Social Work in Mental Health

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/wsmh20

An exploration of recovery competence among Norwegian peer workers in substance abuse services

Rita Sørly, Kristina Sivertsen & Trond Stalsberg Mydland

To cite this article: Rita Sørly, Kristina Sivertsen & Trond Stalsberg Mydland (2021): An exploration of recovery competence among Norwegian peer workers in substance abuse services, Social Work in Mental Health, DOI: 10.1080/15332985.2021.1968988

To link to this article: https://doi.org/10.1080/15332985.2021.1968988

Published online: 01 Sep 2021.

SOCIAL WORK IN MENTAL HEALTH
https://doi.org/10.1080/15332985.2021.1968988

Routledge
Taylor & Francis Group

An exploration of recovery competence among Norwegian peer workers in substance abuse services

Rita Sørly Kristina Sivertsen, researcher (Nurse) Trond Mydland, senior researcher (Master degree Social Anthropology) [a,b], Kristina Sivertsen[b], and Trond Stalsberg Mydland[b]

[a]Social Work, Faculty of Child Welfare and Social Work, The Arctic University of Norway, Tromsø, Norway; [b]Department of Social Science, NORCE Norwegian Research Centre NORCE, Bergen, Norway

ABSTRACT

Peer recovery services (PRS) in Norwegian municipalities fill a gap in available care in mental health care and/ or substance abuse treatment. In this qualitative study, we interviewed six peer recovery workers (PRWs). Our aim was to explore how the PRWs understood their competences as vital for carrying out the work in PRS. Through a thematic analysis, we found themes the PRWs recognize as important in their recovery competence. The findings can be of practical relevance to those aiming to develop more recovery oriented mental health distress and substance abuse services.

KEYWORDS

Peer recovery services; peer recovery workers; user organizations; rehabilitation; substance abuse; mental health distress; thematic analysis

Introduction

In the Norwegian welfare state, the public sector provides most healthcare services. National guidelines for services aimed at people with mental health distress and/or substance abuse problems emphasize the importance of coordinated efforts among agencies, continuity and high quality in services, user involvement, and real opportunities for users to influence the provision of care (Ministry of Health & Care Services, 2011). Capacity pressure in health services has led to innovations that rely on contributions from civil society to mental health and substance abuse services.

One of these innovations is peer recovery services (PRS). The growth of PRS in Norwegian municipalities has brought opportunities to organizations and institutions that serve people with substance abuse and mental health distress. PRS fill a gap in available care, and the peer recovery workers (PRWs) in PRS provide a wide variety of services that seem to be beneficial in the pathway to recovery and a healthy life in the community (Eddie et al., 2019; Reif et al., 2014).

CONTACT Rita Sørly rsor@norceresearch.no Social Work, Faculty of Child Welfare and Social Work, The Arctic University of Norway, Tromsø, Norway

The data were collected in two different cities in southern and eastern Norway.

In this study, all the PRWs working for the PRS for former drug addicts had been trained through a user organization in order to be qualified to work as PRWs. The training provided knowledge of various public systems and treatment options, reflections concerning their roles and own recoveries, and various tools for help in engaging with people recovering from addiction. The training emphasized the role of experience competence, explores boundaries, and identifies possible challenges. Over a three-day course, the PRWs were also provided with knowledge of relevant public health rights. The work of the PRWs was then organized with the help of a program coordinator who followed up a team of several PRWs. This program coordinator has a key role in their training and supervision and is intended to offer guidance and support in both practical work tasks and in challenging situations that may arise.

In previous studies on PRS, the lived experiences of the PRWs are often highlighted as a central part of their competences (Davidson, Chinman, Sells, & Rowe, 2006; Kemp & Henderson, 2012; Kessing, 2021). But how do the PRWs themselves define and understand their competence? The research question in our study was *what do PRWs recognize as important when providing services to people with mental health distress and substance abuse problems? How can their knowledge be used to create more recovery-oriented services?*

Access to substance abuse treatment needs to be improved, and sustainable and cost-effective strategies for engaging and retain hard-to-reach individuals in care need to be identified (Dara et al., 2016). Knowing more about PRS and the required competence(s) can be a step closer to achieving more efficient and user-friendly services. By identifying what it takes to become a competent PRW, future training of PRWs can become more recovery-oriented, which will benefit both service users and the PRWs themselves.

This qualitative study examines how PRWs understand their own competences, and how their role as PRWs affects their own recovery process. We interviewed six PRWs working as paid employees for a nonprofit PRS and analyzed the interviews thematically, seeking to gain more knowledge of the competences of the PRWs and PRS they work for. This study contributes to the expanding literature on PRS and is aimed at practitioners and peers who work with recovery services in substance abuse and mental health care.

