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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 A model of psychiatry in which the doctor tells the patient what to do, how to live and what to think is no longer valid.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.

References

Chinman M, George P, Dougherty RH, Daniels AS, Ghose SS, Swift A, Delphin-Rittmon ME, 2014. Peer support services for individuals with serious mental illnesses: assessing the evidence. *Psychiatr Serv.* 65(4):429-41. doi: 10.1176/appi.ps.201300244

Degano KL, Petersen J, 2018. *Projektbericht und Evaluation des Modellprojekts Sicherstellung einer gelingenden Implementierung des Genesungsbegleiteransatzes bei den psychiatrischen Organisationen, die (neu) mit Genesungsbegleiter*innen arbeiten* [Project report and evaluation of the model project "Ensuring a successful implementation of the recovery companion approach in the psychiatric organizations working with recovery companions"]. Bremen: Senator for Health, Science and Consumer Protection.

Rogers, EM, 2013. *Diffusion of Innovations.* New York: Free Press.

Ibrahim N, Thompson D, Nixdorf R, Kalha J, Mpango R, Moran G, Mueller-Stierlin A, Ryan G, Mahlke C, Shamba D, Puschner B, Repper J, Slade M, 2020. A systematic review of influences on implementation of peer support work for adults with mental health problems. *Soc Psychiatry Psychiatr Epidemiol.* 55(3):285-293. doi: 10.1007/s00127-019-01739-1

Ihde-Scholl T, 2015. *Vom Ich-Wissen zum Wir Wissen, ein persönlich gefärbter Erfahrungsbericht* [Ex-In: from I-knowledge to we-knowledge – a personally coloured experience report]. Bern: Foundation for the Support of Mentally Ill People in the Canton of Bern, https://www.stiftung-psk-be.ch/media/1041/jahresbericht_2014_web_rz.pdf

Lacroix A, 2017. *Pflege und Peerarbeit* [Nursing and peer work], unpublished lecture manuscript.

Mead S, 2003. *Defining peer work.* https://docs.google.com/document/d/1WG3ulnF6vthAwFZpJxE9rkx6lJzYSX7VX4IIprV5EkfY/edit

Mead S, Hilton D, Curtis L, 2001. Peer support: a theoretical perspective. *Psychiatr Rehabil J.* 25(2):134-41. doi: 10.1037/h0095032

Pelletier JF, Davidson L, 2015. À l'origine même de la psychiatrie comme nouvelle spécialité médicale: le partenariat Pinel-Pussin [At the very roots of psychiatry as a new medical specialty: the Pinel-Pussin partnership]. *Sante Ment Que.* 40(1):19-33

Schaub HA, 2008. Klinische Sozialarbeit. Ausgewählte Theorien, Methoden und Arbeitsfelder in Praxis und Forschung [Clinical social work. Selected theories, methods and fields of work in practice and research]. Göttingen: V&R unipress

Repper J, 2013. *Peer support workers: a practical guide for implementation.* London: Centre for Mental Health and Mental Health Network, NHS Confederation

Repper J, 2013. *Peer Support, Theory and Practice.* ImROC

Utschakowski J, 2015. *Mit Peers arbeiten* [Working with peers]. Cologne: Psychiatrie Verlag

Utschakowski J, Sielaff G, Bock T, Winter A, 2016. Experten aus Erfahrung [Experts by experience]. Cologne: Psychiatrie Verlag

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