Sociology Study, May-June 2024, Vol. 14, No. 3, 129-142
doi: 10.17265/2159-5526/2024.03.001

Experienced Involvement (ExIn) in Social-Psychiatric Care of Germany—Challenges and Chances

Susanne Iris Bauer
Fulda University of Applied Sciences, Fulda, Germany

This study explores the integration of Experienced Involvement (ExIn) in social-psychiatric care in Germany, emphasizing both the challenges and opportunities it presents. The European Leonardo da Vinci Project (2005-2007) established a curriculum for ExIn, promoting participatory structures in psychiatric services. While peer support is well-established in other European countries, Germany's experience is still developing. This research uses a mixed methods design, combining quantitative surveys and qualitative interviews, to investigate the professional experiences of ExIn recovery companions and team colleagues in German clinics and support services. The findings reveal numerous benefits: for social-psychiatric services, ExIn enhances service quality, inclusivity, and accessibility; for team colleagues, it fosters reflexivity, hope, and trust, and improves self-care; for service users, it provides empowerment, easy access to support, trust, and hope, and offers credible role models. Despite these benefits, challenges such as stigmatization, lack of recognition, and financial constraints remain and require to be addressed. The study highlights the need and provides implications for a dedicated and inclusive approach to effectively implementing ExIn, ultimately enriching psychiatric care through experiential knowledge and reducing prejudice within mental health services.

Keywords: peer involvement, professionalized peer support, social psychiatry, inclusion, education of social works

Research

The European Leonardo da Vinci Project "Experienced Involvement 2005-2007"[1] established a curriculum that set the framework for future implementation of ExIn recovery support. This project involved not only the perspectives of different countries but also those of professionals, experts from experience, and researchers. The WHO recommended the establishment of participatory structures.

> The participation of users of psychiatric services and their relatives is an important part of the reform process. It has been proven that the active participation of psychiatric professionals and their families improves the quality of care and services should also be involved in the development and implementation of training courses to give psychiatric staff a better understanding of their needs. (WHO, 2005, p. 108)

The role of peers in the context of social-psychiatric care is of particular significance. While in neighboring European countries, peers have long been employed in services, there is still limited experience in Germany with peers serving as colleagues and employees, which led to a PhD-project at Fulda University of Applied Sciences,

Susanne Iris Bauer, PhD student, Researcher, Faculty of Social Services, Fulda University of Applied Sciences, Fulda, Germany.
[1] Projects and Products Portal for Leonardo da Vinci. (2005). https://www.ex-in.eu/. (G. Tönnes, Hrsg.). Abgerufen am 20. 05 2024 von https://www.ex-in.eu/2005-2008-.

Germany, exploring the anchoring of Experienced Involvement (ExIn) in social-psychiatric care in Germany. Central question of this work is: “When do Experienced Involvement (ExIn) recovery companions experience themselves as acting professionally and what contextual factors arise for this?”. To explore this issue, a mixed methods design was developed to allow collecting quantitative data about employed ExIn, working in clinics as well as in support services, aiming to survey all ExIn employments in Germany by a questionnaire and then exploring qualitatively, how it is and what it takes and what it means to work as ExIn and with ExIn as colleagues in a team. In the following, the term service user is used for the recipients of social-psychiatric care as an established term in the international discourse on service user involvement (Bauer, Dettmann, & Weser, 2024).

Design

A mixed methods design was constructed to explore these questions, consisting of the quantitative recording of data by means of a questionnaire and qualitative elements with focus groups with prospective ExIn and expert interviews with both ExIn recovery supporters in employment and their team colleagues. With the questionnaire, beneath the total survey of ExIn, the extent and context of their employment and the fields of activity were queried, but also reasons for non-employment and possible future positions. The pool for the random selection of the tandems of interview partners with one team colleague and one ExIn working in the same teams was generated from the response out of the questionnaires; the selection was gender-sensitive and aimed to cover different regions.

The mixed methods design is shown in Figure 1:

