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ORIGINAL ARTICLE

Non-peer professionals' understanding of recovery and attitudes towards peer support workers joining existing community mental health teams in the North Denmark Region: A qualitative study

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Abstract

Peer support is a collaborative practice where people with lived experience of mental health conditions engage in supporting like-minded. Peer support impacts on personal recovery and empowerment and creates value at an organisational level. However, the implementation of peer support into existing mental health services is often impeded by barriers embedded in organisational culture and support in role expectations. Non-peer professionals' recovery orientation and attitudes towards peer support workers (PSWs) are essential factors in the implementation of peer support, and this study explored non-peer professionals' understanding of recovery and their attitudes towards PSWs joining existing community mental health teams in one region of Denmark. In total, 17 non-peer professionals participated in three focus groups. Thematic analysis led to three themes: (1) Recovery is a process of "getting better" and balancing personal and clinical perspectives; (2) Realising recovery-oriented practice: a challenging task with conflicting values; and (3) Expectations and concerns about peer support workers joining the team. Recovery-oriented practice faces challenging conditions in contemporary mental health services due to a dominant focus on biomedical aspects in care and treatment. Implementation facilitators and barriers in the employment of PSWs point towards fundamental aspects that must be present when employing PSWs in an organisation. The issues described leading up to the employment of PSWs reflected in this study underpin the importance of preparing an organisation for the employment of PSWs based on the available knowledge.

KEYWORDS
focus groups, mental health services, peer support, qualitative research, recovery

INTRODUCTION

Recent years have brought a development in mental health services from traditional biomedical thinking towards an increased focus on rehabilitation and recovery (Keet et al., 2019; Stupak & Dobroczyński, 2021). However, this development is not a smooth transition and the social dimension of the biopsychosocial model continues to be neglected in mental health services

(Johnson, 2017). Current barriers to reach an increased focus on rehabilitation and recovery include the organisation of health care at a structural level, which causes fragmentation of mental health care, general health care, and social services (Bento et al., 2020). The movement towards more recovery-oriented practices within mental health services includes the development of services targeted people with severe mental health conditions living in the community, such as assertive community treatment (ACT) (Stein & Santos, 1998; Stein & Test, 1980) and flexible assertive community treatment (FACT) (van Veldhuizen, 2007; Van Veldhuizen & Bähler, 2015). One element of FACT that has been recognised as facilitating a recovery-oriented focus in clinical practice is the employment of peer support workers (PSWs) within mental health services. However, the implementation of peer support remains a challenge, for example, in regard to organisational culture, role clarity, and healthcare professionals' attitudes towards working with PSWs (Ibrahim et al., 2020). In this study, traditional healthcare professionals are referred to as non-peer professionals, and the study explored non-peer professionals' understanding of recovery and their attitudes towards PSWs joining existing community mental health teams in one region of Denmark.

BACKGROUND

Peer support is a collaborative practice where individuals make use of their personal experiences with mental health conditions to support like-minded (Ibrahim et al., 2020; Mutschler et al., 2022). Peer support has been described as the fastest growing workforce in mental health services, and PSWs increasingly become engaged in mental health practices in different ways. Building on a history of grassroots and activist movements, over the years the use of peer support has evolved and now includes the employment of PSWs into mental health organisations. This marks a move towards professionalisation of PSWs and may be the result of attempts to embed PSW into existing mental health services (Roennfeldt & Byrne, 2021). Peer support impactson personal recovery and empowerment and could potentially impact the working alliance between service users and non-peer professionals, and social network support (Cooper et al., 2024; White et al., 2023). Additionally, the employment of PSWs creates value at an organisational level (Ibrahim et al., 2020).

The international endorsement of the implementation of peer support is linked to an expectation that peer support can promote the recovery orientation of an organisation such as mental health services. However, the implementation of peer support into existing mental health services is influenced by barriers found in organisational culture, training, and support related to role expectations, and these need to be considered before and during implementation (Ibrahim et al., 2020). Additionally, a recovery-oriented organisational culture with openness to change and focus on person-centred principles can support the implementation of peer support (Byrne et al., 2022; Ibrahim et al., 2020). By contrast, an organisation with a traditional biomedical approach and a lack of commitment to peer support is an implementation barrier (Ibrahim et al., 2020).