The recovery model and its connection to PRS

Recovery is a complex construct including many interconnected processes and outcomes underpinned by access to personal or social resources (Tew et al., 2015). The recovery model has been put forward as a counterpoint to traditional biomedical models in both mental health care and substance abuse related work and use of this model has led to a broader understanding of mental health and substance abuse issues and promoted social inclusion (Thornton & Lucas, 2011). However, there is little consensus about what "recovery" means, even though the

concept has become more familiar in mental health policy, practice, and research (Hummelvoll, Karlsson, & Borg, 2015). We understand the recovery model to include the following characteristics first listed by in a UK policy paper (2011, as cited in Thornton & Lucas, 2011, p. 24):

- Recovery is about building a meaningful and satisfying life, as defined by the person themself, whether or not there are ongoing or recurring symptoms or problems.
- Recovery represents a move away from a focus on pathology, illness and symptoms to a focus on health, strengths and wellness.
- Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives ("agency") and by seeing how others have found a way forward.
- Self-management is encouraged and facilitated. The processes of self-management are similar, but very different processes might be effective for different individuals. In self-management there is no "one size fits all".
- The relationship between a clinician and a patient moves away from being a typical expert/patient relationship to one where the expert is more of a "coach", or where the two parties are "partners" on a journey of discovery. Clinicians are there to be "on tap, not on top".
- People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles in local communities, and recovery cannot happen if services are segregated.
- Recovery is about discovering or re-discovering a sense of personal identity that is separate from illness or disability.

Community mental health care and outreach approaches have been established in Norway that draw on the perspectives of the recovery model. These innovative services have often been met by barriers rooted in the more traditional biomedical model, the dominant psychiatric cultures, and bureaucratic administrative procedures (Clossey, Gillen, Frankel, & Hernandez, 2016; Hummelvoll et al., 2015; Karlsson, 2008). Giving people a central position in their own recovering process and challenging the bureaucracies and hierarchies when promoting the ideal of human beings as equals, can be understood as a step away from those professionals' programs and orders (Hummelvoll et al., 2015).

The recovery process helps people feel as if they belong in their communities and assists them in establishing identities distinct from their mental distress or substance abuse (Davidson et al., 2006). PRS are effective for promoting feelings of community and empowerment and using PRWs helps to engage others seeking recovery (Brown & Townley, 2015). PRS can be defined as an outreach service for people with mental health distress and/or substance abuse issues, consisting of giving and receiving nonprofessional,

nonclinical assistance from individuals with similar experiences, conditions, or circumstances with the goal of achieving long-term recovery from psychiatric, and/or drug- or alcohol-related problems (Tracy & Wallace, 2016). Peer services provide an alternative to inpatient care and can help decrease costs associated with hospitalization or rehabilitation services. Internationally, countries have sought to reform services to maximize the potential of users and patients to have control over health care decisions and throughout their trajectory of care (Ness et al., 2014; Ness, Kvello, Borg, Semb, & Davidson, 2017). A recovery systems orientation involves collaborating with people's personal goals, conveying hopefulness, promoting choice, and focusing on people's strengths (Chinman et al., 2017). These services can be defined as a system of giving and receiving help founded on key principles of respect, shared responsibility, and a mutual agreement about what is helpful for people in similar situations (Mead, Hilton, & Curtis, 2001).

Andersson, Otterholt, and Gråwe (2017) found that users in residential addiction institutions in Norway were dissatisfied with the support provided for housing, finances, and employment. A study by Biringer, Davidson, Sundfør, Ruud, and Borg (2017) underlined that recovery is tightly interwoven with personal aims, hopes for future life, and expectations related to practical and financial problems, and that a more comprehensive approach is needed that provides more support with family issues, social life, education, work and financial issues. Hårvik (2018) stated there are challenges related to giving service providers ways to assess the quality of their services, increasing contact and dialogue with users, and gaining insight into user needs.

PRS are diverse and can take many forms and directions, including self-help, which is the name of the process of change from being a passive receiver of help to an active participant in life (Sjåfjell & Myra, 2015). Different PRS include help with self-help, where the focus is to identify one's own resources, take responsibility for one's own life, and steer that life in the direction one wants.

In this study, the PRS was performed by a nonprofit user organization for former drug addicts and people with mental health distress, focusing on help with self- help. Our aim was to explore how the PRWs in that PRS defined and understood their competences as contributing to (and perhaps even vital for) carrying out the work in PRS.