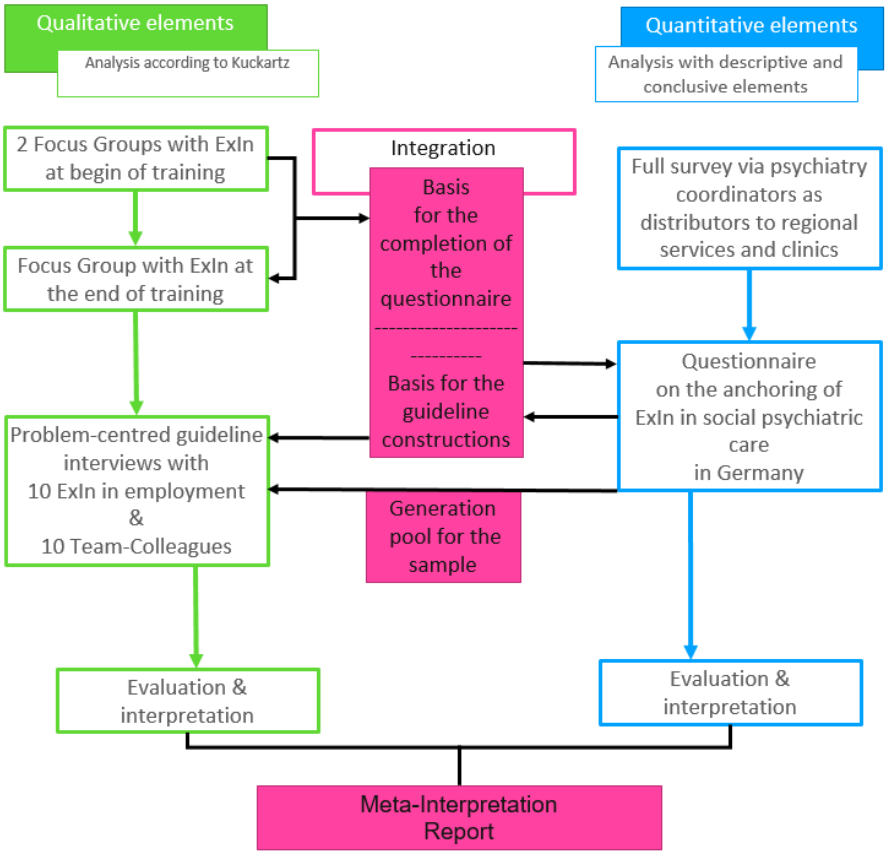

Figure 1. Mixed methods design—The anchoring of Experienced Involvement in social-psychiatric care of Germany.

In three rounds of focus groups the expectations about their future working life were discussed with prospective ExIn: Their issues for research were recorded and enriched the catalogue of questions for the guideline-supported interviews with each one ExIn and one of their team colleagues. To be able to capture changes since the first employment of an ExIn, the team colleague had to be longer in the very service than the ExIn, the ExIn itself had to be at least 6 months in service. The interviews took place with each person in one-to-one contact, the range of questions dealt for ExIn as well as the team colleague with the perception of barriers, factors for success as well as surprises along the way of implementation.

Introducing the Concept of Experienced Involvement

An ‘expert by experience’ in health care is someone who has had active experience of illness, disability and/or mental health problems and who has acquired specific competences to live with that illness, disability and/or mental health problems and to deal with the socio-cultural and institutional context in which the illness, disability and/or mental health problems are significant (Koster & van Haaster, 2005). This special expertise is utilized by the ExIn-project for the professional use in social-psychiatric care.

In the curriculum of ExIn-training the conditions for being accepted as ExIn-trainee are explicated: Recommended are at least 1.5 years of active participation in self-help/user/expert groups or in trialogue seminars or being in a situation where knowledge acquired in the ExIn course can be directly applied in practice. Further checks on reflexivity, willingness to share own and accept others’ experiences, no actual crisis, etc. are further mentioned there (ExIn partners, 2019).

The process of qualification includes 12 modules with about 240 hours of theory and practical experience in different settings, the theoretical training covers the following content consecutively, as shown in Figure 2:

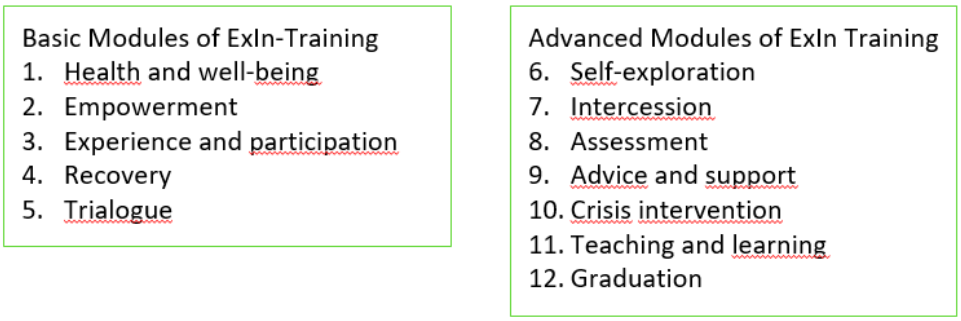

Figure 2. Content of ExIn modules, own graphic, based on ExIn partners, 2019 (ExIn partners, 2019).

Central elements of this process are learning about and dealing with concepts of hope and recovery, representing the message of the end of incurability, as counter-draft of the still and widely spread idea of mental illnesses as life-long verdicts (Amering & Schmolke, 2007). Introducing the concept of salutogenesis with an understanding of health and illness as a continuum between these poles of rather than the dichotomous perception of either healthy or ill (Antonovsky, 1997 [1987]). Another crucial step in the program is to reflect and develop together as a group what van Haaster called “we-knowledge”: starting with the personal experience of me-knowledge, sharing it, listening to the other shared experiences, learning about and reflecting on the different ways of recovery and respecting them as valuable, broadening the perspectives (van Haaster, 2016).

In Germany meanwhile services in about 30 cities[2] offer the qualification: always led by a tandem of two qualified trainers, at least one of them officially being acknowledged as an ExIn—expert of experience. In 2018 ExIn is recommended for the first time in the S3-guidelines of the DGPPN (German society for psychiatry, psychotherapy and neurology) for people with severe mental illness (DGPPN—Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde, 2018, p. 88), also this research-project started out by the distribution of the questionnaires.