Another important element to consider in employing PSWs is workplace preparation and continuous training of non-peer professionals in peer support and the PSW role to increase understanding of the value of peer support and to ensure role clarity (Byrne et al., 2022; Mutschler et al., 2022). Previous research has described how non-peer professionals possess knowledge about recovery and how this is linked with providing personalised care (Jørgensen et al., 2023). However, non-peer professionals also point towards some difficulties related to enacting recovery-oriented practices, as they experience a mismatch in delivering personalised care in mental healthcare contexts which are structured by standards that must be followed (Jørgensen et al., 2023).

Non-peer professionals' attitudes towards PSWs play an important role in the implementation of peer support, and qualitative studies have examined non-peer professionals' experiences with their own professional role and of working with the PSWs employed at their workplace (Järvinen & Kessing, 2023; Korsbek et al., 2021). In general, non-peer professionals had a positive attitude towards peer support, but expressed many concerns, for example, related to the difference between their own role and job function and that of their PSW colleagues, the relationship between the PSW and the mental health users, and issues related to PSWs keeping confidentiality (Grim et al., 2023; Järvinen & Kessing, 2023; Korsbek et al., 2021). Some concerns experienced by non-peer professionals decrease as collaborative relationships with PSWs develop (Korsbek et al., 2021). Based on these insights, it seems that unnecessary negative attitudes and expectations may develop among non-peer professionals prior to PSWs being employed and that this may influence how PSWs are welcomed into mental health services.

Building on existing knowledge about the role of the attitudes of non-peer professionals towards PSWs in the implementation of peer support, this study aimed to explore non-peer professionals' understanding of recovery and their initial attitudes towards peer support workers joining existing community mental health teams.

METHODS

Design

The study was designed as a qualitative focus group study. The epistemological stance of this study lies within constructionism and is built on the assumption

that the meaning that we ascribe to the world that surrounds us is contingent on our social practices and continuously shaped when we interact with our surroundings (Burr, 2003). Ontologically, this emphasises how individuals actively construct their own notions of reality through cognition resulting in the existence of multiple realities.

Setting

In 2020, eight PSWs were employed in eight newly established FACT teams in the mental health services of the North Denmark Region. The FACT model used in this setting is an adapted version of the original FACT model (Van Veldhuizen & Bähler, 2015) with a specific focus on selected elements. This local model worked with increased flexibility in the services delivered to each patient and the employment of PSWs. The PSWs are paid workers employed to work 20 hours per week in the existing teams and to support personal recovery in everyday practices.

The study setting comprised eight community mental health teams. The teams were part of the mental health outreach services that target adults (+18 years) with mental health conditions within the psychosis spectrum (ICD-10). This study was conducted during the implementation of FACT in the existing community mental health teams and sought to gain insight into what non-peer professionals experienced in the time leading up to PSWs starting their employment. From here on, we refer to the teams as FACT, as this is how they are identified in the mental health organisation. At the time of the study, the teams consisted of psychiatrists, nurses, psychologists, social workers, healthcare assistants, and one PSW. The average caseload in the teams was 20–25 patients. The teams had no prior experience with having PSWs employed.

Participants

In total, 25 non-peer professionals from the eight FACT teams were invited to take part in the study, and 17 participated. They were recruited using a combination of purposeful and convenience sampling (Patton, 2015). By applying purposeful sampling, the research team aimed for breadth among participants in gender, age, and occupational groups represented in the FACT teams. The sampling strategy included convenience sampling as it also became the pragmatic choice to recruit the non-peer professionals who were available at the specific times of data generation. The team managers provided information on potential participants, and these were approached by email. The participants had different occupational backgrounds (Table 1) and were affiliated with seven of the eight FACT teams. Seven of the participants had been appointed the role as peer mentors to the PSWs during the first year of the PSWs' employment. All new staff in the organisation were appointed a mentor. The peer mentors had been appointed to this task by their FACT manager.