Methods

Context of the study

The context of the study was a new collaboration model and mentor program, namely a peer recovery service (PRS), that was organized by a national nonprofit organization. Former drug addicts were engaged as paid support

persons (PRWs) for other drug addicts who were in rehabilitation for substance abuse. Many of the service users also struggled with mental health distress. The PRWs, by virtue of their experiences of becoming drug-free themselves, function as a role models, bridges, and translators for the service users. Areas where the service users have had the greatest need for support from a peer have been inclusion in drug-free activities and in drug-free networks. Another important function that the peer served was as a translator and coordinator of public services and treatment facilities. The peer thus appears in this model as a personal, easily accessible "door opener" – a role model and a supporter for the service users (Author 2 & X, 2021). Each PRW is organized by a program coordinator, who establishes contact between the PRW and the person in need of assistance (a service user). The contact between the PRW and the service user is established based common denominators regarding their experience, background, interests, age, and the service users wants and needs. The program coordinators are responsible for follow-up and counseling the PRWs. Typically, PRWs work with their service user for up to two years.

Our hypothesis was that PRW training could be made more user-friendly and recovery oriented if we could explicitly identify the competences that the PRWs themselves thought would be important and useful in their roles as peer helpers.

Data were collected in two different cities in south and east Norway at the beginning of 2020, and interviews were performed by author 1 and 2. We did semi-structured, individual in-depth interviews with six PRWs. In Southern Norway, the PRS had been in operation for years, while in Eastern Norway, the PRS was established in 2018.

Informants and data collection

The informants were six PRWs of both sexes, between the ages of 35 and 55. They all worked in the peer recovery service provided by the same user organization. Some of them had worked in the organization for several years, others for less than one year. They were all recruited through their program coordinators in the nonprofit organization. The PRWs' mental health diagnoses or statuses as former substance abusers were not collected in this study. Information letters were distributed to the informants, and individuals who were interested in participating signed letters of consent. The informants could bring a companion to the interviews if they wanted, and they were asked what language they wanted to use during the interview. All interviews were conducted in Norwegian according to the wishes of the informants. A thematic interview guide was used. The main topics were related to the informants' own experiences with being a peer recovery worker. Most interviews were approximately 60 minutes long. The interviews were digitally recorded, and the sound files were transcribed verbatim. The excerpts from

the interviews presented in this paper have been transformed into coherent pieces. This process involved constructing comprehensive, condensed excerpts. Comments or questions from the interviewers were omitted to improve the coherence of the excerpts.

The interviews began with the open question "Can you tell me what made you become a peer recovery worker?" The open questions were designed to elicit a narrative account (Thornhill, Clare, & May, 2004), and the interviewees were invited to speak as freely as possible. The interviews varied in terms of how the informants told their stories. Some told their stories without interruptions, while others needed more prompting. Each new research interview represented new stories and a new storytelling (Author 1 et al., 2013). The study was approved by the Norwegian Center for Research Data in 2020. Ethical challenges in the study were obtaining informed consent, recruiting informants through the PRS program coordinators, participating in the storytelling during the interviews with care and ethical awareness, and asking questions related to the unexpected (Klausen, 2017).

Data analysis

Thematic analysis is one approach used to identify patterns of meaning across a qualitative dataset, and the method can offer great flexibility (Braun, Clarke, & Weate, 2016). The analysis is a product of deep and prolonged data immersion, thoughtfulness, and reflection, a process that is active and generative (Braun & Clarke, 2019). In line with Riessmann (2008), we performed an experience-oriented analysis that allowed the data to drive the analysis rather than attempting to fit the data into a preexisting coding frame or analytical preconceptions ((Klausen, Karlsson, Haugsgjerd and Lorem, 2016). By performing semi-structured interviews, we concentrated on understanding and accurately representing peer recovery competence among PRWs. As stated by Braun and Clarke (2019), qualitative research is about context-bound, positioned and situated meaning-making, and telling stories, interpreting, creating (but not discovering) the "truth" that is "out there" (or that is to be found in the empirical data). The approach chosen analyzes people's experiences in relation to PRS. We followed the analysis model as developed by Braun et al. (2016) through the following six phases: 1–2) familiarization and coding, 3–5) theme development, refinement, and naming themes, and 6) writing up. The analysis is a recursive process, and we moved back and forth among different phases. We analyzed the PRWs' stories in terms of particular patterns of shared meaning across the datasets rather than summarizing the data in relation to a particular topic (Braun & Clarke, 2019). The thematic analysis demonstrated the informants' complex experiences of being PRWs and contributes to the knowledge related to competences among the peers. The themes are "creative and interpretive stories about the data, produced at

the intersection of the researchers' theoretical assumptions, their analytic resources and skill, and the data themselves" (Braun & Clarke, 2019, p. 594). We have strived to make our analysis process transparent, reflexive, and collaborative rather consensus-seeking.

Results

The analyses were performed with the intention to provide rich descriptions from the breadth and complexity of PRWs' experiences, and four themes emerged. The themes can be understood as steps toward better knowledge about the skills required of a PRW and, in chronological order, describe the development of recovery competence. In the PRWs' experiences, knowledge is needed of 1) one's own experience with substance abuse. After that, knowledge is needed 2) to gain distance from one's own illness. Next, knowledge is needed about 3) recovery as a joint challenge, and 4), flexibility as a prerequisite for recovery services.