As there are no central overviews of social-psychiatric services in Germany or in the individual federal states, there is no data basis that can be drawn upon. The task of psychiatric coordination has been established in the individual regions and districts, albeit with different designations and territorial responsibilities. Through these offices, the questionnaire could be distributed to 2,415 clinics and services (the latter sometimes are hosted by regional authorities which are separately recorded, regarding differences in structural localization). ExIn Deutschland e.V. also supported the survey distribution. The adjusted[3] response rate of 485 questionnaires was 20.08%. Most of the responses came from complementary institutions with 77.3%, while 16.1% came from clinics and 5.2% from authorities (Bauer, 2023, p. 3; see Table 1).

Table 1

Response According to Types of Institutions (Bauer, 2023, p. 3)

Response according to types of institutions	Authority	Complementary service	Clinic	Others
Total (n = 485)	25	375	78	5
In %	5.2%	77.3%	16.1%	1%

The responses showed broad recognition of the ExIn concept, only 9.7% of those having answered had not heard about it by then (ibid). From the total of 485 adjusted responses 314 (corresponding to 64.74%) stated no employment of ExIn so far. The survey recorded the reasons for this: most frequently mentioned was the lack of clarity on refinancing with 126 responses (equivalent to 25.98%), closely followed by the lack of applications with 121 responses (24.94%). In addition, less than 10% of respondents stated a lack of courses in their region, a lack of information or a lack of interest (see Table 2).

Table 2

Reasons for not Employing ExIn (Bauer, 2023, p. 3)

Reasons for non-employment	No employment of ExIn	No application	No ExIn courses	No information	Unclear refinancing	No interest	Not specified
Total (n = 485)	314	121	42	48	126	18	27
In %	64.74%	24.94%	8.66%	9.89%	25.98%	3.7%	5.57%

Nevertheless, approximately 87% of these respondents indicated that they considered future employment with ExIn to be a viable option. These potential employment opportunities were presented in a multiple-choice format, with respondents able to select more than one answer per question, organized by area of application.

[2] EX-IN Deutschland e.V. (2024). https://ex-in.de/ex-in-kurse/. (C. Flader, Produzent). Abgerufen am 20. 05 2024 von www.ex-in.de: https://ex-in.de/ex-in-kurse/.

[3] The adjustment sorted out wrongly addressed offices like Insurance Agencies as well as services that stated the employment of ExIn but only as volunteering service.

Table 3

Conceivable Further Deployment of ExIn (Bauer, 2023, p. 4)

Conceivable deployment of ExIn	Accompanying inpatient	Accompanying outpatient	Advisory outpatient	Working with relatives	Advanced training	Others	Not specified
Total (n = 314)	70	126	106	88	50	44	72
In %	22.29%	40.13%	33.76%	28.03%	15.92%	14.01%	22.93%

In light of these considerations, it can be observed that the distribution of data from the application fields (total; complementary facilities: 77.3%, clinics: 16.1%, government: 5.2%) demonstrates that ambulatory care may have the greatest potential for future employment, not only during the survey period. Furthermore, it can be seen that this area shows the greatest potential for future employment with 40.13% outreach and 33.76% in consultancy (ibid; see Table 3).

Peers as Colleagues—Extension of Employment Regarding German Social System

A review of the employment landscape reveals that 35.3% of the surveyed utilize or have previously utilized ExIn. Furthermore, the survey revealed that 30.3% of all services (equivalent to 147 services) employed two or more ExIn. This indicates that a significant number of services employ multiple ExIn and the practical knowledge in the teams about working together with peers as colleagues is growing as well as what effects can be gained for services, service users and the team colleagues themselves.

The recordings also captured data about the extent of employment with fee-for-service—offers such as performing recovery groups in 18% of the cases, while approximately 34% of the ExIn were employed in low-wage occupations. Furthermore, a total of 48.3% of the employment relationships are to be recorded as employment subject to social security contributions (see Table 4).

Table 4

Extent of Employment (Bauer, 2023, p. 6)

Extent of employment	Single hours, fee based	Low-wage	Part time < 15h	Part time 16-30h	> 30h/fulltime
Total (n = 242)	43	83	40	53	24
In %	17.8%	34.3%	16.5%	21.9%	9.9%

This is remarkable, regarding the German social system: Social security contributions are only levied on income above €450 (2018). This threshold applies to contributions to pension insurance, among other benefits. Concurrently, the social system incorporates replacement benefits in the form of the disability pension, which is available to individuals who are partially (performance > 6h/day) or fully (performance > 3h/day) incapacitated[4]. The amount of the pension payments is contingent upon the amount of contributions made in a defined period. Prior to the need for replacement benefits, the higher the contributions, the higher the pension payments. In the event that the aforementioned conditions cannot be met, the minimum income is utilized to assist with the individual's livelihood. This includes, in particular, those with a pension entitlement that exceeds the minimum income, who may be at risk of taking up employment subject to social security contributions. In the event that this performance cannot be sustained indefinitely, there is a risk of relapse to the

[4] Bundesregierung, P. u. (Hrsg.). (2024). https://www.bundesregierung.de/breg-de/themen/arbeit-und-soziales/sozialhilfe-und-buergergeld-2253064. (Presse und Informationsamt der Bundesregierung). Abgerufen am 20. 05 2024 von https://www.bundesregierung.de/: https://www.bundesregierung.de/breg-de/themen/arbeit-und-soziales/sozialhilfe-und-buergergeld-2253064.

minimum income. Moreover, there are additional earnings limits that result in a reduction or loss of eligibility for state benefits when exceeded. Bridging these insecurities, by e.g. allowing a period of time, maybe of 5 years, as a test phase without the risk of loosing pension claims by not working more than these hours might increase the amount of peers back to employment relationships which are relevant for social security.

