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ORIGINAL ARTICLE

Peer support worker training: Results of the evaluation of the Experienced Involvement training programme in Switzerland and Germany

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ABSTRACT: *The 'Experienced Involvement' (EX-IN) training programme prepares and certifies individuals who have experienced mental health problems to work as peer support workers and to support others challenged by similar conditions. We aimed to assess the impact of the EX-IN training on hope, self-efficacy, introspection, stigma resistance, personal recovery, health-related quality of life and employment in participants. Data was collected using standardized assessment instruments before the training started (t1) and upon course completion (t2). Data from 103 participants who participated in both measurement times were included into data analysis. Participants significantly improved their recovery, stigma resistance and introspection during the EX-IN training. In addition, a significant higher proportion of participants were employed at t2. Participants whose last inpatient stay was 0–1 year before the start of the EX-IN training showed significantly lower levels of stigma resistance, and self-efficacy at t1 than participants with two or more years since the last inpatient stay. There were no significant changes in mean values over time, or in the mean values at t2 between the two groups. EX-IN training has a positive influence on the handling of stigma, on one's recovery path and introspection. This indicates that EX-IN training has a therapeutic effect on the participants. EX-IN training seems to meet the challenges of peer support work. Therefore, the training can be recommended as preparation for working as a peer support worker as well as an intervention to improve one´s recovery process.*

KEY WORDS: *mental health, peer support work, psychiatry, recovery, training.*

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IMPACT AND IMPLICATIONS

Participants of the peer support worker training significantly improved their recovery, stigma resistance and introspection during the training programme. Our results suggest that the training has a therapeutic effect and imparts skills that facilitate the entry into the labour market.

INTRODUCTION

As part of recommendations in guidelines and position papers related to recovery orientation of mental health services (Deutsche Gesellschaft für Psychiatrie Psychotherapie und Nervenheilkunde (DGPPN) 2012; National Institute for Health and Care Excellence (NICE) 2014) peer support increasingly attracts attention. As a result, the emphasis on peer support is actively growing in practice and research, especially in German-speaking countries of Europe (Mahlke *et al*. 2014). Peer support workers (PSW) are individuals with lived experience of mental health problems and of service use who utilize their acquired knowledge and skills to support others challenged by similar conditions (Davidson *et al*. 2006). Peer support values include: hope and recovery, self-determination, empathetic and equal relationships, dignity, respect and social inclusion, integrity, authenticity and trust, health and wellness, lifelong learning and personal growth (Sunderland *et al*. 2013). Existing findings provide evidence that peer support represents a promising approach to improve patient orientation and quality of care in mental health services and might affect not only service users but also PSWs and mental health service delivery (Gillard & Holley 2014). Even if the body of research on the effectiveness of PSW is currently small, existing studies show positive effects on service users, mainly concerning health-related outcomes such as hope, recovery, quality of live and empowerment (Chinman *et al*. 2014; Fuhr *et al*. 2014; Lloyd-Evans *et al*. 2014).

One of the propulsive forces during the work as a PSW is the wish for normalization and self-preservation (Vandewalle *et al*. 2018). In their work, PSWs might experience personal improvements as well as challenging situations. Findings indicate positive effects on PSW's themselves, such as increased confidence at work, self-esteem, as well as improvements in their social networks, mental illness management and general health, for example, through an increased understanding and awareness of mental health issues, increased self-care behaviour and improved clinical status (Johnson *et al*. 2014; Moran *et al*. 2012; Walker & Bryant 2013). Additionally, PSWs reported advancement in their own recovery process (Johnson *et al*. 2014), which is characterized by connectedness, hope and optimism about the future, identity, meaning in life and empowerment (Leamy *et al*. 2011). Moreover, peer support work can be seen as a stepping stone into employment (Hegedüs *et al*. 2016; Moran *et al*. 2012; Walker & Bryant 2013).