Theme 1) one's own experience with substance abuse

All the informants underlined the importance of their own experiences with substance abuse when working with the PRS, and they applied this expertise in different ways. One of the informants, a man that had been struggling with alcohol addiction for many years, explained that he can connect and relate to a service user on a different level than social workers, by virtue of his own experiences. He intentionally uses his own experiences to establish trust and destigmatize the service users' behaviors.

> *Two of them* [i.e., his service users] *have social workers that I assume are like YOU guys, that have read a lot about addiction and stuff like that. But they do not get through to these service users the way that I do, not at all. Because I can give them examples from my own life that are so bad . . . I have done some very weird crazy stuff, and I understand the way that they think, and they understand that I understand how they think. And they are honest with me about their drug abuse.*

Another PRW, a man who had been a drug addict for 25 years, had started as a peer four months before the study started. He said he wanted to use his painful self-experience to do something useful:

> *I feel that is a good feeling in a way . . . to be the one . . . be sober and, to be a role model for somebody else . . . But I don't know. I am done with drugs, so that's not a . . . But it gives me energy, of course, and courage and that sort of thing – to see people changing themselves.*

One peer, a man who had been a broker for years, had used drugs and alcohol until he couldn't cope anymore. He likes being a PRW and using his own experiences in the work made him realize how far he has come in his own recovery:

> *This job, I can handle this job excellently. I like what I am doing very much, and it is a plus for ME too . . . It is me helping him. [. . .] I am very motivated. I tell them* [his service users] *how I've been before, and how I am NOW. I have been where you are, I say, I have been there. Imagine how much better I am doing now! Everybody understands that.*

Another informant stressed the importance of having personal experiences with substance abuse:

> *But I also think that the whole mentoring scheme and how it works is great. I could probably have had more than three* [i.e., service users] *. . . It's an idea that's really great. Because we also — the group of recovery workers at the guidance meetings — we have a competence, and we can look each other in the eyes in a COMPLETELY different way than you will ever understand.*

The PRWs highlight several elements connected to own experience in the interviews. Connecting to service users in ways other than as professionals is defined as basic for establishing trust and destigmatization. Destigmatizing the service users means adding nonprofessional, but equally important, perspectives regarding addiction, illness, and care to the services. Using their experiences was seen as one way of expressing the PRWs' roles as experts on illness, substance abuse and the need for care.

Theme 2) gaining distance from one's own illness

The informants expressed development within themselves as they worked as PRWs. They got more practical knowledge of "what works" while working with people who are currently using drugs.

A man who had struggled with alcohol abuse for many years said he had quit his job as an accountant to start working with the PRS services. At the time of the interview, he had been a PRW for six years. He wanted something else in his life, and now he has gained competence in what he was doing:

> *I have become more experienced. When I think of new PRWs, they can become someone who makes things possible. [. . .] I think it is important that you* [as a peer recovery worker] *have a distance to drugs. And you must ask yourself if you are ready for this. It is very easy to become . . . co-dependent, or to become someone who makes things possible . . . if you don't have a certain – a certain . . . not distance, but like . . . not to be too close.*

Another man had just started as a peer recovery worker. He had one peer he was working with at the time of the interview, and he said:

> *I am open for that people I work with are currently using drugs. But we need to have a plan for that. [. . .] I remember how I was when I was using drugs, it was very easy just to push people away, avoid appointments and just forget things. [. . .] But now, I tell my service users that I have expectations.*

Another PRW underlined the necessity of being patient in the job:

> *It* [i.e. patience] *is important if the situation is getting out of balance. There can be surprises that you . . . are not ready for. You might have a service user that is . . ., that can . . . explode in anger . . . you name it . . . or something like that.*

The PRWs expressed that having distance from one's own substance abuse is vital for peer work, and sometimes they needed to concentrate to remind themselves of that. At the same time, it was important for the PRWs to accept that service users might be using drugs while still in a treatment process. In this way, the PRWs may expand the existing limited understanding of drug rehabilitation and contribute to alternative approaches to drug rehabilitation.