What Tasks Do ExIn Have in the Services?

As already introduced in the table above, ExIn are working in various fields of social-psychiatric care. The tasks assigned to ExIn vary not only in terms of the number of hours, but also in terms of the content of their tasks. For successful implementation, the interviewed ExIn-workers and their team colleagues recommend an open attitude towards the process of assigning tasks and tasks for ExIn-workers, including the joint development of the same. The type of institution and care mandate must be taken into account as well as the individual competencies of the ExIn. This differs from the usual approach to recruitment processes, in which job descriptions usually make it very clear what expectations and functions are placed on the employee to be hired and how these are to be remunerated in accordance with collective agreements or collective bargaining structures. This may be due to the establishment of peers as pioneering work, but in practice, in addition to the challenge of temporarily increasing the time required for procedural support and evaluation, it also opens up a space for qualitative value development. In the implementing process of peer involvement, the broadening of perspectives makes it possible, for example, to identify content-related needs in team structure, gaps in access and communication or offers towards service users as well as to address these in a reflective manner.

In the interviewed services, quite different conceptions of ExIn-job-models were shown in various combinations; the following roles and elements were presented:

- “Just being there”: Offering a very low access towards service users, like being there as someone who shares the space without having any assignment to motivate, prompt or request in clinical settings. This was described as some kind of relieving experience of not having to be alone, but also as not being a threat to service users. Latter occurs in context of ExIn working in outpatient assistance as well: it may be a hint of how professional help sometimes is perceived, experienced or designed and leaves even more occasion on reflection.
- “Special offers”: A range of different offers can be provided, such as ExIn-specific groups for service users, e.g. recovery groups as well as ExIn-focused counseling for colleagues, trainings for colleagues on ExIn-specific topics, being part of developmental of concepts using ExIn-expertise, to give an impression without claim to completeness, as there is dynamic in development.
- “Person of trust”: In some services ExIn accompany service users to appointments as person of trust, such as medical or official appointments supporting, bridging gaps in communication, helping with questions or matters who to address e.g. for organizing paperwork.
- “Supporting activities of daily life” in outpatient settings in different measures: Some ExIn visit service users at home, supporting whatever needed and possible to achieve for them in their cooperation, helping to address specialists when necessary.
- “Assistant-Co-Worker”: ExIn support their colleagues during their shifts and are accessible to service users, as they have less concrete orders and more room to offer a low access approach to service users than team colleagues.
- “Coworker”: ExIn work just the same load and assignment as being a part of the work force, being able to either to apply their own skill-management or being recovered so far, that need for special considerateness is

not given (any more). Further there are ExIn working as trainers in in-house education for the own institution, give presentation with others or on their own, or, with further education being ExIn-trainers as well.

- "Specialists": ExIn with appropriate training as a specialist and as an ExIn, who has either recovered and is able to use their skills again or ExIn who have successfully completed specialist training after their recovery, who can cope with the associated assignment and workload.

Benefit-Effects of Peer-Work Found

Positive influences through peer involvement can be observed at different levels and for different groups and objectives. Overarching mechanisms are often reciprocally effective, such as the broadening of perspective: The change of role from service user to colleague in the service offers insights into tasks and structures, team constellations and constraints, but also into design possibilities, and thus not only allows an understanding to be developed of where bridges need to be built, but also to initiate changes, close gaps and address demands. Reciprocity is particularly present in dealing with the experience of discrimination, prejudice and stigmatization.

Benefits for social-psychiatric services by customised offers, credibility in matters of inclusion, accessibility, strengthening of participation and therefore a selling point:

- Quality of concepts is enriched by the irreplaceable perspective of experiential knowledge.
- Credibility in representing inclusion by working with peers as colleagues being vehicle for the message of an non-judgemental, empowering attitude.
- Credibility in messaging hopefulness by working with peers as colleagues one great sorrow of people with mental illness is met: there believe in recovery and being able to have a job (again)—read more therefore below.
- Gaining accessibility towards service users, being able to provide support earlier than before and towards service users with fears or former negative experiences with support.
- Portfolio of offers and proceedings are customised and allow to meet needs differently, e.g. by strengthening participation or providing peer run offers such as recovery groups.
- Selling point towards other services and institutions but also towards cost units: Being innovative, being inclusive, being participatory, working with strong recovery-orientation, developing further, fighting prejudice on a new level, meeting the requirements of UNCRPD and rights of service users (UN General Assembly, 2007), being up-to-date with research.

Benefits for team-colleagues: by the strengthening of their own reflexivity, hope and self-care, shared knowledge and broadening perspectives, gaining trust.

- Reflexivity is enhanced by providing a surface of reflection, which is provided by the peer perspective and the experiential knowledge—not only of peers but also their own if present, advancing in dealing with own vulnerabilities.
- The ExIn self-care competences and open handling of these encourage to reflect on own strategies of self-care and self-management.
- Reducing prejudice: Reflexivity, e.g. with regard to choice of words, of developing sensitivity for being or reproducing discriminative or prejudiced helps to recognize and to reduce them.
- Making sense is satisfying: Shared (experiential) knowledge and broadening of perspectives allow deeper insights and better adjusted support.

