
14.	Shared/supported decision-making, making decisions together, is an approach in which the professional and the service user make decisions together regarding the therapies of service users, exchange the available information about effective therapies and support service users in considering the different options. In essence, deciding together is about	Shared/ supported decision making	Samen/ ondersteunend keuzes maken	Gemeinsame/unterstützte Entscheidungsfindung	Κοινή/ Υποστηριζόμενη λήψη αποφάσεων	samvalg	wspólne podejmowanie decyzji

	self-direction (self-determination) of service users and as such it also fits into the ideas about recovery in which the wishes and preferences of the service users and the right to decide for themselves are emphasised						
15.	In essence, the principles of positive health and recovery mean distancing ourselves from the traditional model: diagnosis–therapy–healing. Diagnosis involves more than a classification of clients' complaints into the categories of the DSM-5. The categorisation of symptoms does not explain these phenomena, nor does a need for care directly arise from these symptoms. The individual profile is the story the service user tells as the reason why he/she came into care. We call it personal diagnosis, for which four questions are central: • *What happened?* This is not about what is wrong with a service user, but what he or she has gone through	Personal diagnosis	Persoonlijke diagnose	Persönliche Diagnose	Προσωπική εκτίμηση ψυχικής υγείας/ Διαγνωστική εκτίμηση σύμφωνα με το μοντέλο recovery	Personlig diagnose	spersonalizowana diagnoza

	• *What is your vulnerability and your resilience?* Together with the service user, the professional maps out which factors influence (or have influenced) the occurrence and maintenance of the problem and what the relevant protective or hindering factors are. Important concepts here are: dimensionality (see "dimensions of recovery"); reactivity – to what extent are vulnerability and resilience responsive to the environment; relationality – the degree to which symptoms and resilience mutually influence each other; and functionality – the degree to which symptoms have an impact on psychological functions such as memory and attention . • *Where do you want to go?* This question introduces a long-term perspective of recovery and a commitment to a satisfying life "beyond" the condition into the						

	diagnostic process. Even if the patient is still in the phase of being overwhelmed by the experience, it is important to get a first perspective of the process in which these experiences can be given a place. • *What do you need?* This involves mapping out the care needs of the service user.						
16.	Experiential knowledge is about knowledge gathered based on a (psychological) disruption a person has experienced first-hand.	Experience based knowledge	Ervaringskennis	Erfahrungsbasiertes Wissen	Γνώση βασισμένη στην εμπειρία	Erfaringsbasert kunnskap	wiedza oparta na doświadczeniu
17.	Scientific knowledge is about knowledge gathered on the basis of results from scientific research.	Scientific knowledge	Wetenschappelijke kennis	Wissenschaftliches Wissen	Επιστημονική γνώση	Vitenskapsbasert kunnskap	wiedza naukowa
18.	Professional knowledge is about knowledge gathered on the basis of education in a specific profession, knowledge from the professional field and further development in the profession.	Professional knowledge	Professionele kennis	Berufliches Wissen	Επαγγελματική γνώση	Profesjonell kunnskap	wiedza zawodowa

19.	Professional field is everything concerning the profession or discipline of peer support workers.	Professional field	Vakgebied	Berufsfeld	Επαγγε-λματικός τομέας	Fagfelt	dziedzina zawodowa
20.	Professional literature concerns all relevant documentation in the practical field of peer support work and recovery.	Professional literature	Vakliteratuur	Fachliteratur	Βιβλιογραφία σχετική με το επάγγελμα	Fagliteratur	literatura specjalistyczna
21.	Knowledge from professional practice arises from experience applied in practice by representatives of the profession of peer support workers.	Knowledge from professional practice	Professionele praktijkkennis	Wissen aus der Berufspraxis	Γνώση από επαγγελματική πρακτική	Kunnskap fra profesjonell praksis	wiedza zdobyta w praktyce zawodowej
22.	Professional development is about the process of becoming more mature and experienced in applying principles and skills of the profession.	Professional development	Beroepson-twikkeling	Berufliche Entwicklung	Επαγγελματική ανάπτυξη	Faglig utvikling	rozwój zawodowy
23.	You are working with a professional attitude if you relate to your practice and people involved in a way that is in accordance with assumptions of the profession and the grounded vision of experiential expertise.	Professional attitude	Beroepshouding	Professionelle Einstellung	Επαγγελματική στάση	Profesjonell holdning	profesjonalne podejście

24.	Expertise is the degree of knowledge and acquired skills necessary for the proper practice of the profession.	Expertise	Deskundigheid	Fachwissen	Εξειδίκευση	Kompetanse	wiedza ekspercka
25.	Promotion of expertise concerns all activities in the field of education, further education and training, broadening knowledge and skills for practicing the profession.	Expertise promotion	Deskundigheids-bevordering	Förderung von Fachwissen	Προώθηση της εξειδίκευσης	Kompetanseut-vikling	promowanie wiedzy eksperckiej
26.	Life areas are the different domains in which life takes place, such as relationships, work-related activities, social participation etc.	Life areas	Levensgebieden	Lebensbereiche	Τομείς ζωής	Livsområder	obszary życia
27.	The world of experience is the world as seen through the perspective of experiences (for instance disruption and recovery).	World of experience	Ervaringswereld	Erfahrungswelt	Ο κόσμος της εμπειρίας	Erfaringsverden	świat doświadczany
28.	The perceived world is the effect that events, facts and experiences have on the individual person in terms, the way in which they are processed and the associated feelings.	Perceived world	Belevingswereld	Wahrgenom-mene Welt	Αντιληπτός κόσμος	Den opplevde verden	świat postrzegany
29.	Self-determination is when somebody is taking decisions autonomously (in all relevant life areas).	Self-determination	Zelfbepaling / beschikking	Selbstbestim-mung	Αυτοπροσ-διορισμός/ Αυτοδιάθεση	Selvbestemmelse	samostanowienie

30.	Self-awareness is being aware about your own identity, personality, ambitions and wishes.	Self-awareness	Zelfbesef	Selbsterkenntnis	Αυτογνωσία	Selvbevissthet	samoświadomość
31.	Self-esteem is being aware of your own value and dignity.	Self-esteem	Eigenwaarde	Selbstachtung	Αυτοεκτίμηση	Selvtillit	samoocena
32.	Self-help is helping yourself whether or not stimulated by others in the personal network like professionals or other people involved.	Self-help	Zelfhulp	Selbsthilfe	Αυτοβοήθεια	Selvhjelp	samopomoc
33.	Method-based self-help is helping yourself in a standardised manner according to a described pattern.	Method-based self-help	Methodische zelfhulp	Methodenbasierte Selbsthilfe	Αυτοβοήθεια βάσει συγκεκριμένης μεθόδου	Metode basert selvhjelp	samopomoc oparta na metodzie
34.	The control function is when somebody directs decision making, initiatives, activities and operations themselves.	Control function	Regiefunctie	Kontrollfunktion	Λειτουργία προσωπικού ελέγχου	Kontrollfunksjon	funkcja kontrolująca
35.	Self-management is controlling activities and operations yourself.	Self-management	Eigen regie	Selbstverwaltung	Αυτοδιαχείριση	Selvledelse	samozarządzanie
36.	Self-direction is when you are leading or coordinating yourself.	Self-direction	Zelfsturing	Selbstlenkung	Αυτοπροσανατολισμός	Selvkoordinering	samokierowanie
37.	Self-handling is giving priorities in your own life or work based on self-knowledge, knowledge of weaknesses and strengths as well as areas for improvement.	Self-handling	Zelfhantering	Selbstmanagement	Διαχείριση/ αξιοποίηση του δυναμικού του ατόμου	Selvprioritering	samoobsługa