However, challenging aspects of PSW were also reported and are characterized by confronting expectations, the feeling of being needy and vulnerable and unclear role definitions (Cleary *et al*. 2018; Hegedüs *et al*. 2016; Ibrahim *et al*. 2020; Moran *et al*. 2013). Furthermore, the perception of a power imbalance between doctors and patients or PSWs (Cleary *et al*. 2018), rejecting attitudes from non-peer staff and the challenge of being treated as a patient rather than a colleague (Ibrahim *et al*. 2020; Walker & Bryant 2013) are described. Some mental health professionals even consider that PSWs are placing their mental health at risk (Hornik-Lurie *et al*. 2018) and that stable mental health is required to be able to provide good work (Aguey-Zinsou *et al*. 2018).

In order to be ready to face these challenges and to perform a fulfilling role, PSWs wish to acquire self-care skills and knowledge on how to constructively approach peers and health professionals (Moran *et al*. 2013; Vandewalle *et al*. 2018). These expectations are closely linked to their drive to help peers, their desire for meaningful participation, and their urge for self-preservation (Vandewalle *et al*. 2018). In order to be prepared for their tasks and to anticipate possible challenges, PSWs wish to have specific training programmes that meet professional standards (Gillard *et al*. 2014; Moran *et al*. 2013). There are recommendations to offer and run such training (McLean *et al*. 2009; Sunderland *et al*. 2013). Experiences from Ontario, Canada, show that especially in rural areas, it is important to establish a minimum standard of PSW training (Rebeiro Gruhl *et al*. 2016). The Ontario Peer Development Initiative provides such solid foundational training for PSWs (Initiative 2019). In order to further accelerate peer support, the US and Canada, developed certifications for PSW (Kaufman *et al*. 2014; Peer Support Canada 2019). Training is even obligatory in order to be certified and, in the US, to being able to reimburse through Medicaid, a government insurance programme for persons whose income and resources

are insufficient to pay for health care (Kaufman *et al*. 2014).

However, there is no international agreement on their contents and extent or an internationally recommended well standing PSW training programme are missing. Across Europe including Switzerland, Germany and Austria, the standardized Experienced Involvement (EX-IN) training has been established (Denk & Weibold 2015; EX-IN Deutschland e.V. 2020; Verein EX-IN Schweiz 2020). However, potential training effects on participants and how participant characteristics (eg the time distance between the last psychiatric hospitalization and the start of PSW training) might affect training outcomes have not been examined yet. As a result, it is unclear whether EX-IN training improves participants' employment and relevant aspects for PSW like self-efficacy, hope, personal recovery or health-related quality of life.

EX-IN training

The curriculum of the EX-IN program was developed through a cooperative process between service users, mental health professionals, researchers and trainers in six European countries and was funded by the Leonardo da Vinci program (Utschakowski 2008). The EX-IN training attempts to enable potential PSWs to gain a collective experience of mental illness and recovery reflecting personal experiences and the experiences of their colleagues. The training programme is aimed at increasing their involvement in mental health services, improving their employability, strengthening their competencies to promote recovery and applying their collective experience in supporting others with mental health problems (Utschakowski 2008, 2012). Upon completion, participants are eligible to work as PSWs in mental health services.

Persons who are interested in the training apply with a written CV and motivation letter. Participants are selected by a PSW and health professional after an assessment interview. They have a stable mental health (ie are no longer greatly affected by their mental health issues in everyday life, can deal with the issues and questions of others and are no longer under acute mental health treatment), are able to reflect on their experiences and have at least one important, supportive person in their lives.

The training lasts 1.5 years and includes coursework and two practical training. Coursework classes comprise an introduction day and ten three-day sessions that are held monthly. These sessions cover the following ten modules: (i) promoting health and well-being; (ii) trialogue; (iii) empowerment in theory and practice; (iv) experience and participation; (v) perspectives and experiences of recovery; (vi) independent peer advocacy; (vii) self-exploration; (viii) recovery-based assessment and planning for people in crisis; (ix) peer support; and (x) teaching (200 hours in total). Additionally, participants perform two practical training of 40 and 150 hours (80 hours in Germany) respectively in the field. Given the content mentioned above, the EX-IN training is in line with the suggestions of Moran *et al*. (2013), namely to focus PSW training on peer competencies, interpersonal and helping skills, and PSW label and identity.