- Building trust: Working with peers as colleagues shows trustworthiness and non-judgemental attitude towards service users.
- Gaining trust and self-efficacy themselves, being able to experience development.
- Conceptional work on and progress in participation: Working processes partially need different ways, allowing new learnings and structures: discussion and development of concepts with ExIn or even some steps further, driven by the empowerment of ExIn, the processes of participation of service users including shared decisions about conceptions was started. Meaning not alone to allow involvement, but also working on issues like procedural trust, enhancing review and reflexivity and learning together.

Benefits for service users: by provision of empowerment, easy access, trust, hope, acknowledgement and sharing of experiential knowledge and role models.

- Hope as a message is strongly provided by having ExIn as part of support: by sharing their we-knowledge about recovery processes, as well as being provided with role models (s.b.).
- Hope is also provided by literally proving mental illness as not incurable (Amering & Schmolke, 2007) or a (lifelong) verdict having no control about the own life or quality of life.
- Being accepted and respected and not judged is a crucial experience for people having experienced or witnessed prejudice, stigmatization, being treated paternalistic or patronizing or even having experienced being victimized, mistreated or having suffered violence by people, by system or by psychiatric treatment or having
- Empowerment to find own ways for recovery.
- ExIn as allies with high credibility, easy access to help and trust in team colleagues.
- ExIn as role models for being able to openly live with mental illness and for being able to work (again).

Benefits for ExIn in active support themselves: through change of role, by broadening of perspective, partly professional activity/securing livelihood (improvement of economic situation), social and political participation, self-efficacy and self-esteem, status enhancement, “being established”, recognition for experiential knowledge.

- Self-efficacy experienced in dealing with the issues of the own mental illness, being able to manage lots of challenges and creating quality of life for oneself.
- Change of roles: Being help-provider, not (only) a help-recipient.
- Acknowledgement of experiential knowledge.
- Self-confidence by being able to share an irreplaceable source of knowledge, making a difference, being able to contribute.
- Being able to empower people: service users as well as team colleagues (or further, relatives).
- Quality of life aspects:
  - Daily structure, is gained by having a job to do, being expected somewhere.
  - Belonging somewhere/gain in status: to a team, a service, the working people means not only increase of social contacts and network, but also gain in status.
  - Social networks are expanded, (re-)constructed, restored.
  - Liberation of hiding mental issues, side-effects of treatment, means a great relief.
  - Make a living (or contribution to it).
- Being part of a community, being able to change things.

Barriers & Challenges

Only some of the existing barriers and hurdles can be dealt with here: these vary according to the culture in the system and how challenges are dealt with in the process; the focus here is on the prominent challenges that seem to be overcome everywhere, albeit to varying degrees. It should be noted that in addition to formulating these, both ExIn and their team colleagues formulated recommendations on how to address them: there was a consensus on the approach in particular: ExIn must be wanted: this binding commitment is what makes successful implementation possible in the first place.

In the questionnaires, free text fields were offered in addition to the multiple-choice options when asked why no ExIn had been employed to date. This option was used by 48.1% of respondents, with 4.3% stating that there was no interest on the part of the provider due to a lack of funding, no recognition of need or responsibility, but also that the professional suitability of peers as colleagues could not be assumed, due to data protection concerns or "...because psychiatry is a difficult subject" (Bauer, S. I.; not yet published). In the free text field of this item under the heading "Other", respondents indicated a lack of conceptual discussion or embedding, in addition to the predefined answers regarding barriers to the cost of financing the courses themselves. Concerns were also raised about possible competition for jobs with existing employees, with regard to the mission and professional suitability of ExIn in the provision of care.

These experiences were partially confirmed in the interviews with the ExIn themselves and their colleagues: according to Allport having prejudice is a completely natural part of human behaviour, a technique for survival being challenged to quickly decide whether a new encounter is a threat or not. Trouble with prejudice is only if not checked, classified, reflected on and overcome as such (Allport, 1954). Recognizing oneself as being prejudiced or reproducing prejudice is not a pleasant situation; it is uncomfortable to put the own attitude to the test. The confrontation with this discrepancy in self-image is perhaps particularly painful for people in social works and trying to support or help others every day, who are already aiming to improve the quality of life for and with those who need support to advocate for themselves and their concerns. It is all too easy to assume that one would do everything possible—then such a realization can also trigger shame. And shame is an obstacle to exchange and further development, since shame is rarely discussed and can therefore lead to a disconnection in social interactions. Shame upon shame creates strong emotions:

> Recursive shame-based sequences, whether shame about anger, shame fear, or shame about shame, need not stop after a few steps. They can spiral to the extent that they rule out all other considerations. (Scheff, 2013, p. 90)

Scheff points to the extreme avoidance of the topic, to the point that works that deal directly with the concept of shame or are even titled do not receive any attention. Works that deal with shame in content but use other terms, even a fragmented description help:

> A taboo is implied in the many studies of shame that do not use the forbidden word at all. Instead, the focus is on one of the many shame cognates (Retzinger (1995) lists hundreds). One way of hiding shame is to behaviourize it: there are many studies of feelings of *rejection, loss* of social status or the *search* for recognition (sic!). (Scheff, 2013, p. 89)

Statements by the interviewees on experience of discrimination, stigmatization, self-stigmatization, prejudice and dealing with it in work context, were a prominent category in the study. The following aspects were (inductively) recorded:

- Avoidance of contact or confrontation by not addressing the issue, evasion, concealment.

