World Health Organization

European Region

Transforming mental health through lived experience

Roadmap for integrating lived and living experience practitioners into policy, services and community

Abstract

Integrating lived/living experience practitioners into health-care and social systems is crucial to realizing recovery-oriented mental health care. Practitioners model recovery and bridge gaps between traditional health-care structures and service users, humanizing and promoting inclusivity of services. This roadmap, co-created under the WHO Regional Office for Europe's collaboration with the European Commission under the "Addressing mental health challenges in the European Union, Iceland and Norway" project, provides a structured framework to integrate lived/living experience expertise into mental health systems and workforce through six essential actions. Case studies from a variety of European countries are presented to illustrate these actions in practice. The roadmap is for use by governments, mental health policy-makers, service providers, people who use services, lived/living experience workers and advocates.

Keywords

MENTAL HEALTH, MENTAL HEALTH SERVICES, RECOVERY, HEALTH WORKERS, HUMAN RIGHTS, HOPE, POLICY

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Contents

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Catherine Brogan (operational lead and project manager) and Michael Ryan (taskforce chair) directed the project. Ronda Barron served as senior researcher, developing the research and mapping methodology, writing the first draft of the roadmap, and incorporating feedback from taskforce members and consultation participants into subsequent drafts. Sarah McEntire served as research assistant, writing sections and compiling case studies. Elona Bokshi and Claudia Marinetti co-organized in-person and online consultations with participating countries to refine the roadmap content. Jason Maurer and Melita Murko wrote sections of the document and ensured its adherence to the project outputs, under the technical guidance of Natasha Azzopardi-Muscat and Ledia Lazëri, WHO Regional Office for Europe.

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Glossary

This glossary integrates core definitions aligned with Mental Health Europe's Glossary *(1)* and the roadmap's principles. It aims to provide clarity and promote shared understanding among diverse stakeholders.

Authenticity	Authenticity is the quality of being genuine, transparent and true to oneself, reflected in the ability of lived/living experience practitioners to share their stories, experiences and insights without compromising their individuality. Authenticity is foundational to building trust, fostering connections and modelling recovery in mental health systems.
Boundary management	This is the practice of establishing and maintaining clear boundaries in professional relationships, especially in peer support roles.
Burnout prevention	Burnout prevention refers to strategies and practices aimed at reducing the emotional, physical and mental exhaustion caused by prolonged stress or demanding work environments.
Co-creation	Co-creation is a collaborative approach where stakeholders – including individuals with lived experience, policy-makers, service providers and communities – work together as equals to design, implement and evaluate mental health policies and services. It is rooted in inclusivity, respect and shared power to ensure that outcomes reflect diverse needs.
Community-based care	Community-based care includes a range of services that enable individuals to live and thrive in their communities rather than in institutions. This model promotes social inclusion, autonomy and access to mainstream services like housing, health care and education.
Dual identity	The concept of dual identity refers to the combination of personal experience and professional responsibilities of lived experience practitioners.
Experts by experience	Experts by experience are individuals with lived experience of mental health problems who have gained expertise through advocacy, peer support roles or policy contributions. Their input ensures that systems and services are informed by firsthand insights.
Hierarchical barriers	Hierarchical barriers are structures or norms in organizations that maintain a power imbalance between different roles, often limiting open communication and collaboration.
Lived/living experience	In mental health systems, lived/living experience refers to personal experience of emotional and cognitive challenges that may or may or may not have led to encounters with mental health services. It is the learning that arises from these experiences: how this feels; what helps and what hinders; what could have been done better; and what was absent. These experiences constitute the wisdom arising from adversity that can bring a distinct and complementary expertise to mental health service design, delivery, policies, practice and workforce. It highlights the expertise derived from these experiences, emphasizing their value in shaping recovery-oriented systems and policies.