The EX-IN training programme in the German-speaking parts of Europe is offered by different providers (Initiative zur sozialen Rehabilitation e.V. 2015; Psychosoziale Zentren GmbH 2015; Schweizerische Stiftung Pro Mente Sana 2018; Verein EX-IN Schweiz 2020). In Switzerland, EX-IN training is offered regularly since 2010. All training of all providers in Switzerland and of one in Germany are evaluated using the same methods. Course evaluations provide the opportunity to identify changes in participants' outcomes that are relevant for the work as PSW. Thus, on the basis of the aims of the EX-IN training, the benefits of peer support and according to the peer support values (Sunderland *et al*. 2013) and the five core aspects of personal recovery (Leamy *et al*. 2011), we selected recovery in general, hope, introspection, stigma resistance, health-related quality of life and self-efficacy as outcome measures of the evaluation. Our study aimed to assess the influence of the EX-IN training on participants' hope, self-efficacy, introspection, stigma resistance, personal recovery, health-related quality of life and working situation. Besides, we aimed to identify how the time distance between the last inpatient stay and the start of the training affects the outcome variables described above.

METHODS

Study design

For this study, we used a pre-post-test design. To evaluate the EX-IN training programmes, quantitative and qualitative methods were used. Qualitative results were published previously (Hegedüs *et al*. 2016) and are therefore not a subject of this paper.

Participants

All participants of the EX-IN training programmes in Switzerland (8 trainings between 2010 and 2016) and in Germany (one training in 2016) were eligible for inclusion in the study.

Data collection

On the first day of the training, all participants were briefly informed and received an information letter including an informed consent form and the questionnaires. Written informed consent was obtained from all participants enrolled in the training. In order to guarantee anonymization, informed consent forms were returned separately from the completed questionnaires. Data were collected at three different time points: before the training started ($t1$) and 16 months later, upon course completion ($t2$) and for single training one year after completion ($t3$). This article refers to the results of $t1$ and $t2$ and therefore includes cross-sectional as well as longitudinal data.

Measures

Sociodemographic information including gender, age, education, living and employment status health-related characteristics (the type of diagnosis, age at onset and year of the last psychiatric hospitalization, number of psychiatric hospitalizations) and previous experience as PSW were assessed by corresponding questions.

To assess introspection, self-efficacy and hope, we used the corresponding subscales of the Questionnaire to Assess Resources and Self-Management Skills (FERUS [in German] (Jack 2007)). The FERUS is a reliable and valid instrument and the subscales have demonstrated good internal consistency (Cronbach's α: introspection: 0.87; self-efficacy: 0.91; hope 0.91), factorial homogeneity and good test–retest reliability (Pearson's correlations: introspection: $r = 0.78$; self-efficacy: $r = 0.69$; hope: $r = 0.77$). Maximum score of the subscale introspection is 35, for self-efficacy it is 45 and for hope 50 and higher scores indicate better outcomes.

In order to assess Stigma resistance, we used the Internalized Stigma of Mental Illness Inventory (ISMI), designed to measure the subjective experience of stigma (Sibitz *et al*. 2013). The German version of the ISMI showed high internal consistency (Cronbach's α: 0.73) and test–retest reliability ($r = 0.69$; Sibitz *et al*. 2013). The maximum score of this scale is 20 and a higher score indicates a higher resistance against stigma.

Health-related quality of life was assessed with the Short Form (SF)-12, the short version of the SF-36 Health Survey designed to reproduce Physical Component Summary (physical health) and Mental Component Summary (mental health) scores (Bullinger & Kirchberger 1998; Gandek *et al*. 1998; Ware *et al*. 1996). The maximum score for both subscales is 100 and higher scores indicate better outcomes.