38.	Method-based action is executing activities in a standardized manner according to a described pattern.	Method-based action	Methodisch handelen	Methodenbasiertes Handeln	Λειτουργία βάσει συγκεκριμένης μεθόδου	Metodebasert tiltak	działanie oparte na metodzie
39.	Education is providing data or facts about certain subjects.	Education and/or Information	Voorlichting	Bildung und/oder Information	Εκπαίδευση/πληροφόρηση	Utdannelse	edukacja i/lub informacja
40.	Educational material is all data and facts including tools needed to provide information.	Educational and/or information material	Voorlichtingsmateriaal	Bildungs- und/oder Informationsmaterial	Εκπαιδευτικό/πληροφοριακό υλικό	Undervisningsmateriell	materiały edukacyjne i/lub informacyjne
41.	Treatment is the way in which one approaches someone else.	Treatment	Bejegening	Begegnung	Θεραπεία/θεραπευτική αντιμετώπιση	Behandling	traktowanie
42.	Disruption is undergoing severe damage to personal balance, health and well-being.	Disruption	ontwrichting	Störung	Αποδιοργάνωση/ Διατάραξη	Avbrudd	zaburzenie
43.	Disrupting experience is an experience causing severe damage to the personal balance, health and well-being.	Disrupting experience	Ontwrichtende ervaring	(Ver)störende Erfahrung	Διαταρακτική εμπειρία	Erfaring med avbrudd	doświadczenie zaburzające
44.	Stigma is a kind of "brand mark" (for instance when somebody is suffering from a certain disease). It is a powerful negative social mark mostly based on prejudices. It has a profound effect on the way people see themselves and are seen by others.	Stigma	Stigma	Stigma	Στίγμα	Stigma	Stygma

45.	Stigmatisation is a process in which a group of people is negatively labeled, condemned and excluded. This happens on the basis of common, deviating characteristics and/or behaviours that evoke fear or aversion.	Stigmatisation	Stigmatisering	Stigmatisierung	Στιγματισμός	Stigmatisering	stygmatyzacja
46.	Anti-stigmatisation are activities or campaigns to prevent or combat stigma.	Anti-stigmatisation	Anti-stigmatisering	Maßnahmen gegen Stigmatisierung	Αποστιγματισμός	Anti stigmatisering	anty-stygmatyzacja
47.	We also call self-stigma internalised stigma. If you start to see your "label" as an important part of your identity, self-stigma will arise. You then believe that the prevailing negative images and prejudices are correct. And that they apply to you.	Self-stigma	Zelfstigma	Selbststigmatisierung	Αυτο-στιγματισμός	Selv stigmatisering	autostygmatyzacja
48.	Exclusion exists if someone is not allowed to participate in certain activities or to participate in a certain setting, company, environment, community or population.	Exclusion	Uitsluiting	Ausgrenzung	Αποκλεισμός	Ekskludering	wykluczenie
49.	Discrimination exists if someone is rejected based on the (negative) characteristics of the group of people he belongs to.	Discrimination	Dicriminatie	Diskriminierung	Διάκριση	Diskriminering	dyskryminacja

50.	Exclusion mechanism is the system that causes exclusion.	Exclusion mechanism	Uitsluitings-mechanisme	Ausgrenzungs-mechanismus	Μηχανισμός αποκλεισμού	Ekskluderings mekanisme	mechanizm wykluczenia
51.	Equivalence exists when people are considered to be equally valuable.	Equivalence	Gelijkwaardig-heid	Gleichwertigkeit	Ισοτιμία	Likeverdighet	równoważność
52.	The core of experiential ex-pertise consists of the ability to make and hold on to free space for recovery (on the basis of one's own recovery experience). It is intended to create a safe research environment. As a result, a service user is invited to develop his or her own way in recovery. "Leave someone in their own space".	Free space	Vrije ruimte	Freiraum	Ελεύθερος χώρος	Åpent rom	wolna przestrzeń
53.	Diagnosis-free space is the context in which it is not permitted to use (medical) diagnostic terms. We do this as we know that this is not supporting to make and hold the space that people need to find their own path to recovery.	Diagnosis-free space	Diagnosevrije ruimte	Diagnose-freier Raum	Χώρος ελεύθερος από διαγνώσεις	Diagnose fritt rom	przestrzeń wolna od diagnoz

54.	Power-free space is the context in which it is not allowed to use elements of dominance or inequality. This is necessary as we know that this is not supporting to make and keep the space that people need to find their own path to recovery.	Power-free space	Machtsvrije ruimte	Machtfreier Raum	Χώρος ελεύθερος από εξουσία	Maktfrihet	przestrzeń wolna od autorytetów
55.	A personal network is the sum of people with whom someone maintains a personal relationship.	Personal network	Persoonlijk netwerk	Persönliches Umfeld	Προσωπικό Δίκτυο	Personlig nettverk	sieć relacji osobistych
56.	A power source is the entity from which someone derives strength. This entity might be a person (or persons) as well as emotions or feelings.	Power source	Krachtbron	Kraftquelle	Πηγή ενέργειας	Energikilde	źródło siły
57.	Personal strength conference is a meeting in which a person together with his personal network and/or professional care providers is enabled to formulate a plan in order to solve problems.	Personal strength conference	Eigen krachtconferentie	Konferenz zu den persönlichen Stärken	Συνεδρία προσωπικής ενδυνάμωσης	Personlig styrke konferanse	konferencja siły osobistej
58.	An action strategy is formulating a plan with activities that are necessary to achieve a certain goal.	Action strategy	Handelingsstrategie	Handlungsstrategie	Στρατηγική/ Σχέδιο δράσης	Handlingsstrategi	strategia działania

59.	A social support system is the sum of elements or persons in the social environment that can contribute to support.	Social support system	Maatschappelijke steunsystemen	Soziales Unterstützungssystem	Σύστημα κοινωνικής υποστήριξης	Sosialt støttesystem	system wsparcia społecznego
60.	Crisis is a very urgent situation that requires immediate intervention.	Crisis	Crisis	Krise	Κρίση	Krise	Kryzys
61.	A crisis card contains practical instructions, for those who have access, how to act or support someone in a crisis.	Crisis card	Crisiskaart	Krisenpass	Σχέδιο κρίσης	Kriseplan	karta kryzysowa
62.	A crisis intervention is acting in urgent or emergency situations with the aim of preventing further escalation and creating a more stable circumstance in which a regular approach is possible.	Crisis intervention	Crisisinterventie	Krisenintervention	Παρέμβαση σε κρίση	Kriseintervensjon	interwencja kryzysowa
63.	The Wellness Recovery Action Plan (Mary Ellen Copeland) is an evidence-based recovery model which focuses on a person's strengths. People develop their own personal WRAP in a group, taking into account the recovery knowledge of that group. In the final WRAP you make action plans of what you can do in different phases from when you don't feel well to the point of disruption.	Wellness Recovery Action Plan (WRAP)	Wellness Recovery Action Plan (WRAP)	Wellness Recovery Action Plan (WRAP)	Το Σχέδιο Δράσης για την ανάρρωση WRAP	Wellness Recovery Action Plan (WRAP)	Wellness Recovery Action Plan (WRAP)