Theme 3) recovery as a joint challenge

The most significant challenge that all the informants talked about was the need for boundaries in the work as a PRW. Maintaining boundaries was difficult both in relation to maintaining appropriate distances in their emotional connection to the service user, and in relation to drawing boundaries for the amount time spent in peer work. Boundaries could also be an expression of difficulties that they needed to manage in their own recovery processes. Several of the PRWs emphasized the role and support of the program coordinator as significant to their work and well-being. All the informants indicated positive feelings toward their contact with the program coordinator. When asked about the monitoring by the program coordinator, one peer recovery worker said:

> *I think it works very well! I think it is great that we as peer recovery workers also get some guidance. (. . .) Because it is very important that we keep ourselves, in a way, healthy and drug-free and stuff. If not, it all goes down the drain.*

One PRW emphasized the need for emotional distance:

> *You know, I have been to [name of institution for drug rehabilitation], and people have been having lunch with me, and some hours later they are dead. You get used to . . . you get used to distancing yourself . . . from the big crises. [. . .] The most important is that you need to have like . . . an intimate zone, you have to learn . . . take it HERE, but don't let it get to you. [. . .] You have to protect yourself.*

Another PRW felt the need for boundaries in his work:

> *I must admit that one of them* [i.e. one of his service users] *is calling me too much. It is in fact a challenge for me. He calls and calls and calls, and I must talk with him for a long time. I am so TIRED of him. I am tired of him calling me. My coordinator, she called him, and told him not to call me that often. But he still does. [. . .] Completely without boundaries. I was in Spain in the weekend, and then . . . He called me both Saturday and Sunday, even though he knew I was in Spain with my family for the weekend. I did not pick up the phone.*

Another experienced PRW also talked about the danger of co- addiction:

> *For someone that is new in this game* [i.e., as a peer recovery worker],*there are triggers. And that you can fall to pieces yourself . . . Setting boundaries is so important. It's like; a drug addict can be . . . manipulative and get what he wants, you know. So, if there is a peer recovery worker that is very — who cares a lot — it becomes like a co-addiction, you know. It can become like that.*

One PRW talked about the problem of being too involved:

> *We* [i.e., PRWs] *have to take care so that we don't get too involved. I know other PRWs; they talk with their service users three times a day. I don't have time or the strength to that. I would have been exhausted.*

The PRWs valued guidance from the program coordinators and looked upon the guidance process as a part of their own recovery. Functioning as a PRW within substance abuse services was a part of their own way back to a more normal, drug-free life. The challenges with, and need for, boundaries also created pictures of their own recovery processes. They recognized the potential limitlessness of the service users, which helped them understand the need to set limits for themselves at the same time. So, in many ways, the recovery process is a joint challenge, which is something that the program coordinators, the PRWs and their service users need to be aware of, because they are all taking part in several ongoing recovery processes. In this process, working as a peer may be therapeutic in itself. As a PRW, one not only takes a responsibility for one's own recovery, but also for a service users' recovery.

Theme 4) flexibility as a prerequisite for recovery services

In contrast to most public health services, the PRWs are available outside ordinary working hours and also on the weekends. One PRW emphasized flexibility in the service as a way of creating a feeling of safety and availability for the service user.

> *She* [i.e, the service user] *knows she can call me at any time. But she never does. But it is just the safety – knowing that you can. And that's like – I have had a [drug rehabilitation] team following me for almost eight years now, and I have kept them, even though I'm doing fine. And they have been people I can call at any time. And I still can. And it's something about that — when you have that safety, you don't use it, because you know it's there. That feeling; you don't need to be in a bad shape 8 to 4 Monday to Friday. You can feel like shit in the weekends, too. That's the best part with this PRS services. You have this safety.*

Several of the peer recovery workers emphasized the benefits of flexible working hours, and that the flexibility in the work facilitated their own adaptation to working life. One of the men said the flexible organization of the PRS was important because it enabled him to better manage his everyday life:

> *It is wonderful that it is so free. I can choose to NOT meet anybody for a whole day and take a day off – I can be my own boss.*

Flexibility in how the PRWs approached the service users and how they chose to reach out to them was appreciated by the PRWs and was an opportunity to experience feeling of mastery in their work.

> *I think the most important thing you do is to create a good relationship* [with the service user]. *It is perhaps one of those . . . one of the things I like best to do, sort of, or am best at also, perhaps, to in a way create a sense of security.*

On the other hand, another PRW perceived the flexibility as a new experience in his working life and something he had to get used to:

> *I'm a man who is very much into structure. I have worked — I have worked with finance and accounting and payroll and stuff like that, so it's a bit like a shock . . . because [name of user organization] is like: Yes, okay, then we try it, and — yes, it is a little free [about structure] then. But at the same time, I love it, because it is very different from what I was used to. There is the fact that there is room to make suggestions and find new things to do.*

The flexibility needed in the services requires an understanding and acceptance of the life of the service users from the PRWs' view. The PRWs emphasized flexibility in terms of freedom by acknowledging that the mutual involvement of the PRWs and the service users may encourage greater social inclusion for both groups.