Focus groups

Three focus groups were conducted in November 2021. The focus group method provided opportunity for accessing shared meanings and group norms (Green & Thorogood, 2018). Participants were grouped so that the three focus groups represented two different locations of the mental health service (focus groups 1 and 2) and the peer mentors (focus group 3). The focus groups were structured using a moderator guide containing questions related to the non-peer professionals' understanding of the concept of recovery and their attitudes towards PSWs joining their teams (Table 2). The questions were based on existing literature on what influences the implementation of peer support (Ibrahim et al., 2020; Mutschler et al., 2022). In the initial phase of the focus groups, participants were asked to write their immediate understanding of the concept "recovery." The focus groups were facilitated by a moderator (third author) and two observers (fourth author and a student, both with lived experiences). The focus groups were conducted in meeting rooms in the mental health organisation; they lasted between 103 and 104 min; and they were audio-recorded and transcribed (Table 1).

TABLE 1 Characteristics of participants and focus groups.

Focus group	Participants (*n*)	Female (*n*)	Age mean (range)	Years in mental health services mean (range)	Years in team mean (range)	Occupational groups represented	Duration
1	6	5	54 (41–65)	21 (9–31)	8 (1–31)	Registered nurse Psychiatrist Consultant	1:44:45
2	4	2	43 (34–61)	15 (3–32)	9 (3–16)	Registered nurse Social worker Psychologist	1:43:19
3	7	7	51 (40–58)	15 (10–23)	6 (2–16)	Registered nurse	1:44:11
Total	17	14	50 (34–61)	17 (3–32)	8 (1–31)		5:12:15

TABLE 2 Moderator guide.

Theme	Research question	Interview question
Understanding the concept "recovery"	What characterises non-peer professionals' understanding of recovery?	• How do you understand the concept "recovery?" • How do you understand the concepts "personal recovery" and "clinical recovery?" • Are you working recovery-oriented in your teams?
Attitudes towards PSWs joining the existing teams	What characterises non-peer professionals' attitudes towards PSWs joining their teams?	• What were your thoughts when you heard about PSWs joining their teams? • How did you experience the reactions of your colleagues? • How were you prepared for receiving the PSWs? • What do you know about the PSW function description and area of competences? • What do you know about the PSW training programme? • Are you familiar with the education, function description, and competencies of your other colleagues? • What do you think the PSWs' function should be in your teams? • Which patient groups could benefit from receiving peer support?
Future perspectives		• How do you see the future perspectives of peer support in the mental health services – is it something that is here to stay or is it only here for a few years to come? • Do you think that PSWs are a necessary part of treatment in the mental health services?
Close		• Does anyone have comments to share – something which you have not had the opportunity to say?

Reflexivity

Most members of the research team had lived experience of mental health conditions or being a relative to someone facing these challenges. Except for two, the members of the research team were employed in the mental health organisation where the study took place. None had prior working relationship with the participants, and there was no dependent relationship between the authoring team and the participants of the study. All, but one in the research team, were female.

Five members of the team were experienced researchers in the field of mental health and some with a particular focus on recovery. Planning of the research was done by two of the experienced researchers. Data generation involved members of the team with different experience and knowledge about recovery and the work of PSWs. The analysis was led by one of the experienced researchers, who did not take part in the generation of data. All authors were involved in drafting the manuscript.

Ethics

The invited non-peer professionals received written and oral information about the study and their rights as participants prior to giving their written consent to participate. The study was reported to the regional research administration. According to current legislation, no approval was needed from the regional research ethics board. The study was carried out in accordance with existing rules for storage and management of research data.

Analysis

The data were analysed using a thematic approach (Braun & Clarke, 2022). The flexible application of thematic analysis allowed for an inductive exploration of the data focused on patterned themes (Braun & Clarke, 2022). The analysis consisted of six phases: In phase 1, the authors familiarised themselves with the data material, which was read through several times. During this phase, the semantic content of the focus groups was described in memos. In phase 2, the first author developed initial codes to capture extracts of data related to non-peer professionals' understanding of recovery and their attitudes towards PSWs joining the teams. In phase 3, codes and memos were the basis for identifying initial themes across the material. In phase 4, the first author further developed the initial themes by merging content across the themes. Phase 5 entailed definition and naming of three final themes. The first, second, and last authors contributed to phase 5. In phase 6, a report on the three themes was written up and structured with contextualised quotes extracted from across the data material. All authors contributed to phase 6. Table 3 illustrates themes with data extracts.