64.	A monitoring plan is a written document describing different expressions or behaviours of a person corresponding to different phases in the development towards psychosis. The document also clarifies how to act in those phases.	Monitoring plan	Signaleringsplan	Beobachtung-splan	Πλάνο Παρακο-λούθησης	Kartleggingsplan	plan monitorowania
65.	A forced admission is an admission to a closed clinical psychiatric setting without the consent of the individual concerned.	Forced admission	Gedwongen opname	Zwangseinwei-sung	Ακούσια νοσηλεία	Tvangsinn-leggelse	przymusowe przyjęcie
66.	Free space is a meeting place for the free exchange of ideas (or a space to discover what personal recovery means), like for example recovery colleges, self management centre.	Free space	Vrijplaats	Freiraum	Χώρος ελεύθερης έκφρασης	Åpen møteplass	wolna przestrzeń
67.	Making quarters is the transfer of knowledge in the field of recovery to the neighborhood of service users or to all layers of the organisation or other relevant institutions. The aim is to promote a social climate (sensitising of neighbourhood or	Make quarters	Kwartiermaken	Quartier machen	Τομέας καινοτομίας	Recovery tankesmie	robienie miejsca

	organisation) in which more opportunities arise for people on the margins to belong and participate according to their own wishes and possibilities.						
68.	Giving fulfillment in life means that something, a (personal) event or some activity, gives the conviction or feeling of being meaningful.	Giving fulfillment in life	Zingeving	Dem Leben Bedeutung geben	Νοηματοδότηση	Meningsfulle aktiviteter	nadawanie poczucia spełnienia w życiu
69.	A multicultural society is a society in which people with different backgrounds such as culture, religion, nationality or language are living together.	Multicultural society	Multiculturele samenleving	Multikulturelle Gesellschaft	Πολυπολιτισμική κοινωνία	Flerkulturelt samfunn	społeczeństwo wielokulturowe
70.	Diversity is a term that indicates differences in cultural, national or religious backgrounds.	Diversity	Diversiteit	Diversität	Ποικιλομορφία	Mangfold	różnorodność
71.	Mindfulness is a form of training focused on stress reduction by finding the right balance between workload and private life.	Mindfulness	Mindfulness	Achtsamkeit	Ενσυνειδητότητα	Mindfulness	uważność

72.	Empowerment is the process in which people get more influence on events and situations that are important for them, like decisions regarding their well-being. It is also achieved by discovering and making use of their own strength.	Empowerment	Vergroten eigen kracht	Selbstbefähigung Eigenkraftentwicklung	Ενδυνάμωση	Empowerment/ Myndiggjøring	wzmocnienie
73.	Developmental psychology studies psychological changes with increasing age from (early) childhood, adolescence to old age.	Developmental psychology	Ontwikkelingspsychologie	Entwicklungspsychologie	Αναπτυξιακή/ Εξελικτική ψυχολογία	Utviklingspsykologi	psychologia rozwojowa
74.	System treatment is a therapy not focused only on the person primarily involved but on the coherent context of the most important personal network surrounding the person, e.g. family.	System treatment	Systeembehandeling	Systemische Behandlung	Συστημική προσέγγιση	Systembehandling	podejście systemowe
75.	A life event is an event with a major impact on a person's life.	Life event	Levensgebeurtenis	Lebensereignis	Γεγονός ζωής	Livshendelse	wydarzenie życiowe
76.	Non-verbal expressions are all expressions not being oral but for example through gestures.	Non-verbal expressions	Non-verbale uitingen	Nonverbale Ausdrucksformen	Μη λεκτικές εκφράσεις		wyrażenia niewerbalne

77.	Psychopathology is the science describing mental suffering or manifestations that may indicate a mental illness.	Psychopathology	Psychopathologie	Psychopathologie	Ψυχοπαθολογία	Non-verbale uttrykk	psychopatologia
78.	Border crossing behaviour is behaviour that goes beyond what is decent and socially acceptable.	Border crossing behaviour	Grensoverschrijdend gedrag	Grenzüberschreitendes Verhalten	Εκτός ορίων συμπεριφορά	Psykopatologi	zachowanie przekraczające granice
79.	Knowing one's own limitations is being aware of the limitation of one's own ability to perform or ability to tolerate dissatisfaction or stress.	Knowing one's own limitations	Eigen grenzen kennen	Die eigenen Grenzen kennen	Γνώση των ορίων του εαυτού	Uakseptabel sosial atferd	świadomość własnych ograniczeń
80.	Conversation or interviewing techniques are different methods of verbal conversation which contribute to making communication as optimal as possible.	Interviewing techniques	Gesprekstechnieken	Befragungstechniken	Τεχνικές συνέντευξης	Å kjenne egne begrensinger	techniki konwersacyjne
81.	Motivational interviewing is an approach of interviewing aiming at getting someone motivated to solve their own problems or get support/ treatment.	Motivational interviewing	Motiverende gespreksvoering	Motivierende Gesprächsführung	Συνέντευξη κινητοποίησης	Intervjuteknikker	rozmowa motywująca

82.	Outreaching work implies that (supportive or treatment) contacts are offered in one's own living environment.	Outreaching work	Outreachend werken	Hilfsangebote	Κοινοτική φροντίδα	Motiverende intervju (MI)	praca środowiskowa
83.	Demand-oriented work is an approach where the input is determined by the wishes of the person himself (as opposed to an approach whereby the aid offer is defined by the provider of services).	Demand-oriented work	Vraaggericht werken	Bedarfsorientiertes Arbeiten	Εργασία εστιασμένη στις ανάγκες	Oppsøkende arbeid	praca zależna od zapotrzebowania
84.	Professional acting is acting in accordance with guidelines of the profession and generally accepted quality standards.	Professional acting	Beroepsmatig handelen	Professionelles Handeln	Επαγγελματική στάση	Oppdragsbasert arbeid	profesjonalne zachowanie
85.	A skill is the ability to perform an action in a competent way.	skill	Vaardigheid	Fertigkeit	Δεξιότητα	Profesjonelle retningslinjer	umiejętność
86.	Context bound means involving all relevant factors in the relevant situation.	Context bound	Contextgebonden	Kontextgebunden	Εντός πλαισίου	Ferdighet	zależny od kontekstu
87.	Professional responsibility is a responsibilty within the limits of professional practice.	Professional responsibility	Beroepsmatige verantwoordelijkheid	Berufliche Verantwortung	Επαγγελματική ευθύνη	Kontekstbundet	odpowiedzialność zawodowa

88.	Transfer is the ability to transfer learning points from one recovery experience to another recovery experience.	Transfer	Transfer	Transfer	Μεταφορά εμπειρίας	Faglig ansvar	transfer
89.	Intervision is an arranged conversation between persons employed or in training for the same profession to promote reflection, learning from and with each other and quality.	Intervision	Intervisie	Intervision	Αλληλοϋποστήριξη μεταξύ συναδέλφων	Erfaringsdeling	interwizja
90.	Supervision is an individual learning process that addresses personal learning questions that someone has with regard to their work.	Supervision	Supervisie	Supervision	Εποπτεία	Reflekterende samtale	superwizja
91.	Writing skill is the ability to express yourself well in writing.	Writing skill	Schriftelijke vaardigheid	Schreibfertigkeit	Δεξιότητα στο γραπτό λόγο	Veiledning	umiejętność pisania
92.	Oral skill is the ability to express yourself well verbally	Oral skill	Mondelinge vaardigheid	Sprachliche Fertigkeit	Δεξιότητα στον προφορικό λόγο	Skriftlige formidlingsegenskaper	umiejętność mówienia
93.	Competence is the ability to perform a task with the right knowledge and skills and therefore to act adequately.	Competence	Competentie	Kompetenz	Επάρκεια	Muntlige Formidlingsegenskaper	kompetencja
94.	A competency profile is the overview of knowledge and skills that are deemed necessary for the performance of a certain function.	Competency profile	Competentie-profiel	Kompetenzprofil	Απαιτούμενα προσόντα	Kompetanse	profil kompetencji