Discussion

This paper aims to contribute knowledge about PRWs' experiences with the PRS, and what they themselves recognize as important in their competences. People with previous addiction challenges, who act as paid support persons for others with ongoing substance abuse challenges, often feel the need to explain to professionals what they contribute in terms of mental health and substance abuse services (see Mancini, 2018). The thematic analysis revealed that the PRWs have four steps related to their own experiences as former drug addicts that they consider essential for being able to practice and develop as a peer recovery worker. In addition to earlier research literature, focusing on PRWs lived experience (Davidson et al., 2006; Kemp & Henderson, 2012; Kessing, 2021), we understand the PRWs four steps, as articulated in this paper, as prerequisites for practicing as a PRW.

The first theme is about the importance of one's own experience with substance abuse, which allows the PRWs to be experts on a particular illness. The PRWs' notions of their own recovery processes in relation to other people's processes is prominent. The second theme, getting some distance from one's own illness, underlines the importance of developing professional skills as a peer recovery worker. The PRWs in this study have developed a distance to their own substance abuse challenges, and they feel they can handle those challenges in a different way in relation to their service users.

They think about their own security, and they have an ongoing consciousness related to their own way out of addiction. One way of handling a peer's drug abuse is to keep an emotional distance and protect oneself, which is tightly interwoven with the third theme, being recovery as a joint challenge. The informants underlined the importance of not crossing important boundaries. Doing so is seen as a risk, not only to oneself, but also to the service user's recovery process: the PRWs are very aware of the double recovery process that is going on. The fourth and last theme is related to flexibility as a prerequisite to recovery services. "Normal business hours" is not necessarily adjusted to the life and routines that the service users live by, and not necessarily the PRWs' lives either. The PRWs expressed appreciation for being able to have different working hours and for being able to help somebody outside "office hours." Flexibility is also connected to the PRS and its approach to service users. When all these four steps are acknowledged by a PRW, she or he has gained a recovery competence necessary for practicing in PRS.

Our findings contribute to an understanding of the importance of recovery competence in the field of drug rehabilitation. This competence enables the PRWs to have a unique understanding of the service users' situations (Foster, 2011; Greenwood, Habibi, Smith, & Manthorpe, 2015; Kling, Dawes, & Nestor, 2007; Visa & Harvey, 2019). The informants in our study highlight the PRS as advantageous for the wellbeing of both PRWs and the service users. The relation between being a role model and being an expert-by-experience gives the PRWs an additional way to self-recovery while at the same time they are helping their service users. The PRWs give their service users emotional support, which leads to an enhanced ability to cope themselves (Visa & Harvey, 2019). The PRWs know, from their own rehabilitation, how important it is that support be flexible and accessible. To take control over one's own life again, and to stop being controlled by the need for drugs, one needs flexible support. Flexibility, from underneath the umbrella of support, can be thought of as the ribs from which successful rehabilitation derives. Flexibility is, in our view, closely related to mutual trust, trust that is based on the common ground of the peer's own experience with substance abuse.

From our point of view, there are several benefits of the PRWs having recovery competence within the PRS. We have categorized these benefits of competence into six themes: (1) the PRWs are experts on their own illness and need for care, and can therefore approach peers as equals (2) the PRWs have a variety of important perspectives on addiction, illness, and care, (3) the work of PRWs may help everyone better understand drug rehabilitation, (4) the PRWs can contribute alternative approaches to drug rehabilitation (the acceptance of service users being in a process to become drug free), (5) working with peer recovery may be therapeutic in itself, and, finally, (6) mutual involvement from the PRWs and the service users encourages greater social inclusion for both groups.

Limitations of the study

There were some methodological shortcomings to this study. We did not collect the diagnoses from the PRWs and knowing those details could have provided further richness to the findings. Furthermore, the study originally intended to include more interviews with more informants, but due to the Covid-19 pandemic, those plans had to be changed. Conducting the interviews face to face was an important issue for us, so instead of trying to interview people remotely, we decided to start working with the six interviews we had already collected. The study might have benefited from a larger sample, but the six informants reflected multifaceted experiences. The informants were recruited by their own program coordinators, which may have influenced their participation. Lastly, the informants also may have felt a pressure to positively evaluate the rehabilitation model. However, we informed them of our independence of their user organization and secured their anonymity. All the informants said they were happy to take part in the study, and they felt they were contributing to something important for the PRS.

Implications for practice

Our findings contribute to the understanding of how PRWs can supplement community health services and highlight the unique benefits that PRWs and former drug addicts can provide. These benefits can be important to peoples' rehabilitations, and for the wellbeing of PRW and the person in need of assistance.