The study was reported using the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007).

TABLE 3 Themes, descriptions, and supporting data.

Theme	Description	Examples of supporting data
(1) Recovery is a process of "getting better" and balancing personal and clinical perspectives	The theme unfolds the non-peer professionals' understanding of recovery and their perspectives on this as an individual process of "getting better." Recovery includes personal and clinical aspects, which should be combined in clinical work. Recovery represents an alternative way of thinking to the traditional biomedical model.	The first thing I wrote was also 'to get better' in quotation marks. And it's a process, a process which requires insight, a process which to the patient requires first and foremost an accept of the current state. (Focus group 1, participant 3) It's a very individual experience of finding the life that I want to live. What is that life to the individual? Quality of life, joy, meaningfulness? Well, it's not for me to decide whether there is recovery. It's up to that individual. And then maybe, on a professional clinical level, I don't think it works that well. But if the person thinks "Well, I'm actually living a good life", then this patient is going in the direction of recovery. (Focus group 1, participant 2) Well, I think that it's optimum if it goes hand in hand. And I think that we are also obligated to have eyes for both and to involve the patient in both. (Focus group 3, participant 6)
(2) Realising recovery-oriented practice: a challenging task with conflicting values	The theme depicts how existing structures in clinical practice challenge the possibilities for enacting recovery-oriented practice. It includes descriptions of individual attempts to be recovery-oriented and how this seems to be relying on a few persistent non-peer professionals across the teams.	Well basically, if you're a practitioner in this system and want to help them with personal recovery, then you stand between paradigms which are clashing right now. And more so than ever before, in that there are all these good thoughts in recovery, right, and I think most practitioners can see themselves in this role – it's meaningful, right. Because isn't it also what matters to all of us? It's about what we do being meaningful, right. […] And on the other side there is a system, where the conditions are totally locked, and then they just do like this [smashes hands together]. (Focus group 2, participant 3)
(3) Expectations and concerns about peer support workers joining the team	The theme describes the initial reactions and attitudes of the non-peer professionals towards PSWs joining their teams. These include both positive expectations and concerns. It depicts how unnecessary concerns were built in the time leading up to the employment of PSWs due to insufficient preparations.	Well, I thought yes, finally something is happening on the patient side in relation to all the superior guidelines that state: patient involvement, patient involvement. And how are we supposed to get that if the patient isn't present? This is about us hiring someone with user experience, so that we get the patient perspective out to all occupational groups. (Focus group 3, participant 7) I was thinking 'how do you get peer support into the treatment?' You know, how? […] What they could have in common with someone, is that they themselves have had or still has a mental illness, which has caused them to have symptoms, and that is what they can go out and talk with the patient about, I thought […] We always deal with treatment and symptoms and things like that. Do they go out and do the same? Without really having the experience other than their personal one. (Focus group 1, participant 1)

RESULTS

The analysis led to three themes, which were given as follows: (1) *Recovery is a process of "getting better" and balancing personal and clinical perspectives*; (2) *Realising recovery-oriented practice: a challenging task with conflicting values*; and (3) *Expectations and concerns about peer support workers joining the team*. Together, they unfold the non-peer professionals' understanding of recovery, their ways of trying to work recovery-oriented, and their initial attitudes towards PSWs joining their teams.