95.	The primary process is the core business of an organisation (as opposed to conditional tasks such as administration or finance).	Primary process	Primair proces	Primärprozess	Βασική δραστηριότητα	Kompetanse-profil	proces podstawowy
96.	The task area is the area to which the performance of the task is limited.	Task area	Taakgebied	Aufgabenbereich	Περιοχή εργασιών	Primær prosess	obszar zadania
97.	Task rearrangement is the structural redistribution of tasks and responsibilities between different professional groups.	Task rearrangement	Taakherschik-king	Neuordnung von Aufgaben	Αναδιάταξη εργασιών	Oppgaveområde	zmiana układu zadań
98.	The core task of an organisation (or profession) is the task most relevant in terms of a formulated vision, because of law or external regulations or magnitude of the external demand.	Core task	Kerntaak	Kernaufgabe	Βασικό αντικείμενο	Oppgaveforde-ling	główne zadanie
99.	A set of tasks is the combi-nation of tasks for the execu-tion of which a person or an organisation is responsible.	Set of tasks	Takenpakket	Aufgaben-Block	Σύνολο εργασιών	Kjerneoppgave	zestaw zadań
100.	Core quality is the kind (or aspect) of quality for which an organisation, profession or sector appreciates the most by formulated vision or by external regulation.	Core quality	Kernkwaliteit	Kernqualität	Θεμελιώδης αξία	Sett med oppgaver	główna cecha
101.	A solution strategy is a step-by-step plan with the aim of solving a problem.	Solution strategy	Oplossingsstrat-egie	Lösungsstrategie	Στρατηγική επίλυσης προβλημάτων	Kjernekvalitet	strategia rozwiązania problemu

102.	Reciprocity is an attitude respecting differences in experiences at the same time recognising common assumptions.	Reciprocity	Wederkerige inbreng	Wechselseitigkeit	Αμοιβαιότητα	Løsningsstrategi	wzajemność
103.	Non-judgemental listening is being able to listen openly (without prejudice) to yourself and others.	Non-judgmental listening	Oordeelloos luisteren	Unvoreingenommenes Zuhören	Μη επικριτική ακρόαση	Gjensidighet	słuchanie bez osądzania
104.	The presence approach is an approach in which a relationship of trust is being built by showing someone else that he is being seen and heard, and is considered as a fully-fledged human being. The aim is to come to an understanding of what the other really needs in this situation at this moment.	Presence approach	Presentiebenadering	Präsenzansatz	Προσέγγιση της συνειδητής παρουσίας	Ikke-dømmende lytting	podejście oparte na obecności
105.	Raising awareness is promoting consciousness of events, feelings, interests, risks etc.	Raising awareness	Bewustwording	Bewusstsein	Ευαισθητοποίηση	Tilstedeværende tilnærming	podnoszenie świadomości
106.	Spirituality is the personal inner experience (for instance in the context of religion).	Spirituality	Spiritualiteit	Spiritualität	Πνευματικότητα	Øke bevissthet	duchowość
107.	Finding meaning is about searching for the meaning, goal, utility of life or activities we perform.	Finding meaning	Zingeving	Sinngebung	Εύρεση νοήματος	Åndelighet	poszukiwanie znaczenia

108.	Reflection is a way of trying to understand experiences, analysing and giving meaning to them.	Reflection	Reflectie	Reflexion	Προβληματι-σμός/ Περισυλ-λογή/ Στοχασμός	Å finne mening	refleksja
109.	Reflection on meta level is reflection on the way the process of reflection takes place.	Reflection on meta level	Reflectie op metaniveau	Reflexion auf der Metaebene	Μετα-προβληματισμός/ Αναλο-γισμός/ Αναστο-χασμός	Refleksjon	Meta-refleksja
110.	Critical self-reflection is reflecting on one's own person in a critical way (without taking anything for granted).	Critical self-reflection	Kritische zelfreflectie	Kritische Selbstreflexion	Κριτικός αυτο-προβληματισμός/ Κριτικός ανα-στοχασμός	Refleksjon på overordnet nivå (meta)	krytyczna autorefleksja
111.	Introspection is self-reflection where one's own thoughts, feelings and memories are subject of further analysis.	Introspection	Introspectie	Introspektion	Ενδοσκόπηση	Kristisk selv-refleksjon	introspekcja
112.	Non-medical language is communicating without use of professional medical words (in order to support free space).	Non-medical language	Niet medisch taalgebruik	Nicht-medizinische Sprache	Μη ιατρική γλώσσα	Introspeksjon	język niemedyczny
113.	Non-diagnostic language is a form of communication that avoids using medical (psychiatric) diagnostic terms (because there is no added value in the recovery process). The aim is also to support free space.	Non-diagnostic language	Niet diagnostisch taalgebruik	Nicht-diagnostische Sprache	Μη διαγνωστική γλώσσα	Ikke -medisinsk språk	język niediagnostyczny

114.	A behavioural characteristic is the description of elements in behaviour that is typical of a certain person.	Behavioural characteristic	Gedragskenmerk	Verhaltensmerk-mal	Χαρακτηριστικό συμπεριφοράς	Ikke-diagnostisk språk	charakterystyka behawioralna
115	Contact skill is the ability of someone to search and establish contact with another person in a competent way.	Contact skill	Contactuele vaardigheid	Kontaktfähigkeit	Δεξιότητες διαπροσωπικών επαφών	Atferdsegenska-per	umiejętność nawiązania kontaktu
116	Communication skill is the ability of someone to realise an adequate information transfer to others.	Communication skill	Communicatieve vaardigheid	Kommunika-tionsfähigkeit	Δεξιότητες επικοινωνίας	Sosial kompetanse	umiejętność komunikacji
117.	Conceptual thinking is the ability to formulate designs for improvements, renewal, change processes etc.	Conceptual thinking	Conceptueel denken	Konzeptionelles Denken	Εννοιολογική σκέψη	Kommunikas-jonsevner	myślenie konceptualne
118.	Normative thinking is a way of thinking where someone shows implicit or explicit use of certain norms or standards.	Normative thinking	Normatief denken	Normatives Denken	Κανονιστική σκέψη	Konseptuell tenking	myślenie normatywne
119.	Result responsibility means that someone in an organisation has the liability for the result of certain activities or efforts.	Result responsibility	Resultaatverant-woordelijkheid	Ergebnisverant-wortung	Ευθύνη παρακολούθησης αποτελεσμάτων	Normativ tenking	odpowiedzial-ność za rezultat
120.	Proactive acting is anticipating ertain steps that need to be taken into account to achieve a goal.	Proactive acting	Proactief werken	Proaktives Handeln	Προληπτικές ενέργειες	Resultatansvar	działanie proaktywne

121.	A bond of trust is a bond that can be forged based on shared belief in each other's honesty and kindness.	Bond of trust	Vertrouwens-band	Vertrauensver-hältnis	Σχέση εμπιστοσύνης	initiativrik	więź oparta na zaufaniu
122.	Living conditions are conditions that determine which elements play a role in the situation someone is living.	Living conditions	Leefsituatie	Lebensbedingun-gen	Συνθήκες διαβίωσης	Tillitsbånd	warunki życia
123.	Resilience is the ability to make use of internal and external opportunities to overcome a problem and then be "back on track."	Resilience	Veerkracht	Widerstands-fähigkeit	Ψυχική ανθεκτικότητα	Levekår	odporność psychiczna
124.	In the context of psychiatry it means the vulnerability that comes with the psychiatric challenges.	Vulnerability	Kwetsbaarheid	Vulnerabilität/ Verletzlichkeit	Ευαλωτότητα	Motstandskraft/ Robusthet	podatność, wrażliwość
125.	Integrity characterises someone when they are sincere, honest and incorruptible.	Integrity	Integriteit	Integrität	Ακεραιότητα	Sårbarhet	prawość
126.	A group process is a process in which every member of the group is involved and where mutual interaction is important.	Group process	Groepsproces	Gruppenprozess	Ομαδική διαδικασία	Integritet	proces grupowy
127.	Group dynamics is about processes that can occur within a group due to mutual influence.	Group dynamics	Groepsdynamica	Gruppendy-namik	Δυναμική της ομάδας	Gruppeprosess	dynamika grupy