Conclusions

The findings from this study can be of practical relevance to those aiming to develop mental health distress and substance abuse services, encourage greater patient participation, and further investigate aspects of participatory peer service development. The experiences of users are increasingly recognized as valuable assets and have been built into the development of different services, and co-produced goals have gained a greater focus. At this time, the role of municipal and specialist health services as service providers has diminished, which creates the need for participation in self-help and emphasizes the need for peer recovery workers (PRWs) to collaborate with service providers in service development. New organizational solutions promoting sustainable health services, recovery, coping, user involvement, and more efficient peer recovery services (PRSs) are needed to realize this opportunity. Collaborative practices can expand to embrace the active participation of service users (Beresford & Carr, 2016; Karlsson & Borg, 2013). The Norwegian government's policy on PRS

underlines the need to ensure user involvement through free treatment options, additional user-driven solutions, and stronger participation in designing the services (Ministry of Health & Care Department, 2016).

Acknowledgments

We would like to thank all the participants in the study for telling their stories and sharing their experiences.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The research was funded by the Norwegian Directorate of Health

ORCID

Rita Sørly Kristina Sivertsen, researcher (Nurse) Trond Mydland, senior researcher (Master degree Social Anthropology) http://orcid.org/0000-0001-9741-6472

References

Andersson, H. W., Otterholt, E., & Gråwe, R. W. (2017). Patient satisfaction with treatments and outcomes in residential addiction institutions. *Nordic Studies on Alcohol and Drugs*, *34* (5), 375–384. doi:10.1177/1455072517718456

Beresford, P., & Carr, S. (2016). Social care, service users and user involvement. *Aotearoa New Zealand Social Work*, *28*(2), 95. doi:10.11157/anzswj-vol28iss2id229

Biringer, E., Davidson, L., Sundfør, B., Ruud, T., & Borg, M. (2017). Service users' expectations of treatment and support at the community mental health centre in their recovery. *Scandinavian Journal of Caring Sciences*, *31*(3), 505–513. doi:10.1111/scs.12364

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. doi:10.1080/2159676X.2019.1628806

Braun, V., Clarke, V., & Weate, P. (2016). Using thematic analysis in sport and exercise research. In *Routledge handbook of qualitative research in sport and exercise* (pp. 191–205). New York, USA: Routledge.

Brown, L. D., & Townley, G. (2015). Determinants of engagement in mental health consumer-run organizations. *Psychiatric Services*, *66*(4), 411–417. doi:10.1176/appi.ps.201400150

Chinman, M., McInnes, D. K., Eisen, S., Ellison, M., Farkas, M., Armstrong, M., & Resnick, S. G. (2017). Establishing a research agenda for understanding the role and impact of mental health peer specialists. *Psychiatric Services*, *68*(9), 955–957. doi:10.1176/appi.ps.201700054

Clossey, L., Gillen, J., Frankel, H., & Hernandez, J. (2016). The experience of certified peer specialists in mental health. *Social Work in Mental Health*, *14*(4), 408–427. doi:10.1080/15332985.2015.1038412

Dara, M., Solovic, I., Sotgiu, G., D'Ambrosio, L., Centis, R., Tran, R., . . . Migliori, G. B. (2016). Tuberculosis care among refugees arriving in Europe: A ERS/WHO Europe Region survey of current practices. *European Respiratory Journal*, *48*(3), 808–817. doi:10.1183/13993003.00840-2016

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, *32*(1), 443–450. doi:10.1093/schbul/sbj043

Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., Hoeppner, B., . . . Kelly, J. F. (2019). Lived experience in new models of care for substance use disorder: A systematic review of peer recovery support services and recovery coaching. *Frontiers in Psychology*, *10*, 1052. doi:10.3389/fpsyg.2019.01052

Foster, K. (2011). 'I wanted to learn how to heal my heart': Family carer experiences of receiving an emotional support service in the well ways programme. *International Journal of Mental Health Nursing*, *20*(1), 56–62. doi:10.1111/j.1447-0349.2010.00710.x

Greenwood, N., Habibi, R., Smith, R., & Manthorpe, J. (2015). Barriers to access and minority ethnic carers' satisfaction with social care services in the community: A systematic review of qualitative and quantitative literature. *Health & Social Care in the Community*, *23*(1), 64–78. doi:10.1111/hsc.12116

Hårvik, V. (2018). Brukerstemmen i nord. [The users' voices in the north.] Rapport. MARBORG/RIO.

Hummelvoll, J. K., Karlsson, B., & Borg, M. (2015). Recovery and person-centredness in mental health services: Roots of the concepts and implications for practice. *International Practice Development Journal*, *5*. doi:10.19043/ipdj.5SP.009

Karlsson, B., & Borg, M. (2013). *Psykisk helsearbeid: Humane og sosiale perspektiver og praksiser. [Mental health care: Humane and social perspectives and practices]*. Gyldendal akademisk.