Theme 1: Recovery is a process of "getting better" and balancing personal and clinical perspectives

Across the focus groups, the non-peer professionals presented different understandings of the concept of recovery. In general, their immediate understanding was based on different versions of "*getting better*" or "*getting well after being ill*." They typically elaborated on this by adding descriptions of some processual aspects of recovery. One said:

> The first thing I wrote was also 'to get better' in quotation marks. And it is a process, a process which requires insight, a process which to the patient requires first and foremost an accept of the current state. And it is a process you get through via interaction, I think, between health care professionals and the patient.
>
> (Focus group 1, participant 3)

Some participants described recovery as a particular approach to understand psychiatry, which was built on hope and optimism. It was described as an alternative way of thinking about mental illness, which was not only based on a traditional biomedical perspective focused on diagnosis, symptoms, and reduction of illness, as one participant described:

> It's an alternative to an illness model where the mental health services for a long time have been thinking that people are as they are because there's something wrong with them. And they have symptoms, which you then try to repress or eliminate with different measures. I understand recovery as an alternative framework to this, which instead of focusing on deficits and symptoms and reduction is focused on things like self-understanding and the context of peoples' lives, their life story, and also agency, you know peoples' ability to act.
>
> (Focus group 2, participant 2)

In this way of thinking, recovery was lifted to a higher level than the individual process and reflected a broader way of thinking within psychiatry. In addition, some participants also elaborated their understanding using the concepts of personal and clinical recovery. One explained:

> There is the clinical [recovery]. And the personal, which is the inner; It's dreams, it's hope. Where the clinical concentrates on data and the outer assessments and clinical measures.
>
> (Focus group 3, participant 1)

The general understanding among the non-peer professionals was that personal and clinical recovery were two sides of the same coin and that they were obligated to include both perspectives in their everyday work practices, as one participant expressed it:

> Well, I think that it is optimum if it goes hand in hand. And I think that we are also obligated to have eyes for both and to involve the patient in both.
>
> (Focus group 3, participant 6)

Even though the participants described patients' recovery as something that they took part in, they also believed that only the person experiencing recovery from mental illness could know what this process entailed for his or her life. One participant explained:

> It's a very individual experience of finding the life that I want to live. What is that life to the individual? Quality of life, joy, meaningfulness? Well, it's not for me to decide whether there is recovery. It's up to that individual. And then maybe, on a professional clinical level, I don't think it works that well. But if the person thinks 'Well, I'm actually living a good life', then this patient is going in the direction of recovery.
>
> (Focus group 1, participant 2)

From the perspective of the non-peer professionals, their contribution to the patients' recovery processes was to approach collaboration with the patient in a way in which they could balance professional knowledge on psychopathology and symptoms with the needs, wishes, and preferences of each individual patient.

Theme 2: Realising recovery-oriented practice: A challenging task with conflicting values

Practicing in a recovery-oriented manner in everyday work situations was described by participants as a difficult task in the context of contemporary mental health services. According to the participants, everyday

practices in FACT were characterised by a strong focus on illness, symptoms, and medical treatment, leaving challenging conditions for enacting recovery-oriented practice. Several participants voiced critiques towards the organisation of the mental health services more broadly, which was perceived as constituting structural barriers to a recovery-oriented practice. One said:

> Well basically, if you're a practitioner in this system and want to help them with personal recovery, then you stand between paradigms which are clashing right now. And more so than ever before, in that there are all these good thoughts in recovery, right, and I think most practitioners can see themselves in this role – it's meaningful, right. Because isn't it also what matters to all of us? It's about what we do being meaningful, right. […] And on the other side there is a system, where the conditions are totally locked, and then they just do like this [smashes hands together].
>
> (Focus group 2, participant 3)

Such conflicting values were described as affecting everyday practices and resulted in recovery-oriented practices being something "*we need to think about*" or something "*we need to hold each other up to doing*." And so, rather than being a fundamental part of the mental health services recovery-oriented practices were portrayed as depending on a few non-peer professionals' individual attempts to enact a recovery-oriented approach. Some of the participants described how they believed they tried to be recovery-oriented in their approach to meeting the patients. One explained:

> I'm aware of finding a balance, and I'm very aware in my conversation with the patient that there is also a focus on managing life, hopes, and resources, and that's kind of what I see as the personal recovery. While the other part, where we speak about the symptoms and hearing voices, and delusions, I also include that part, because often we provide medicine to decrease those symptoms. So, I do see that part. That's the clinical [recovery].
>
> (Focus group 1, participant 4)

According to some non-peer professionals, mental health services had changed during the past 20 years approaching a more recovery-oriented practice and more active involvement of patients in their own treatment trajectories. Some linked the implementation of the FACT model in their own workplaces to approaching a more recovery-oriented mental health service. Especially, PSWs joining the teams was described as something that could impact on everyday practices making the non-peer professionals more aware of how they could take steps towards being more recovery-oriented.