128.	A (safe) group climate is the atmosphere that prevails within the group and the emotional impact (feeling safe) that it has.	(Safe) group climate	(Veilig) groepsklimaat	(Sicheres) Gruppenklima	Ομαδικό κλίμα	Gruppe dynamikk	(bezpieczna) atmosfera w grupie
129.	Group development is the development of the group from the perspective of the interaction of the members.	Group development	Groepson-twikkeling	Gruppenent-wicklung	Εξέλιξη της ομάδας	(Trygt) gruppemiljø	rozwój grupy
130.	A self-help group is a group of people who (mostly without guidance) are encouraged to solve problems of their own.	Self-help group	Zelfhulpgroep	Selbsthilfegruppe	Ομάδα Αυτο-βοήθειας	Gruppeutvikling	grupa samopomocowa
131.	An intervision group is a group of people of the same profession arranging conversations to promote quality of their service.	Intervision group	Intervisiegroep	Intervisions-gruppe	Ομάδα αλλη-λοϋποστήριξης μεταξύ συναδέλ-φων	Selvhjelpsgruppe	grupa interwizyjna
132.	Group interest is something of benefit for all group members.	Group interest	Groepsbelang	Gruppeninter-esse	Ομαδικό συμφέρον	Tiltaksgruppe	interes grupy
133.	A co-trainer is a trainer who functions under the responsibility of the head trainer and may operate independently on parts of the training.	Co-trainer	Co-trainer	Co-Trainer	Συν-εκπαιδευτής	Gruppeinteresse	trener współpro-wadzący

134.	A co-facilitator operates in a group of peers. The term "facilitator" indicates that the essence of the work lies in making it easier, creating conditions necessary for participants to gradually find more control over their lives (make and keep "free" space) and to start a course towards a satisfactory life according to their own standards.	Co-facilitator	Co-facilitator	Co-Moderator	Συν-διαμεσολαβητής	Delansvarlig (Co-trainer)	facylitator
135.	A format is a template or global design for similar activities or programmes (for instance training programmes).	Format	Format	Format	Πρότυπο διαμόρφωσης	Tilrettelegger (Co-facilitator)	format
136.	A roadmap is a document in which steps are described in sequence that ultimately lead to the intended goal.	Roadmap	Stappenplan	Roadmap	Σχέδιο δράσης	Mal	mapa drogowa
137.	A work plan is a document describing all activities that need to be done in order to finish the work.	Work plan	Werkplan	Arbeitsplan	Πλάνο εργασιών	Veiviser	plan pracy
138.	A scenario is a document with a chronological description of activities in a programme (for instance a training programme).	Scenario	Draaiboek	Szenario	Χρονοδιάγραμμα	Arbeidsplan	scenariusz

139.	A social map is an overview of formal and informal organisations active in different domains such as living, care, welfare, work, income etc.	Social map	Sociale kaart	Soziale Landkarte	Κοινωνικός χάρτης	Moduler	mapa społeczna
140.	Social resources are resources in the social domain or community being supportive in the field of welfare, care, education, good health etc.	Social resources	Maatschappelijke hulpbronnen	Soziale Ressourcen	Κοινωνικοί πόροι	Oversikt	zasoby społeczne
141.	Support systems are systems or structures that support, for example, the social well-being or (mental) health of individuals or (groups in) the population.	Support systems	Steunsystemen	Unterstüt-zungssysteme	Υποστηρικτικά συστήματα	Sosiale ressurser	systemy wsparcia
142.	A curriculum is a plan with a specified learning content that describes a specific training course.	Curriculum	Leerplan	Lehrplan	Πρόγραμμα σπουδών	Støttestystem	program nauczania
143.	A learning path describes the following order of parts in a a curriculum.	Learning path	Leertraject	Lernweg	Διαδρομή μάθησης	Pensum	ścieżka edukacyjna
144.	A development path describes the following order of elements in a development plan.	Development path	Ontwikkeltraject	Entwicklungsweg	Πορεία ανάπτυξης	Utdanningspro-gram	ścieżka rozwoju
145.	A learning process is the progress and course of development during education.	Learning process	Leerproces	Lernprozess	Μαθησιακή διαδικασία	Utviklingspros-ess	proces uczenia się

146.	Education is a collective term for all forms of training.	Education	Scholing	Bildung	Εκπαίδευση	Læringsprosess	edukacja
147.	Further education is training following the previously achieved (lower) level of training.	Further education	Bijscholing	Weiterbildung	Επιμόρφωση	Utdanning	dalsza edukacja
148.	An internship is practical work in the context of professional orientation or as a part of vocational training.	Internship	Stage	Praktikum	Πρακτική άσκηση	Etterutdanning Videreutdanning	staż
149.	Resistance (in the psychological sense) is conscious or unconscious opposition or reluctancy against unwanted experiences.	Resistance	Weerstand	Widerstand	Αντίσταση	Praksisopplæring	opór
150.	Divergent interaction is a situation in which there is no explicit agreement between student and coach about the goals and process in the training programme.	Divergent interaction	Divergerende interactie	Divergente Interaktion	Διάσταση απόψεων	Motstand	interakcja rozbieżna
151.	A role model is a person having an example function for certain professions, individuals or a certain population.	Role model	Rolmodel	Vorbild	Μοντέλο λειτουργίας	Motstridende samhandling	wzór do naśladowania
152.	Psychosocial disorders are problems (or challenges) in the mental and/or social domain.	Psychosocial disorders	Psychosociale aandoeningen	Psychosoziale Störungen	Ψυχοκοινωνικές διαταραχές	Kunnskapsbærer	zaburzenia psychospołeczne

153.	Psychiatric disorders are problems (or challenges) as identified by mental health care practitioners.	Psychiatric disorders	Psychiatrische aandoeningen	Psychiatrische Störungen	Ψυχιατρικές διαταραχές	Psykososiale utfordringer/ lidelser	zaburzenia psychiczne
154.	Traumatising is caused by a (large) number of very serious damaging experiences in the past, causing mental problems.	Traumatisation	Traumatisering	Traumatisierung	Τραύμα	Psykiske utfordringer/ Lidelser	traumatyzacja
155.	Service user related tasks are activities carried out in the context of (direct) care for service users.	Sevice user related tasks	Cliëntgebonden taken	Aufgaben in Zusammenhang mit Nutzern der Dienste	Καθήκοντα που αφορούν στους λήπτες	Traumer	zadania związane z pacjentem
156.	Organisation-related tasks are activities carried out in the context of implementing rules or regulations that the organisation requires.	Organisation-related tasks	Organisatiegebonden taken	Organisationsbezogene Aufgaben	Καθήκοντα που αφορούν στον οργανισμό	Brukerorientert arbeid	zadania związane z organizacją
157.	Occupational tasks are activities that are performed in the context of the exercise of a profession.	Occupational tasks	Beroepsgebonden taken	Berufliche Aufgaben	Επαγγελματικά καθήκοντα	Organisasjonsrelaterte oppgaver	obowiązki zawodowe
158.	Professional development is the development in the execution of a selected profession through the accumulation of more knowledge and experience over time.	Professional development	Beroepsontwikkeling	Berufliche Entwicklung	Επαγγελματική ανάπτυξη	Yrkesoppgaver	rozwój zawodowy
159.	Professionalisation is the way in which work-related activities are increasingly brought into line with professional standards.	Professionalisation	Professionalisering	Professionalisierung	Επαγγελματοποίηση	Faglig utvikling	profesjonalizacja