Karlsson, B., Borg, M., & Kim, H. (2008). From good intentions to real life: Introducing crisis resolution teams in Norway. *Nursing Inquiry*, *15*(3), 206–215. doi:10.1111/j.1440-1800.2008.00416.x

Kemp, V., & Henderson, A. R. (2012). Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. *Psychiatric Rehabilitation Journal*, *35*(4), 337–340. doi:10.2975/35.4.2012.337.340

Kessing, M. L. (2021). Doing peer work in mental health services: Unpacking different enactments of lived experiences. *Health Sociology Review*, 1–15. doi:10.1080/14461242.2020.1865183

Klausen, R. (2017). Relational insight and user involvement in the context of Norwegian community mental health care: A narrative analysis of service users' stories. PhD Thesis, UiT The arctic university of Tromsø, Norway

Klausen, R.K., Haugsgjerd, S. & Lorem, G.F. (2013) The Lady in the Coffin - Delusions and Hearing Voices: A Narrative Performance og Insight. *Qualitative Inquiry*,*19*(6), 431–440

Klausen, R.K., Karlsson, M, Haugsgjerd, S. and Lorem, G.F. (2016)Motherhood and mental distress: Personal stories of mothers who have been admitted for mental health treatment. *Qualitative Social Work*,*15*(1), 103–117.

Kling, L. W., Dawes, F. J., & Nestor, P. (2007). Peer specialists and carer consultants working in acute mental health units: An initial evaluation of consumers, carers, and staff perspectives. *International Journal of Psychosocial Rehabilitation*, *12*(2), 81–95.

Mancini, M. A. (2018). An exploration of factors that effect the implementation of peer support services in community mental health settings. *Community Mental Health Journal*, *54*(2), 127–137. doi:10.1007/s10597-017-0145-4

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, *25*(2), 134–141. doi:10.1037/h0095032

Ministry of Health and Care Department. (2011). Nasjonal helse og omsorgsplan (2011–2015). Meld. til Stortinget no.16. [Report 16 to the Storting (white paper) National Health and Care Services Plan (2011–2015)]

Ministry of Health and Care Department (2016). Proposisjon til Stortinget. Opptrappingsplanen for rusfeltet (2016–2020). [Proposition to the Storting. The escalation plan for the substance abuse field (2016–2020)]

Ness, O., Karlsson, B., Borg, M., Biong, S., Sundet, R., McCormack, B., & Kim, H. S. (2014). Towards a model for collaborative practice in community mental health care. *Scandinavian Psychologist*, *1*, e6. doi:10.15714/scandpsychol.1.e6

Ness, O., Kvello, Ø., Borg, M., Semb, R., & Davidson, L. (2017). "Sorting things out together": Young adults' experiences of collaborative practices in mental health and substance use care. *American Journal of Psychiatric Rehabilitation*, *20*(2), 126–142. doi:10.1080/15487768.2017.1302369

Reif, S., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., … Delphin-Rittmon, M. E. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, *65*(7), 853–861. doi:10.1176/appi.ps.201400047

Riessman, C. K. (2008). *Narrative methods for the human sciences*. SAGE, California, USA: Sage.

Sivertsen, K. and Stalsberg Mydland, T. (2021). Likepersontjenester innen rus og psykisk helse under covid- 19 - utfordringer og muligheter. Tidsskrift for psykisk helsearbeid, 18 (02), 222–228.(2019)

Sjåfjell, T. L., & Myhra, A. B. (2015). Selvhjelp og likemannsarbeid – Mulige verktøy for å oppnå mestring og empowerment? [Self-help and peer work – Possible tools to achieve mastery and empowerment?]. *Tidsskrift for Psykisk Helsearbeid*, *12*(2), 140–148. doi:10.18261/1504-3010-2015-02-05

Tew, J., Larsen, J., Hamilton, S., Manthorpe, J., Clewett, N., Pinfold, V., & Szymczynska, P. (2015). 'And the stuff that I'm able to achieve now is really amazing': The potential of personal budgets as a mechanism for supporting recovery in mental health. *British Journal of Social Work*, *45*(suppl_1), i79–i97. doi:10.1093/bjsw/bcv097

Thornhill, H., Clare, L., & May, R. (2004). Escape, enlightenment and endurance: Narratives of recovery from psychosis. *Anthropology & Medicine*, *11*(2), 181–199. doi:10.1080/13648470410001678677

Thornton, T., & Lucas, P. (2011). On the very idea of a recovery model for mental health. *Journal of Medical Ethics*, *37*(1), 24–28. doi:10.1136/jme.2010.037234

Tracy, K., & Wallace, S. P. (2016). Benefits of peer support groups in the treatment of addiction. *Substance Abuse and RH*, *7*, 143–154. doi:10.2147/SAR.S81535

Visa, B., & Harvey, C. (2019). Mental health carers' experiences of an Australian carer peer support program: Tailoring supports to carers' needs. *Health & Social Care in the Community*, *27*(3), 729–739. doi:10.1111/hsc.12689