Personal recovery was measured with the German Version of the Recovery Assessment Scale (RAS) (Cavelti *et al*. 2017; Corrigan *et al*. 1999). The RAS is a frequently used instrument to assess the personal recovery from a service users point of view (Cavelti *et al*. 2012). The twenty-four items are rated on a 5-point Likert scale ranging from 1 (completely disagree) to 5 (completely agree). The maximum score is 120 and a higher score indicates higher recovery.

Data analysis

In order to be able to evaluate pairwise, only data from participants who participated in both measurement times were included for further data analysis. All datasets were merged into one dataset. Missing values were imputed by the mean of the corresponding scale (Little & Donald 2002). Data were analysed using IBM SPSS Statistics for Macintosh version 25. For descriptive statistics, we calculated absolute (n) and relative (%) values. In order to identify relevant differences in the outcome variables either between groups or over time ($t1$ to $t2$), t tests for paired samples were conducted. To calculate changes over time for dependent categorical dichotomous variables, the McNemar χ^2 test was used. To examine whether the closeness of the last inpatient stay, as a probable indicator of acuity of mental health problems, has a significant influence on the outcome variables, the sample was split into two groups (time to the last inpatient stay: up to one year ago vs. ≥2 years ago).

Ethical considerations

The evaluation of the EX-IN training was part of quality assurance measures. Approval for the conduction of the study was granted by the ethic committee of the canton of Berne (Req-2020-00775). The ethical principles, according to the Declaration of Helsinki, were respected.

Peer involvement

A PSW was involved into the data collection, manuscript preparation and substantially contributed to the presentation and discussion of the results.

RESULTS

Over 186 participants started one of the nine training included in our study. One hundred forty-five of them took part in the *t*1 survey (78.0%). One hundred forty-four finished the training, and of those, 107 participated in the *t*2 evaluation (74.3%). One hundred three participants took part in both time points. This represents our data set for further analysis.

Participant's description before starting the PSW training

The mean age of the participants ($N = 103$) at *t*1 was 44.3 years. Two-thirds (67.6%) of the participants were female. Approximately half of the participants (47.6%) stated to lived alone. 48% had completed vocational training and 16.7% a university degree. 28.2% were employed or self-employed and 34% to have had experience in PSW before starting the training. The most frequently reported primary diagnoses according to the ICD-10 classification (World Health Organization 1994) were Mood Disorders (F3; 42.2%). On average participants reported having two diagnoses (Range 1–6). The last inpatient stay was in mean 4.34 years before the start of the EX-IN training (more details see Table 1).

Variability of personal recovery, hope, introspection, stigma resistance, self-efficacy and health-related quality of life over time

Table 2 shows mean sum scores of all outcome variables at *t*1 and *t*2. With the exception of mental health-related quality of life, all outcome variables increased during the training. The increase of the following three outcome measure was statistically significant: personal recovery ($t = -3.73$; $df = 88$; $P = \leq 0.000$); stigma resistance ($t = -3.54$; $df = 87$; $P = 0.001$) and introspection ($t = 1.99$; $df = 100$; $P = 0.049$).

Changes in employment status and income

Compared to *t*1 ($n = 23$, 31.9%), a significant higher proportion of participants were employed at *t*2 ($n = 36$, 50.0%) right after having completed the EX-IN training (χ^2 (1, $N = 72$) = 5.760, $P = 0.015$, odds ratio = 3.2). The proportion of participants having their main income from any employment did not change significantly between *t*1 and *t*2 (χ^2 (1, $N = 70$) = 0.364, $P = 0.549$). At *t*1, 5 participants had an income as PSW. At *t*2, this number slightly increased to 8.

Impact of the time distance of the last inpatient treatment on participants' outcomes

Participants whose last inpatient stay was 0–1 year before the start of the EX-IN training showed significant lower mean values in stigma resistance ($t = -2.365$; $df = 79$; $P = 0.020$), and self-efficacy ($t = -2.202$; $df = 87$; $P = 0.030$) at *t*1 than participants with two or more years since the last inpatient stay. There were no significant changes in mean values over time, as well as in the mean values at *t*2 between the two groups (Table 3).