160.	A professional level is the extent to which the practice of a professional meets the professional standards.	Professional level	Beroepsniveau	Professionelles Niveau	Επαγγελματικό επίπεδο	Profesjonalisering	poziom umiejętności zawodowych
161.	Job differentiation is the expansion of duties and responsibilities within functions and the associated job profiles.	Job differentiation	Functiedifferentiatie	Berufliche Differenzierung	Διαφοροποίηση καθηκόντων εργασίας	Kompetansekrav	zróżnicowanie pracy
162.	A recovery employee is an employee practicing the profession of peer support worker with the aim of contributing to the recovery of others.	Recovery employee	Medewerker herstel	Genesungsbegleiter	Εργαζόμενος με εμπειρία ανάρρωσης	Kompetanseplan	pracownik w obszarze zdrowienia
163.	A recovery policy officer is an employee responsible for the (further) development of recovery policy in an organisation.	Recovery policy officer	Beleidsmedewerker herstel	Gesundheitsbeauftragter,	Υπεύθυνος πολιτικών ανάρρωσης	Erfaringskonsulent/Likemann	specjalista ds. procesu zdrowienia
164.	A recovery coordinator is responsible for managing multiple peer support workers contributing to the recovery of others.	Recovery coordinator	Coördinator herstel	Genesungsbegleitungskoordinator	Συντονιστής προγραμμάτων ανάρρωσης	Recovery fagutvikler	koordynator procesu zdrowienia
165.	An improvement process is a described trajectory that indicates which improvements in the performance of employee(s) or the quality of the service must be achieved.	Improvement process	Verbetertraject	Verbesserungsprozess	Διαδικασία βελτίωσης	Recoverykoordinator	proces doskonalenia

166.	Quality improvement is the improvement of elements in the service that the organisation has determined to be of qualitative value.	Quality improvement	Kwaliteitsverbetering	Qualitätsverbesserung	Βελτίωση της ποιότητας	Forbedringsprosess	poprawa jakości
167.	A project group is a group of persons brought together because of their ability and expertise to carry out a specific project.	Project group	Projectgroep	Projektgruppe	Ομάδα Έργου	Kvalitetsforbedring	grupa projektowa
168.	Coaching is the guidance (or support) of a person or a group to improve professionalism and functioning.	Coaching	Coaching	Coaching	Coaching	Prosjektgruppe	coaching
169.	We speak of organisational level when organisational aspects (for instance administrative structures, finances etc.) of an institution are involved.	Organisational level	Organisatieniveau	Organisationsebene	Οργανωσιακό επίπεδο	Veiledning	poziom organizacji
170.	We speak of policy level when policy aspects of an institution are involved.	Policy level	Beleidsniveau	Gesundheitspolitische Ebene	Επίπεδο πολιτικής οργανισμού	Organisasjonsnivå	poziom tworzenia polityki
171.	Interdisciplinary collaboration is a cooperation between representatives of different professional groups.	Interdisciplinary collaboration	Interdisciplinaire samenwerking	Interdisziplinäre Zusammenarbeit	Διεπιστημονική συνεργασία	Politisk nivå	współpraca interdyscyplinarna

172.	A staff department is a department of employees who are not directly involved in the implementation of the primary process.	Staff department	Stafdeling	Stabsabteilung	Τμήμα ανθρωπίνων πόρων	Tverrfaglig samarbeid	dział personelu
173.	A care program is the description of the component parts of care and the following order in which these are offered.	Care program	Zorgprogramma	Pflegeprogramm	Πρόγραμμα φροντίδας	Personalavdeling	program opieki
174.	Network participation is collaboration between representatives of various sectors such as health care and social organisations to achieve a coherent care or support structure.	Network participation	Netwerkparticipatie	Netzwerkbeteiligung	Δικτύωση	HMS (Helse, miljø, sikkerhet) rutiner	udział w sieci
175.	Emancipation is striving for equality of rights, an equal position on the labour market and a full place in society from a disadvantaged position.	Emancipation	Emancipatie	Emanzipation	Χειραφέτηση	Nettverksdeltakelse	emancypacja
176.	Social emancipation is emancipation focusing on an equal place in society.	Social emancipation	Maatschappelijke emancipatie	Soziale Emanzipation	Κοινωνική χειραφέτηση	Frigjøring	emancypacja społeczna
177.	Service user participation is involvement of service users in policy and operational management of (health) care organisations.	Service user participation	Cliëntenparticipatie	Nutzerbeteiligung	Ενεργητική συμμετοχή των ληπτών	Sosial frigjøring	partycypacja pacjentów

178.	Service user movement is when service users are mobilising their efforts and show commitment to defend their interests (in health care organisations).	Service user movement	Cliëntbeweging	Nutzerbewegung	Κίνημα ληπτών υπηρεσιών	Brukermedvirkning	ruch pacjentów
179.	An interest group is a group of people who stand up for their interests (for instance in a social, political or health care context).	Interest group	Belangengroep	Interessengruppe	Ομάδα Ειδικού Ενδιαφέροντος	Pressgruppe	grupa interesu
180.	Service user participation is the way service users can influence policy and management of a (health care) organisation.	Service user participation	Cliëntmedezeggenschap	Beteiligung von Nutzern der Dienste	Ενεργητική συμμετοχή των ληπτών	Interessegruppe	partycypacja pacjentów
181.	A service user council is a body formally regulated by law in health care organisations for service users to advise and co-decide.	Service user council	Cliëntenraad	Nutzerrat/ Nutzerbeirat	Συμβούλιο ληπτών	Brukerråd	rada pacjentów
182.	Laws and regulations are conditions determined by government, health insurers and health care inspection to which health care organisations have to submit.	Laws and regulations	Wet- en regelgeving	Gesetze und Vorschriften	Νόμοι και κανονιστικό πλαίσιο	Lover og forskrifter	przepisy prawa
183.	A care arrangement is offering various healthcare components (such as accommodation, treatment and day activities) in one package.	Care arrangement	Zorgarrangement	Pflegeangebot	Πακέτο φροντίδας	Omsorgsordning	umowa dotycząca opieki

184.	A protocol is a document that specifies how certain activities must be carried out.	Protocol	Protocol	Protokoll	Πρωτόκολλο	Protokoll	protokół
185.	A procedure is an instruction with schedule including certain activities that have to be performed in a specific order (for instance a complaints procedure).	Procedure	Procedure	Verfahren	Διαδικασία	Prosedyrer	procedura
186.	A multidisciplinary guideline is a document with instructions about the form of involvement (and collaboration) of representatives of different professions in treatment or support of a service user.	Multidisciplinary guideline	Multidisci-plinaire richtlijn	Multidisziplinär-er Leitfaden	Κατευθυντήρια οδηγία στο πλαίσιο διεπιστημονικής συνεργασίας	Tverrfaglig retningslinje	wytyczne multi-dyscyplinarne
187.	An acknowledged profession can only be obtained through a certified training course. The professional title is protected.	Acknowledged profession	Erkend beroep	Anerkannter Beruf	Αναγνωρισμένη επαγγελματική ειδικότητα	Yrkestittel	zawód regulowany
188.	Mandatory means required within the framework of legal regulations or regulations by professional association or health insurance company.	Mandatory	Verplicht	Obligatorisch	Υποχρεωτικό/ Απαιτούμενο	Obligatoriske bestemmelser	obowiązkowy

189.	The labour market is the total offer of paid employment in a certain country (or for instance in the European Union).	Labour market	Arbeidsmarkt	Arbeitsmarkt	Αγορά εργασίας	Arbeidsmarkedet	rynek pracy
190.	Working conditions are included in an employment contract and include, amongst other things, salary, working hours, holidays, travel allowance and training.	Working conditions	Arbeidsvoor-waarden	Arbeitsbedin-gungen	Συνθήκες εργασίας	Arbeidsavtale	warunki pracy
191.	A certificate is an official statement regarding the successful completion of education or further education. Certificates are also issued upon successful completion of a skill test.	Certificate	certificaat	Zertifikat	Πιστοποιητικό ολοκλήρωσης παρακολούθησης	Vitnemål Kursbevis	świadectwo
192.	An appraisal session is a periodic consultation between employee and manager about the mutual impressions that exist about the way a job is performed.	Appraisal session	Voortgangsge-sprek	Standortgespräch	Συνεδρία αξιολόγησης	Evaluering	sesja oceniająca
193.	A target group is a group in the population with specific characteristics (for instance exposed to certain risk factors) for which special attention, prevention or interventions may apply.	Target group	doelgroep	Zielgruppe	Ομάδα - στόχος	Målgruppe	grupa docelowa

194.	A manual is a reference work that shows the current state of affairs with regard to a specific scientific or specialist area. Both insights and applications in practice can be included.	Manual	Handboek	Handbuch	Εγχειρίδιο	Håndbok	podręcznik

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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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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Stichting Cordaan Group
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The Norwegian partner Sorlandet Hospital was responsible for the coordination of the creation of this product. Grone-Bildungszentrum für Gesundheits- und Sozialberufe gGmbH and CEdu Sp. z o.o. worked under its guidance. The Dutch experts also provided important input for this.