- Experiencing differentiation between ExIn as colleagues and other colleagues: by not acting inclusive/not being included, being granted fewer rights, being treated differently in an undesirable way, experiencing deny of competence, devaluation, rejection.
- Feeling exposed, needing to come out.
- Reporting need for justification: having to prove oneself.
- Applying anti-stigma strategies: ensuring exchange, raising awareness.

In a comparison of statements regarding these aspects, sorted according to the source of this experience as their own behavior/team events, there are many similarities in the perception of these by ExIn-colleagues and team colleagues. An example therefore is lack of recognition within the team, which was discussed by both parties: ExIn colleagues referred to it in their specific skills, while team colleagues verbalized the lack of recognition of the ExIn concept.

Reflection and adaptation of discriminatory/stigmatizing behaviors in team situations were also reported by ExIn with the use of sensitization for behavior experienced as invasive or transgressive, while team colleagues began to recognize their own stigmatizing language use and began to work actually on it.

> So... I can't say that in general, I can only say that for myself, um... I have a bit of a loose mouth (...) and I sometimes call our clients "the crazy ones" or something like that... and since A. (the ExIn colleague, author's note) came along, I don't do that anymore (laughs), yes, it's changed a bit... (001TK 37)[5]

Aspects associated also became visible in the measures of preparation within the teams for the employment of ExIn or in the first month of discovery phase in working as a team with ExIn: the descriptions of both ExIn and team colleagues show that ExIn first had to prove themselves. Depending on the constellation and willingness to deal with these processes openly, these were either temporary or persistent phenomena that could make collaboration difficult. These can manifest themselves in the experience of not being allowed to call in sick, because this could be generalized as a lack of resilience as an ExIn describes:

> But then I also had the pressure ... (...)- was perhaps not so good: ... I had a slipped disc and then I was still working. Yes. ... yes... because of course I was also worried, right? That it would come across negatively, or that it would be said that it was because of the strain... (002GB 194-196)

One team colleague describes it as a struggle to gain recognition:

> Um, I think what the challenge is, I think, is getting that standing as a recovery companion. So, um, really now to say: Okay, and I am also a full, team member here. I also do, valuable work here. And, um, that it is also recognized and valued. (006TK 95)

When it comes to the perception of prejudices on the part of third parties, team colleagues report a caution in dealing with people with psychiatric experience in colleagues, as is reflected here:

> (…) I notice again and again how this topic, um, psychiatry is often, even though society tries to advance (addition by the author) so/and um, inclusion and integration and everything. That often really remains such slogans that then appear in newspapers, (…) I also notice again and again, um, with colleagues in/around them that people then say: Oh, since this mental illness, ah, there you have to be careful. (008TK 172)

[5] All citation taken from the interviews were carefully translated by the author—being not a native speaker, some using translating programs such as DeepL and Google translate.

It is a well-known phenomenon that prejudices also exist, and to a considerable extent, among psychiatric staff, making it difficult for peers to join a team and change roles from patient to employee in healthcare services (Zuaboni & Werder, 2013, p. 113). Furthermore, as a result of a dichotomous view of health and illness, health is experienced to be a prerequisite for working in psychiatry. ExIn-colleagues, on the other hand, reflected on the insecurity that coming out as a peer to new colleagues or service users can cause and thus addressed the effects of what is described as self-stigmatization[6]. In the brevity of the explanations possible here, it should be pointed out that the isolated consideration of elements strictly assigned to the categories only suffices as highlights of the complex processes: in many places, the handling of situations of vulnerability and insecurity, which are often based on long-term processes of dealing with and processing events and their perceptions and evaluations and in which support, empowerment and setting can contribute as decisive factors to avoid developing a possibly defensive, withdrawing, isolating, hiding way of life in advance (Allport, 1954; Goffman, 1975 [1963]; Thornicroft & Tansella, 2005).

Within the teams with ExIn, defense mechanisms were found that ExIn experienced as competition for roles, while team colleagues addressed the fear of job losses. A lack of recognition was also expressed by both sides: ExIn experienced a lack of recognition of ExIn-specific skills, while team colleagues generally experienced a lack of recognition of the ExIn concept.

When dealing with prejudices, different strategies became clear: in some teams, ExIn experienced their efforts to integrate as a colleague, the main task to work on:

> Integration. That is the most important thing of all. People have to do this work together. This means that a recovery companion should be fully integrated. That is the main task. Because otherwise there is a danger: who have you bought into? This is someone who was mentally ill. Hopefully this won't become a client at some point. (006GB 203-209)

Team colleagues experience defensive mechanisms such as evasive behaviour and even discrimination and recognize the need to assign ExIn a function in the team/to develop one with ExIn in order to facilitate acceptance. Both reflect on the introduction of ExIn skills and the opening of discourse in the team on discriminatory situations, recommend giving the process time and being curious—also daring to be open in dealing with one's own fears.