DISCUSSION

The results of our study indicate that EX-IN training has a positive effect on participants' recovery, stigma resistance and introspection. In addition, our results show that EX-IN training contributes to an increased employment rate after completion. Despite lower levels of stigma resistance and self-efficacy at the beginning of the EX-IN training, participants with more recent psychiatric hospitalizations showed similar improvements in personal recovery, hope, introspection, stigma resistance, self-efficacy and health-related quality of life to participants whose hospitalization was longer time ago.

The results indicate that EX-IN training has a positive effect on the stigma resistance and introspection of the participants. Stigma resistance, defined as the experience of resisting or being unaffected by internalized stigma (Ritsher *et al*. 2003), has been linked to increased self-efficacy, hope, recovery attitudes, insight into one's illness, self-stigma and quality of life (Firmin *et al*. 2016). Through the group setting and intensive examination of one's own experiences, EX-IN training enables participants to create a feeling of belonging to the group and to acquire different views on personal recovery. This knowledge gain contributes to an increased stigma resistance and introspection. As a result, affected individuals are better armed against stigmatizing incidents and might be better prepared for the power gap in psychiatry (Cleary *et al*. 2018).

TABLE 1: *Participants' sociodemographic description before the EX-IN[a] training (N = 103)*

	n (%)	Mean (SD)	Range
Age	103	44.34 (8.89)	(26–66)
Gender			
Female	69 (67.6)		
Male	34 (32.4)		
Living status			
Living alone	47.6 (49)		
Living with partner or others	44.7 (46)		
Living only with Child/Children	7.8 (8)		
Highest education level			
Primary School	7 (6.9)		
Vocational training	49 (48.0)		
University Entrance Diploma	27 (26.5)		
University Degree	17 (16.7)		
Others	2 (2.0)		
Employment status (multiple responses)			
Employed	29 (28.2)		
Housekeeping	22 (22.9)		
Voluntary work	19 (19.8)		
Sheltered employment	13 (13.5)		
Job seeking	12 (12.5)		
Occasional work	8 (8.3)		
Experience as PSW[b]			
Participants with prior PSW experience	35 (34.0)		
ICD-10 Diagnoses (Self-reported)			
Mood disorders (F3)	43 (42.2)		
Disorders of adult personality and behaviour (F6)	18 (17.6)		
Schizophrenia, schizotypal and delusional disorder (F2)	18 (17.6)		
Neurotic, stress-related and somatoform disorders (F4)	14 (13.7)		
Psychological and behaviour disturbances by psychotropic substances (F1)	5 (4.9)		
Others	4 (3.9)		
Age first mental health treatment		26.1 (10.7)	(6–52)
Age first inpatient admission		29.8 (10.3)	(11–58)
Number of inpatient admissions		7.1 (8.2)	(0–50)
Years between last inpatient admission and training start		4.34 (4.6)	(0–20)

[a]EX-IN Experienced Involvement.
[b]Peer Support Worker.

TABLE 2: *Changes of mean sum scores of standard measures over time*

	n	Mean (t_1)	Mean (t_2)	*t*	*df*	*P*
Hope (FERUS)[a]	94	39.76	40.91	−1.756	93	0.082
Self-Efficacy (FERUS)	95	32.12	33.23	−1.971	94	0.052
Introspection (FERUS)	101	27.42	28.31	−1.997	100	**0.049**
Stigma Resistance (ISMI)[b]	88	16.6	17.42	−3.548	87	**0.001**
Personal Recovery (RAS)[c]	89	92.61	96.1	−3.73	88	**0.000**
Physical Health (SF-12)[d]	88	47.66	48.97	−1.547	87	0.125
Mental Health (SF-12)	88	45.49	45.09	0.36	87	0.720

[a]FERUS Questionnaire to Assess Resources and Self-Management Skills.
[b]ISMI Internalized Stigma of Mental Illness Inventory.
[c]RAS Recovery Assessment Scale.
[d]SF-12 Health Survey Short Form-12.
Significant results ($P < 0.05$) are highlighted in bold.