Chapter 2.1 was written by Odette van der Heijden.
Chapter 2.2 was written by Gudrun Tönnes.

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

1. 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. Designing 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.

2. Product description, recommendations, reference material

2.1 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 colleagues, 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 integrat-

ed 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. Workload

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

- In the event of a high workload 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.

Final recommendations

This project provides a flying start for organisations 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.

2.2 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.

3. 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 recom-

mendations, 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]

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

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

[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.

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 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]

[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.

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. 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

[4] Thomas DA, Ely RJ, 1996. Managing Difference Matter: A New Paradigm for Managing Diversity, *Harvard Business Review* 74: 140–142.

[5] Ibid, p. 228.

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 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.

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Erasmus+ Project "European Standards for Peer Support Workers in Mental Health"

Training programme for managers and leaders of therapeutic teams on the cooperation with peer supporters (max. 100 hours)

Concept of training for managers (leaders) of mental health organisations, psychiatric institutions and social organisations on the functioning of diverse peer teams.

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Introduction

Training needs analysis carried out as part of the project "European Profile for Peer Worker" no. 2019-1-DE02-KA202-006547 showed that managers and leaders of teams whose members include peer support workers need to broaden their knowledge and competences.

Diverse knowledge and competences are determined by:

- the workplace, i.e. type of employing organisation,
- position held in the organisational structure,
- occupation.

The type and nature of the organisation where the peer support worker (PSW) works is very important. It may be a medical facility, a social welfare centre, a foundation or a company providing nursing, social and mental support services. The mission, purpose, principles of functioning of the organisation determine its character (organisation as an enterprise). This directly translates into professional relationships within the teams.

The superiors or supervisors of PSWs may hold managerial positions (e.g. president, director, manager of a medical facility, social organisation, social welfare centre, foundation), but they may also be people who are not directly involved in management. Doctors, therapists, nurses and social workers are among partners who most often have direct contact with PSWs. The variety of these positions reflects the diversity of stakeholders who may be interested in this product (training). It also shows that the stakeholders have a wide range of knowledge and competences connected with personnel management, but also diverse skills and experiences.

The team leader's knowledge is directly connected with their profession (usually medical), whereas successful management of employees requires this person to:

- be a good coach, i.e. be able to identify and unlock the potential of their colleagues,
- influence the team, assign and strengthen roles, use various management tools,
- care not only about the success of the team, but also about each member's success and well-being as well as the overall atmosphere,
- be effective, productive, able to set goals and achieve results (not only in terms of profit or revenue, or any other numerical parameter; a new idea about how to overcome a crisis or a new, effective form of support on the way to recovery are also results),
- be a good communicator, listen and share information,
- support their colleagues' professional career development by focusing on tasks, challenges, career path,
- have a clear vision of the team's work and development,

- have decision-making competences (ability to make decisions efficiently) as well as key technical skills to be able to advise the team,
- successfully create an atmosphere of cooperation and respect for diversity in the organisation and team.

Apart from the fact that there is large variation in managers' knowledge and competences (management and medical skills, soft skills connected with aspects such as communication in the organisation), PSWs' attitude towards new tasks, learning and acquiring new skills is also determined by a number of factors concerning the organisation of training.

It is crucial for the training groups to be as uniform as possible, so that the participants would have similar needs and fulfil similar roles in the organisation. Ideally, they should be composed of psychologists, nurses, social workers, and health care managers, for example. However, we are aware that these are ideal conditions, which rarely occur in organisations; therefore, team diversity is a characteristic that should be taken into account in the selection of contents and during the workshops. The diversity of training groups can also be used to improve knowledge about effective cooperation within diverse teams, ways of building a friendly atmosphere at work, eliminating tensions and waste.

To create optimal learning conditions, the following recommendations should be followed:

1. The training programme must take into account the uniqueness of the learners and of their experiences.
2. Learning goals should be clearly defined – the participants must know the exact subject of learning, the intended effects and methods of verification.
3. Drawing on experience – learning new material in the context of what is known and familiar.
4. Gradual acquisition of knowledge – first the basics, then expansion; first individual elements, then structures; first individual problems, then the wider scope – problems of the entire organisation (company).
5. Feedback from participants in order to assess the learning outcomes [M. Sloman, R.M. Smith, P. O'Connell].

This proposal is a training roadmap that should be used to prepare the right programme for specific groups. However, it is the training participants and specific teams – not strict adherence to the programme – that should ultimately determine the content of the workshops and the selection of the discussed case studies. The best training is tailor-made, i.e. preceded by needs analysis, analysis of the team's functioning, observation of how tasks are fulfilled by its individual members.

Due to the nature of contemporary organisations – hospitals, medical centres, social organisations, social welfare centres, companies and public

institutions – and the contemporary management models, teams are required to be flexible. Because of organisational problems, varying workload and resources, the permanent staff may be supplemented by temporary employees, who may work according to non-standard rules. Part-time work, periodic reduction of working time, combinations of paid and unpaid employment, permanent employment and employment on a project basis not only result in the emergence of flexible forms of work, but also pose a number of challenges for the managers. The need for new tools and new approaches to personnel management was reflected in surveys conducted not only among PSWs, but also among people holding managerial positions. On the one hand, the emphasis was on flexibility, employee agility in carrying out various tasks, openness to challenges and new experiences, but it is worth bearing in mind that it also raises a number of problems that the managers must be able to address.

Experience gained during the project and the literature on the subject raise the issue of flexible employment in healthcare and social work, which is connected with the concept of flexicurity. Issues such as undertaking a wide range of activities, combining various forms of work, making decisions about one's own professional activity (taking initiative) were reflected in PSWs' statements and questionnaires describing the challenges they face. They were accompanied by uncertainty regarding the continuity of projects, programmes, internships and employment. These issues should be brought to managers' attention. The PSW profession falls within the contemporary model of flexible organisation, and the COVID-19 pandemic has had further implications for this model, resulting in new problems destabilising the employee's position in the organisation.

Flexibility of employment gives PSWs the opportunity to function in a broader context, share experiences gained in many fields and in many environments. The proposed model includes real tools for managers to use in the event of a crisis situation experienced by employees. It should be stressed that ensuring patient safety and continuity of processes, fulfilling tasks and implementing the mission of the organisation are the prerogatives of the management.

Many PSWs consider full-time work for one employer to be the best solution; however, according to research, in most cases employment is more flexible and closer to freelancing. Although cooperation with freelancers may seem beneficial for the organisation, managers who supervise the tasks entrusted to freelancing PSWs need the right skills, mainly organisational, connected with planning and coordinating work, controlling the performance, preventing discontinuity in work, analysing the intensity and causes of conflicts in the team, setting deadlines, delegating duties, changing the workflow, managing the communication and reporting processes.

Due to the reasons listed above, it is very important for managers to be able to manage diverse teams. Recognising and appreciating diversity may be a key competences for managers supervising teams whose members include PSWs.