Theme 3: Expectations and concerns about peer support workers joining the team

The non-peer professionals described a generally positive attitude towards the employment of PSWs; however, most expressed different forms of negative reactions such as worrying, reservations, or resistance.

Positive attitudes towards PSWs joining their teams arose from non-peer professionals welcoming a new perspective. A perspective that the traditional non-peer professional workforce could not provide and that would speak into the values of the organisation related to patient involvement. One participant said:

> Well, I thought yes, finally something is happening on the patient side in relation to all the superior guidelines that state: patient involvement, patient involvement. And how are we supposed to get that if the patient isn't present? This is about us hiring someone with user experience, so that we get the patient perspective out to all occupational groups. Even though we think we involve the patients, it's not certain that the consultant does it to the same extent or that the social worker knows what our patient is thinking of, dreaming about, or hoping for.
>
> (Focus group 3, participant 7)

Attitudes as the one expressed here reflected how some non-peer professionals believed that PSWs could potentially bring about a change in everyday practices that would increase their focus on the patient.

For some, the positive attitude was closely related to their individual expectations about what the PSWs were going to bring into their team and how it would play out in practice. A participant said:

> You know, my expectation was that the PSW should pave the road or build a bridge between something that we think is difficult and the patients […] I had great expectations that they would be able to do something quite special.
>
> (Focus group 3, participant 1)

In this way, some believed the PSWs would be a much-welcomed answer to some of the difficulties they could face in the team related to patients that were difficult to reach or to engage in their services.

Although these positive attitudes were present across the focus groups, the more negative attitudes and reactions outweighed the positive attitudes. Some

participants expressed feeling worried or sceptical when they heard about PSWs joining their team. Some explained how negative attitudes were caused by huge insecurity about what having PSWs joining their teams would actually mean. One stated:

> I was thinking 'how do you get peer support into the treatment?' You know, how? […] What they could have in common with someone, is that they themselves have had or still has a mental illness, which has caused them to have symptoms, and that is what they can go out and talk with the patient about, I thought […] We always deal with treatment and symptoms and things like that. Do they go out and do the same? Without really having the experience other than their personal one.
>
> (Focus group 1, participant 1)

Statements like this one were related to some non-peer professionals' uncertainty about what role the PWSs were supposed to fill in the team. Were they supposed to do the same as existing staff and what were their qualifications to do so? And how were they to manage having former patients joining the teams? In relation to this concern, some also expressed worrying about how PSWs – someone who was not trained in working as a mental health professional – would manage becoming part of the team and whether they would be able to respect the patients' boundaries.

The process leading up to the actual employment of PSWs was described by the participants as characterised by a general lack of information and a lack of clear explanations about what it would mean to be a PSW in their context of care. One of them said:

> I don't think I remember being prepared for it as such. Actually, I think that was what became my problem. Because when we were talking about, who was supposed to do what, then it was like everything is allowed. You know, like, where do the limits really need to be? At that point, I could have needed more clarity about, of course, what is it the PSWs are a part of? It was not an issue because they would be a part of everything, or is there someone, where you need to think a bit extra about whether to invite them [PSWs] along?
>
> (Focus group 1, participant 2)

The lack of information was not only related to the specific tasks that PSWs were supposed to be part of in the team. According to some of the non-peer professionals, the unclarity also applied for their understanding of the basic and core meaning of employing PSWs in the mental health services. As one explained:

> And then, what is the purpose of this? Because I could easily think that of course there is a purpose, but none of my colleagues knew what it was […] and then I actually started feeling sorry for those poor PSWs who were going to start working here, because well, they are to start in a new position and if I don't even know what they are supposed to do, then how are we going to teach them? Because I think there was way too little information about what it was supposed to be […] I think everything was very confusing.
>
> (Focus group 3, participant 5)