The lack of experience with ExIn or peers as colleagues in common may be one reason why the task is perceived as so challenging. Many ExIn are the first peer-colleagues at their place of work and are literally doing pioneering work in and together with their teams, as this ExIn describes:

> ... mmh ... so I find it difficult to be there as a lone fighter ... (...) that I am the only recovery counselor ... and it is um just not yet so well known and it is not yet so accepted, right? So like we said, there are prejudices... (002GB 206-208)

Structural Hurdles—Focussing Monetary Aspects

As mentioned above, becoming an ExIn requires personal experience with mental health issues and their impact on daily life, including individual experience with coping mechanisms. Some people on their way to become an ExIn may be comfortably equipped with financial resources: most of them probably are not, some

[6] Self-stigmatization is a not uncontroversial term, as it seems to place responsibility on those affected. Its use here is merely linked to the intrapersonal mechanisms of anticipating stigmatization and its effects, regardless of whether they are caused as a result of previously experienced stigmatization or by one's own fears.

receive partial or complete disability pension, some receive social welfare or unemployment benefits if a final assessment has not yet been made as to whether the performance limitation will be permanent or not. The minimum of living benefits (without rent and heating costs and hot water) is currently for an adult, living alone 563€. To put this into perspective, the costs for the qualification course itself are at about 2.500€, to be added are costs for travel, accommodation and supplies for at least the 12 course events. Associated with this is the lack of nearby course-offerings, as mentioned above in the quantitative results, which increase costs and time: in rural areas, it is even worse. Anyway, the costs must be borne by the course participants themselves; they are only occasionally covered by social services willing or being able to invest in later employees, social assistance providers, employment agencies, job centers or social insurance companies. Conversely, a later classification in the tariff system is also challenging. The German tariff system provides for an assignment of services and qualifications for the classification. Many of the companies not bound by collective agreements also follow the system. The assessment of peers as colleagues with lived experience as part of their qualification is not yet scheduled in the system. So far, no agreement has been reached beyond a comprehensive demand of the biggest labor union in Germany (ver.di Bundesfachkommission Psychiatrische Einrichtungen, 2020) and the income is often a matter of negotiation. Working project-based and the jobs are only available to a limited extent. As German bureaucracy has its part in it, the challenge to gain proper refinancing for both courses as work is not to be underestimated.

Implications

The interviewees were invited to share what they would recommend for a successful implementation, in addition, the following aspects were recorded in the category of success and conditions for success, such as experience of effectiveness, of competence, of further development of the service and also personal effects. The category of success conditions in the sense of is referred to here helpful structures and framework conditions, and the necessary precautions as part of an organizational development measure.

Both sides recommend to build a space of open communication in preparation for the teams: Worries, sorrows, prejudices need to be spoken out loudly being able to address them and to find ways. For the ExIn, on the other hand support for at least the start a contact person should be named—or even better working—the partners should be chosen freely, so there also is space created in which these topics, but also further questions can be answered and needs or irritations can be discussed. The contact person model can also help to find out about potentials for shaping of orders and tasks for ExIn within the service, if not fixed and is closely linked with the role identification process. There was also consensus that ExIn should participate in team meetings—in general, it can be said that affiliation and belonging are crucial to successful implementation, furthermore shown in aspects of participation, contribution and integration. Both sides reflected that the employment of more than one ExIn would be helpful—or at least a regular exchange for ExIn with ExIn should be maintained; here there was also a recommendation for the possibility of ExIn supervision as a permanent flanking and support measure. Different opinions prevailed about employing former service users of the own institution the change of roles is, as mentioned before quite difficult. Colleague described the experience of having witnessed a great change of a former service user to ExIn as strengthening for his own self-efficacy:

> (...) And there was such a/ such a/ you can’t say it any other way, such a pile of misery sitting in front of you. And it was incredibly difficult to have a conversation like that because you had to pull everything out of her nose and she was

> very reserved, very introverted (...) Now she's been my colleague for three years and, um, she's a recovery counselor, but she's also a music therapist and remedial teacher. Yes? And now she's also employed by us. That's a quantum leap. (...). And, yes, it's great what you can see, what you can achieve and what I can do. (003TK 37)

This team colleague also stated, along with further, not to recommend to employ former service users of the own institution, being an additional challenge in adjusting to the new roles for both the parties.

Conclusions

Despite the realization and the knowledge, the anchorage of inclusion as part of human rights in the UNCRPD (UN General Assembly, 2007), despite the existing guidelines and the impact of various anti-stigma-projects on the subject of mental health, despite the experiential knowledge available not only in peers, there still is work to do and benefits to be harvested for further development. One step may be to not only utilize the cognitive strategies, but also consider emotional aspects involved—to overcome prejudice. Another step to be taken is implementing experiential knowledge and peer involvement in education of social work, as demanded by the "Global Standards for the Education and Training of the Social Work Profession" (IASSW/IFSW, 2020 [2004]). Yet there is little preparation for students (or nurses) to work together with peers as colleagues, or to utilize own experiential knowledge in becoming and being (and remaining) a social worker. If peers are actually involved in education, still is a question of personal engagement of teachers. One step towards making progress here would be to recognize experiential knowledge as an irreplaceable source of knowledge as an integral part of social work teaching, as a third source of knowledge—alongside scientific knowledge and professional knowledge (Bauer, Dettmann, & Weser, 2024). Building networks, distributing newsletters and organizing conferences like Service User Involvement Germany[7] or the international Power Us[8] are further steps to share knowledge about implementation, working aids and spreading benefits. These reach, as the impact of working with ExIn as colleagues on self-care of team-colleagues and the effects on themselves imply, clearly beyond enhancing quality of services and quality of life for service users and are overdue for embedding in social work education, practice and research as well.