Importantly, diverse competences and experiences as well as multiculturalism increase the likelihood to successfully develop the following strategic issues:

- lean and agile process management,
- increase in knowledge and promotion of mental health protection,
- fostering a creative environment that breaks down barriers.

When deciding on the contents of the training programme as well as methods and techniques of competency development, various barriers and obstacles should be taken into account. Managers of the health care system and team leaders must improve their competencies to be able to manage diverse teams, so that the employees' unique experiences and skills can contribute to the improvement of the efficiency of processes across the organisation. An organisational culture that is open to PSWs, encourages self-development and organisational improvement will provide the right opportunities for learning by creating the optimal working environment, which will eventually contribute to patients' recovery.

Following the definition of Anthony et al., the authors of the training programme define recovery as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way to a satisfying, hopeful and full life despite the limitations caused by the illness. Organisations and their managers should have the right tools to use the individual potential of PSWs to improve the mental health care system.

Hence the suggestion to base the contents of the training and exercises on the diversity management model put forward by R. Kandola and J. Fullerton. Their approach, resulting from in-depth analyses and research of nearly 500 organisations, advocates for the ongoing evolution from traditional equal opportunities policies to an integration-based (inclusive) strategy focusing on the contribution of an individual employee (in our case, PSW) to the organisation.

The researchers' work has led them to propose the MOSAIC model – a tool for effective analysis of organisational activities regarding the diversity policy.

MOSAIC is an acronym for:

M – mission and values

O – objectives and fair process

S – skilled workforce: aware and fair

A – active flexibility

I – individual focus

C – culture that empowers

Adopting this model increases the likelihood that the training will make the managers more aware of the importance of diversity. Diverse teams can contribute to the emergence of different collaborative viewpoints, creative problem-solving, innovation and creativity.

1. General assumptions of the concept

The training programme developed in the project "European Profile for Peer Worker" no. 2019-1-DE02-KA202-006547 (product 6) consists of four modules (from 1 to 4 on the list below).

The training programme is based on:

1. **work standards for peer support workers,**
2. **job specifications,**
3. **competence profile,**
4. **legal framework,**

taking into consideration PSW's place in the organisation and in the therapeutic team.

Organisations interested in the training – stakeholders

- **businesses,**
- **healthcare organisations,**
- **non-governmental organisations,**
- **social work organisations.**

People employed in the organisation (professionals) to whom the training is dedicated. Training for TEAM LEADERS:

- **doctors**
- **occupational therapists**
- **psychotherapists**
- **psychologists**
- **therapeutic nurses**
- **directors, managers of organisations**
- **social workers.**

Structure of the training (segments)

1. Working together in a multi-professional team (the therapeutic team)
2. Strengthening the PSW in their role as a competent team member (competence development)
3. Holding meetings with a multi-professional team
4. Employing the PSW and developing a career path together

1. Working together in a multi-professional team

Skills to be practiced by team leaders:

How does the PSW influence team efficiency?

What PSW skills does the team need?

How can the team be formed taking into consideration PSW's individual competences and predispositions?

How to divide tasks and roles in the team?

How to run multi-professional team meetings in order to control the course and focus of attention?

How to start active work of the team?

How to adapt PSW's work dynamics to the tasks of the team?

How to react in difficult situations?

Content areas for Segment 1

- PSW's role in the team
- Unique characteristics of a team with a PSW
- Communication in the team and running meetings
- Active forms of working with the team
- Managing team creativity

1.	**Total number of teaching hours in Segment 1:**	**Optimum: 12**	**Max: 18**

2. Strengthening the PSW in their role as a competent team member (competence development)

Skills to be practiced by team leaders:

How to choose skills for development?

How to use development to motivate?

How to select development support tools?

How to introduce coaching in a team?

How to agree on the course of joint work?

How to give feedback without jumping to conclusions and judgement?

How to build awareness and a sense of responsibility in the team member?

How to react when a team member disrupts the team, looks for excuses, justifications, makes mistakes, questions goals etc.?

How to tell resistance from the need for support, lack of experience, competence?

Content areas for Segment 2

- Techniques for working in the multi-professional: instructing, assisting, coaching
- Introducing coaching into the team and coaching peer supporters
- Coaching categories – analysing work, monitoring competence development
- Motivating PSWs to engage and develop – dealing with PSWs' resistance
- Feedback – communication without judgement

2.	**Total number of teaching hours in Segment 1:**	**Optimum: 24**	**Max: 38**

3. Holding meetings with a multi-professional team

Skills to be practiced by team leaders:

How should a PSW plan an effective meeting with a patient?

How should strategy be built in cooperation with the patient?

How can the participants' stress be reduced?

How to control the course of the meeting?

How to adapt communication between the multi-professional team and individual patients?

How to approach identified risks and differences?

How to use team diversity to work effectively?

How to promote constructive situations, behaviours, attitudes?

How to deal with difficult situations during meetings with stakeholders in the patient's recovery process?

How to effectively use communication techniques, organise meetings, address problems/solutions/benefits?

Content areas for Segment 3

- Preparation for the meeting with the patient – introduction, introduction to the case, "levels of initiation" in the documentation
- Meeting techniques and methods for active 1:1 work with the group
- Verbal, non-verbal and unconscious communication
- Difficult situations: crises, silent patient, "undisciplined", protesting...
- Summary of the effects of the meeting, effective reporting, formal reporting

3.	**Total number of teaching hours in Segment 3:**	**Optimum: 24**	**Max: 32**

4. Employing the PSW and developing a career path together

Skills to be practiced by team leaders:

How to plan the employment of a PSW?

Are there difficulties in cooperation with, and understanding the functioning of, the employing organisation?

How to integrate the PSW in the work of the therapeutic team?

How to use legal and organisational possibilities to prepare the workplace for the PSW?

How to adapt the work of the team to the legal requirements with regard to diverse members?

How to delegate and implement tasks in accordance with law and ethics?

Content area for Segment 4

- PSWs' role and place in social welfare, health care and NGO systems
- Forms of employment
- Responsibilities, career path, remuneration and method of payment
- Responsibilities for supervision and control of work
- Dividing and delegating tasks
- Legal basis for the employment of PSWs
- Work regulations, code of ethics – areas of cooperation with PSWs

4.	**Total number of teaching hours in Segment 4:**	**Optimum: 12**	**Max: 12**
	Total Segments 1+2+3+4	**Optimum: 72**	**Max: 100**

Summary/conclusions

The foundation for a knowledge-based economy and the development of the information society is the continuous improvement and adaptation of employees; skills to the dynamically changing labour market. The adaptation processes require us to be open to change, but change does not exist without conscious learning [Fontana 1998; Illeris 2009].

There is a growing awareness of the importance of continuous development of employees' skills for the processes of economic growth, but we also see how important it is to reach for "unique resources." Activities aimed at increasing the quality of human capital in accordance with the idea of lifelong learning take various forms and use various programmes, often experimental ones, intended to gain a competitive advantage, bring out the unique potential of employees, teams and entire organisations. A peer support worker with their inimitable experience can be such a unique tool for improving patient support and recovery processes. Employees' skills and competences are often

developed in order to generate and use non-standard solutions. For many organisations and representatives of various professions, employing a PSW is an innovation in itself. How to prepare for it? How to make the organisation open to diversity?

Traditional school and academic education is insufficient to keep up with the pace of changes in the economy. Training programmes are not adapted and updated as quickly as the market for support, nursing and mental health services needs them. For this reason, it is crucial to support employees and promote modern education, including the idea of lifewide and lifelong learning. Its main principles include the appreciation of learning in various forms and places at every stage of life, recognising learning outcomes regardless of the way, place and time of gaining them, effective investment in learning and the universal character of these actions.

The goals connected with the development of human resources can be achieved by supporting vocational education, both formal and non-formal education, including courses and training. The proposed training programme is consistent with the concept of initiatives promoting the acquisition of skills and recognition of the effects of non-formal education.

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