TABLE 3: *Difference of mean values of standard measures related to the last inpatient stay*[a]

	t	*df*	*P*	CI 95%
Hope (FERUS)[b]	−1.019	84	0.311	[−4.73; 1.53]
Self-Efficacy (FERUS)	−2.202	87	**0.030**	[−5.90; −0.30]
Introspection (FERUS)	1.126	90	0.263	[−0.75; 2.72]
Stigma Resistance (ISMI)[c]	−2.365	79	**0.020**	[−2.28; −0.19]
Personal Recovery (RAS)[d]	−0.777	78	0.439	[−7.08; 3.10]
Mental Health (SF-12)[e]	−1.925	83	0.058	[−10.67; 0.17]
Physical Health (SF-12)	−0.323	83	0.748	[−5.47; 3.94]

[a]Time since last inpatient stay 0–1 years vs. ≥2 years.

[b]FERUS Questionnaire to Assess Resources and Self-Management Skills.

[c]ISMI Internalized Stigma of Mental Illness Inventory.

[d]RAS Recovery Assessment Scale.

[e]SF-12 Health Survey Short Form-12.

Significant results ($P < 0.05$) are highlighted in bold.

An essential and significant part of the training´s content focuses on different aspects of recovery. People who are well advanced in their recovery process may be able to deal with failure and manage challenges in a constructive way (Andresen *et al*. 2006; Leamy *et al*. 2011). Our results indicate that EX-IN training has a therapeutic effect by promoting considerable personal growth and skills in terms of recovery, reflectiveness and stigma management. These skills can be essential to manage one´s own mental health condition as well as to address the challenges of the work as PSW effectively (Cleary *et al*. 2018; Hegedüs *et al*. 2016; Hornik-Lurie *et al*. 2018; Moran *et al*. 2012). Especially in the context of the critical views of professionals related to PSWs' stability and recovery (Hornik-Lurie *et al*. 2018), PSW training becomes essential in the implementation of peer support in mental health services.

Another important point to discuss is the impact of the training on the participants' employment and salary situation. This aspect is of great importance because employment and income have a direct influence on the feeling of normalization (Vandewalle *et al*. 2018) and can be supportive for personal recovery (Bailie & Tickle 2015). Although our results showed improvements regarding employment, the income situation of the participants did not change. In another study, however, the results suggest that such effects often occur a year after completion of EX-IN training (Hegedüs *et al*. 2016). Similarly, Salzer *et al*. (2013) revealed an improvement of employment status after the PSW training by 28% of their study participants. However, employment does not always result in a reduction of public assistance payments. Receiving public assistance payments is related to the hours worked rather than to the length of employment (Johnson *et al*. 2014). The review by Walker and Bryant (2013) showed that graduates of PSW courses often receive only low hourly wages and are only employed for a limited number of hours. This is also in line with findings from the German-speaking part of Switzerland, where mean workloads lay between 13 and 15 hours per week (Burr *et al*. 2020; Hegedüs *et al*. 2016). Through consistent presence on the unit, increased workloads can facilitate the integration and consequently the acceptance of PSW in mental health teams (Mulvale *et al*. 2019).

Related to the topic of employment and working conditions, the question arises, whether EX-IN training should be offered predominantly as a job qualification or a vocational rehabilitation intervention. In some German federal states, EX-IN training is funded by the authorities as a vocational rehabilitation intervention aiming to include the participants into the labour market. However, the EX-IN training has mainly therapeutic effects on the participants in terms of increased recovery and consequently may have an impact on quality of life in general. Therefore, we argue that EX-IN training should not be offered with the exclusive goal to return to the labour market and reduce public assistance payments. The training should rather be open for participants whose overriding goal is to improve their recovery and self-care skills. The decision to re-enter the labour market as PSW needs to be made by the participants without pressure from the authorities.