References

Allport, G. W. (1954). *The nature of prejudice* (1st edition; 2nd printing). Cambridge, Massachusetts: Addison-Wesley Publishing Company.

Amering, M., & Schmolke, M. (2007). *Recovery. Das Ende der Unheilbarkeit* (1 Ausg.). Bonn: Psychiatrie-Verlag.

Antonovsky, A. (1997 [1987]). *Salutogenese—Zur Entmystifizierung der Gesundheit*. (A. Franke, Hrsg.; A. Franke & N. Schulte, Übers.). Tübingen: dgvt-Verlag.

Bauer, S. I. (2023). *Experienced involvement in social psychiatric care in Germany—Pioneering work*. Fulda: Hoschschulbibliothek Fulda. Retrieved from https://fuldok.hs-fulda.de/opus4/files/999/ExIn+in+Socialpsychiatric+Care+in+Germany+-+S.Bauer.pdf

Bauer, S. I., Dettmann, M.-A., & Weser, M. (2024). Nicht über sie—mit ihnen: Wie bringen wir Erfahrungswissen in die Lehre ein? In H. Schwering and M. Staats (Eds.), *Instrumentarien zu einem besseren, gelingenderen Leben*. Weinheim, München: Beltz Juventa.

DGPPN—Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde. (2018). *S3-Leitlinie für psychosoziale Therapien bei schweren psychischen Erkrankungen*. DGPPN, Psychiatrie und Psychotherapie. Berlin: Springer Verlag.

EX-IN Deutschland e.V. (2023). *www.ex-in.de*. Retrieved from https://ex-in.de/fragen-antworten/

[7] Service User Involvement Germany. (2022). Newsletter. (M.-A. Dettmann & B. Müller, Hrsg.) Von https://www.researchgate.net/publication/362928433_SUI_Newsletter_Aug-2022 abgerufen.

[8] Power Us—The Social Work Learning Partnership. (2024). www.powerus.eu. Von https://powerus.eu/ abgerufen.

ExIn partners. (2019). *ExIn-Curriculum: Ausbildungsprogramm für Psychiatrie-Erfahrene zur Qualifizierung als Ausbilder und als Genesungsbegleiter*. (H. van Haaster, Hrsg.; J. Utschakowski, Redakteur). Retrieved from https://psychiatrie-verlag.de/wp-content/uploads/2019/01/EX-IN-Curriculum_02.pdf

Goffman, E. (1975 [1963]). *Stigma—Über Techniken der Bewältigung beschädigter Identität*. Frankfurt am Main: Suhrkamp Taschenbuch Wissenschaft.

IASSW/IFSW. (2020 [2004]). *Global standards for social work education and training*. Retrieved from https://www.ifsw.org/global-standards-for-social-work-education-and-training/

Koster, Y., & van Haaster, H. (2005). *Instituut voor Gebruikersparticipatie en Beleid*. Amsterdan: Nicht veröffentlichtes Manuskript, zitiert aus Utschakowski et al. 2009.

Scheff, T. (2013). A social/emotional theory of 'mental illness'. (S. Pub, Hrsg.). *International Journal of Social Psychiatry, 59*(1), 87-92.

Staub-Bernasconi, S. (2000). Soziale Arbeit als Menschenrechtsprofession. In F. Stimmer (Hrsg.), *Lexion der Sozialpädagogik und der Sozialarbeit* (4 Ausg., S. 626-632). Oldenburg: De Gruyter.

Thornicroft, G., & Tansella, M. (2005). Growing recognition of the importance of service user involvement in mental health service planning and evaluation. (C. University, Hrsg.). *Epidemiol Psichiatr Soc, 14*(1), 1-3.

UN General Assembly. (2007). *Convention on the rights of persons with disabilities A/RES/61/106*. Retrieved from https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_61_106.pdf

van Haaster, H. (2016). Der Wert der Erfahrung. In J. Utschakowski, G. Sielaff, T. Bock, & A. Winter (Hrsg.), *Experten aus Erfahrung* (1 Ausg., S. 50-59). Köln: Psychiatrie-Verlag GmbH.

ver.di Bundesfachkommission Psychiatrische Einrichtungen. (2020). *Genesungsbegleiter*innen: Rollen klären, Stellen sichern und finanzieren, Arbeit angemessen entlohnen*. Psychiatrie-Info Positionspapier. (S. D. ver.di Fachbereich Gesundheit, S. Bühler, Hrsg.; G. Neunhöffer, Redakteur). Retrieved from https://gesundheit-soziales-bildung.verdi.de/mein-arbeitsplatz/psychiatrie/++co++f0d2014e-c32a-11e9-880d-001a4a160100

WHO. (2005). *ICF—Internationale Klassifikation der Funktionsfähigkeit, Behinderung und Gesundheit*. Genf.

Zuaboni, G., & Werder, B. (2013). Von der Patientin zum Profi. In C. Burr, M. Schulz, A. Winter, & G. Zuaboni (Hrsg.), *Recovery in der Praxis: Voraussetzungen, Interventionen und Projekte* (1 Ausg., S. 113-125). Köln: Psychiatrie Verlag.