This lack of information and unclarity in the time leading up to the employment of the PSWs impacted on the non-peer professionals' possibilities for preparing for the arrival of the PSWs. Some of the participants experienced this as causing frustration and insecurity among the existing staff in the teams. The insecurity was related to whether the PSWs joining the team would lead to undermining of existing staff's professionality. One said:

> I think if there was someone who had articulated: 'the idea is dak-dak-dak' and 'for this to succeed, we need to help them by giving them room, showing them that it's actually okay to think differently than everyone else here' […] I think that would have prevented some of this. I believe that some have been afraid that they [PSWs] would steal their place and undermine their professionality. You need to be mega-clear about the 'we are better together'-thing, otherwise many people get insecure […] You know, I think that some have been afraid that they would come and state that 'what you do here is wrong' or something.
>
> (Focus group 2, participant 3)

Several of the participants advocated that more information, a clearer and more precise function description, and more preparation in general would have lessened their worries and made the process easier to handle. It seemed that unnecessary resistance was built among the non-peer professionals due to the insufficient preparations.

Some participants explained that the frustration and resistance they experienced among their colleagues might also be exacerbated by a general feeling of exhaustion caused by a continuous line of organisational changes initiated through top-down management strategies, leaving the staff with no choice or say in what was going on in their workplace. One participant mentioned:

> When such a message arrives, then the decision is already made. That also plays a role in who will say something and who will not. It is not like it is up for debate.
>
> (Focus group 2, participant 2)

According to some participants, this was related to the history of the mental health services, and in their experience, the decision to employ PSWs had been no different.

DISCUSSION

This study explored non-peer professionals' understanding of recovery and their attitudes towards PSWs joining FACT teams. They presented a general understanding of recovery as a process of "*getting better*," and their contribution to support patients' recovery was a collaboration building on their professional knowledge and the individual patient's needs, wishes, and preferences. However, recovery-oriented practice was challenged by primary structures in the teams, which were strongly influenced by traditional biomedical thinking, leaving the person-centred approach to rely on individual attempt from a few non-peer professionals. The attitude towards PSWs revealed an initial negative reaction from most non-peer professionals. Nevertheless, some also believed that PSWs would pave the way for an increased focus on the patient perspective.

Overall, our findings mirror those found in previous research, for example, the non-peer professionals' understanding of recovery, which has previously been described as a transformative process, where the person experiencing a mental health condition returns to a state without illness; see, for example, Kuek et al. (2023) and Le Boutillier, Chevalier, et al. (2015). However, our findings also contribute new aspects to the existing knowledge, and we will address some key points in the following.

A psychosocial approach to recovery-oriented practice has been described as difficult to implement and maintain in mental healthcare settings. Implementation barriers are found at system, care provider, and individual levels, constituting complex challenges in clinical care settings (Damsgaard & Angel, 2021). The biggest obstacle to the implementation of a recovery-oriented practice is the long tradition for biomedical thinking (Cusack et al., 2017; Damsgaard & Angel, 2021; Jørgensen et al., 2023; Le Boutillier, Slade, et al., 2015), which leaves poor conditions for the social aspects of biopsychosocial care approaches (Johnson, 2017). Psychiatry, as a biomedical speciality, has been criticised for being a gatekeeper of "true knowledge" even though uncertainty exists. This uncertainty advocates for a mental health service responsive to patient's values and delivering treatment and care that add value to the life of the patients beyond symptom reduction (Van Os & Guloksuz, 2022). A dominant focus on biomedical aspects was also reflected as challenging for practicing a recovery-oriented approach in our findings. Yet, some non-peer professionals expressed an expectation that the employment of PSWs would challenge the traditional biomedical approach and support a shift in focus towards person-centeredness in clinical practice. This finding mirrors that of previous research suggesting the integration of peer support and non-peer professionals enhances the rehabilitation of patients (Meurk et al., 2019; Parker et al., 2023). Nevertheless, moving towards a more recovery-oriented psychiatry cannot rely on single initiatives alone, but it involves institutional transformation (Slade et al., 2014). Therefore, expectations of PSWs to change an organisation with poor conditions for recovery orientation seem unachievable but might also be an expression of resignation and loss of hope of own influence to change practice towards person-centeredness.