The last important result shows that a psychiatric hospitalization in the year before the start of the training did not influence the individual results of the course negatively. Participants with recent hospitalizations are significantly lower in the target parameters at the beginning of the course but improve in absolute terms compared to participants in a better condition. Our results therefore tend to refute the fears and claims from professionals that PSW risk their own mental health (Hornik-Lurie *et al*. 2018) or should be in a stable phase or situation to do such training or work (Aguey-Zinsou *et al*. 2018). In addition, it disputes professionals' views that PSW are unable to cope when they return to work after a relapse (Kemp & Henderson 2012). Our results can be seen as a first indicator, that a recent relapse or hospitalization might be no contraindication for PSW training. It might even be considered as an intervention with therapeutic effects for those with psychiatric hospitalizations within the last year. However, the question arises as to whether PSWs with an unstable mental health are

equally suitable for peer support work. For example, we need more evidence regarding the extent of how the mental state influences the handling of potential challenges.

Limitations

Some limitations should be considered when interpreting the results: Firstly, the design without a control group does not allow assuming causalities between participation and outcomes. So it is unclear if other factors influenced the results or if the results are an effect of the natural recovery process. Since, most of the participants lived in a stable situation over a more extended period before starting the training, it can be assumed that at least a part of the effect is related to the EX-IN training. Secondly, we only included data from participants who took part in both assessment time points. Regarding this, results can be overestimated due to attrition bias. The 22.5% drop-out rate during the training seems to be similar to higher education courses for professionals (Swiss Federal Statistical Office 2005).

CONCLUSIONS

Peer services in mental health are expanding and are an integral part of recovery-oriented system change. EX-IN training has a positive influence on participants´ recovery process, introspection and their handling of stigma. This indicates that EX-IN training has a therapeutic effect on the participants. EX-IN training seems to meet the challenges of peer support work as PSW and health professionals expressed it. Therefore, the training can be recommended as preparation for working as a PSW as well as an intervention to improve one´s recovery process.

In order to better validate the effects of the training, studies with control groups should be performed. It could thus be shown to what extent the effects measured are a consequence of the training rather than a consequence of spontaneous remissions. Moreover, through the assessment of other outcome measures, such as self-care competencies or health literacy, we could generate more profound evidence of its therapeutic effect and the training´s suitability as a therapeutic intervention.

It should also be examined how many participants of the EX-IN training remain in the work as PSWs in the first, for examle, three years following training and what measures need to be taken to facilitate this step (Mahlke *et al*. 2014). With regard to the field of work of PSW in psychiatric settings, the motivation of leaders to prioritize peer support, establish partnerships with peer support organizations and recruit PSWs should also be investigated in order to further accelerate peer support (Forchuk *et al*. 2016). Studies with an extended observation periods and, for example, qualitative studies focusing on PSWs´ work environment are necessary to better understand mechanisms related to PSWs´ work situation and foster knowledge exchange. In addition, at present, we still know too little about the effects of peer support work in German and Swiss psychiatric institutions. Further research is needed to clarify those effects and assess the preconditions needed to offer effective peer support. This evidence could substantially improve PSW training and the provision of peer support work in mental health institutions.

RELEVANCE FOR CLINICAL PRACTICE

Peer support workers are individuals with lived experience of mental health problems and of service use who utilize their acquired knowledge and skills to support others challenged by similar conditions. They are an emerging workforce within mental health systems. It is recommended to prepare future peer support workers through specific training. The 'Experienced Involvement' training programme prepares and certifies individuals to work as peer support workers. Participants of the training significantly improved their recovery, stigma resistance and introspection during the training programme. Our results suggest that the training has a therapeutic effect and imparts skills that facilitate the entry into the labour market.

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ETHICS APPROVAL

Approval for the conduction of the study was granted by the ethic committee of the canton of Berne (Req-2020-00775). The ethical principles, according to the Declaration of Helsinki, were respected.

CONSENT TO PARTICIPATE

Written informed consent was obtained from all participants enrolled in the training.

CONSENT FOR PUBLICATION

All the authors approved the final version for publication.

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