Organisational culture, clear goals, recovery orientation, and openness to change have been described as important factors in the successful implementation of peer support in mental health services (Ibrahim et al., 2020). Also, a clear PSW role definition and staff willingness and ability to work with PSWs were stressed as important facilitators (Ibrahim et al., 2020). Lack of a clear PSW role was a common experience in our study. Concerns towards the employment of the PSWs were caused by a lack of information about the PSW role, the core meaning of employing PSWs, and being prepared to work together. This mirrors the findings of previous research reporting on the implementation of peer support in mental health services (Korsbek et al., 2021; Mutschler et al., 2022). Furthermore, previous research has described conflicting approaches as crucial barriers to the implementation of peer support and recovery-oriented practices. These conflicts arise when biomedically dominated structures are challenged by a social or psychosocial focus in care (Smith et al., 2023). In fact, much literature on implementation facilitators and barriers in the employment of PSWs is available and points towards fundamental aspects that must be present when employing PSWs in an organisation. Yet, the results of our study point in the direction that this knowledge has not been addressed and used in preparing the organisation for the employment of PSWs.

Some participants explained that frustration and resistance among their colleagues might also be exacerbated by a general feeling of exhaustion caused by a continuous line of organisational changes initiated through top-down management strategies, leaving staff with no say in what was going. Exactly, lack of involvement from stakeholders in the implementation of recovery-oriented practice has been found to impede the process (Piat et al., 2022).

Limitations

This study comes with certain limitations that need to be addressed. This study included only one mental health

service in Denmark, and the non-peer professionals in this study were interviewed in November 2021, almost 1 year after the PSWs were employed in the teams. This means that their initial attitudes towards PSWs were not captured until after they had become part of the teams. Hence, the participants' ability to recall their initial attitudes may have been influenced by events in the time that had passed.

Peer mentors were recruited to this study. Given the mentoring relationship they had with the PSWs, it was decided to place all mentors in one focus group in an attempt to minimise potential bias. One assumption was that the mentors could be overly positive towards the employment of PSWs. The reservations were minor in the focus group with the peer mentors. This may be the result of FACT managers only appointing peer mentors that had a positive and open approach to the employment of PSWs. However, the peer mentors also raised critical issues and voiced their concerns during the focus group discussions.

Due to a combination of reasons related to feasibility, our sampling strategy involved both purposeful and convenience sampling, and another limitation is related to how eight of the invited non-peer professionals did not participate in the focus groups after providing initial consent. Three were cancelled for various reasons on the day of the focus group and five failed to appear resulting in a total of 17 participants. As this number of participants represented the ones we were able to recruit, we did not consider the issues of data saturation. Even though some would problematise these circumstances and how they might affect study validity and generalisability of the findings (Vasileiou et al., 2018), this study contributes insights into specific human experiences, hence honouring the aim of qualitative research (Marshall, 1996).

CONCLUSION

This study explored non-peer professionals' understanding of recovery and their attitudes towards PSWs joining their teams. The participants recognised the importance of being recovery-oriented, but also highlighted how recovery-oriented practice continues to struggle in contemporary mental health services due to a dominant focus on biomedical aspects in care and treatment. The study points out how knowledge about implementation facilitators and barriers in the employment of PSWs was not addressed in the preparations made, resulting in unnecessary resistance among the non-peer professionals. Our findings mirror those found in international literature, underpinning transferability across countries and mental health organisations. Based on this, we advocate for the necessity of addressing known implementation barriers before the implementation of peer support – especially in organisations with no prior experience with peer support.

RELEVANCE FOR CLINICAL PRACTICE

The narrative about contemporary mental health services includes the aspirations to shift focus from a traditional biomedical approach towards an increased focus on rehabilitation and recovery. However, recovery-oriented practice faces ongoing challenges in clinical settings where the values of biomedical thinking continue to rule, leaving recovery-oriented practices to be the work of the few but also persistent employees. To achieve true change, fundamental values of care and treatment need to be addressed. Such a process is reliant on proper and thorough preparations and the involvement of employees at different organisational levels.

AUTHOR CONTRIBUTIONS

All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors, and all agree with the submitted manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interests.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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