Mutuality	In a peer support context, mutuality refers to the reciprocal and non-hierarchical relationship between peer support workers and those they support, where both individuals are seen as equally valuable and contribute to the process.
Organizational capacity-building	Organizational capacity-building refers to the process of improving an organization's ability to achieve its goals by enhancing skills, resources and infrastructural support.
Peer support	Peer support refers to the mutual support offered by individuals who have experiences of similar struggles and challenges. Together they are able to generate a sense of possibility/hope; develop shared solutions; and provide practical, social and emotional support. Peer support fosters trust and shared understanding, and can occur informally or through structured roles like lived/living experience practitioners.
Recovery	Recovery is a self-defined and personal process of building a meaningful life, even with ongoing mental health problems. It emphasizes hope, autonomy and the pursuit of individual goals, diverging from clinical recovery focused solely on symptom reduction.
Role ambiguity	Role ambiguity refers to uncertainty about job responsibilities and expectations, which can lead to confusion in the workplace.
Service user	A service user is an individual currently accessing mental health services. The term shifts focus from clinical or passive identities to active participation in service design and decision-making.
Trauma-informed care	Trauma-informed care is an approach to service delivery that acknowledges that there are situational contexts and relationships with characteristics of past traumatic events or in which there is a perceived threat, which may occasion trauma responses. The approach recognizes the impact of trauma; emphasizes physical, psychological and emotional safety; and fosters an environment that promotes recovery and empowerment. It incorporates an understanding of the prevalence of trauma and its effects on individuals, which can be used in all aspects of life as well as within mental health systems.

Reference

1. Mental health: the power of language. Brussels: Mental Health Europe; 2024 (https://www.mentalhealtheurope.org/wp-content/uploads/2025/02/Mental-Health-Europes-Glossary-2024-edition-FINAL.pdf, accessed on 12 May 2025).

Executive summary

Lived/living experience refers to the wisdom arising from mental health adversity – it can bring a distinct and complementary expertise to mental health service design, delivery, policy and practice and the mental health workforce. Integrating lived/living experience practitioners into health-care and social systems is crucial to realizing recovery-oriented mental health care. Lived/living experience practitioners model recovery and bridge gaps between traditional health-care structures and service users, humanizing and promoting inclusivity of services.

This roadmap, co-created under the WHO Regional Office for Europe's collaboration with the European Commission under the "Addressing mental health challenges in the European Union, Iceland and Norway" project, provides a structured framework to integrate lived/living experience expertise into mental health systems and workforce. Its goal is to empower countries to move away from tokenistic inclusion and towards co-creation of mental health services, while acknowledging the systemic challenges of integrating these roles – including resistance from traditional staff, policy constraints and funding inconsistencies.

The roadmap framework is laid out in six actions:

1. strengthening policy by advocating for including lived/living experience practitioners within national mental health policies and strategies, ensuring alignment with recovery-oriented principles;
2. building capacity for organizational readiness by strengthening organizational systems and culture to support the effective integration of lived/living experience practitioners into multidisciplinary teams and broader mental health systems, ensuring alignment with recovery-oriented principles;
3. promoting co-creation, collaboration and integration by embedding co-creation principles in designing, delivering and evaluating mental health services to ensure that lived/living experience and other forms of expertise inform systemic improvements;
4. standardizing training and certification by co-creating and implementing standardized training and certification programmes for lived/living experience practitioners that ensure consistency, professionalism, fidelity to lived experience principles and recovery-oriented practice;
5. enhancing supervision and support by establishing reflective and strengths-based clinical/practice supervision models to provide lived/living experience practitioners with the support to manage emotional challenges and navigate professional expectations, while maintaining best practice and fidelity to the principles of lived experience professional roles; and
6. expanding access through accessible and digital tools by using digital platforms to expand the reach of lived/living experience practitioners, particularly in remote and underserved areas.

Understanding the transformative potential of lived/living experience practitioners in creating recovery-oriented services is critical to envisioning a future where mental health systems are accessible to everyone.

Quick guide

The purpose of this roadmap

This roadmap provides a structured framework to integrate lived/living experience expertise into mental health systems and the mental health workforce. It emphasizes the value of personal experience of recovery in creating more inclusive, engaged and effective mental health systems. The roadmap offers actionable steps to recognize and embed lived/living experiences as a core component of policy, practice and culture.

Why this roadmap is needed

WHO has been promoting the value of lived/living experience in mental health systems for decades. However, in practice, the inclusion of lived/living experience in professional capacities is often tokenistic, and frequently lacks sustainability. This roadmap aims to correct the course across the WHO European Region by offering a set of essential actions that support a standardized approach to integrating people with lived/living experience into mental health systems. The European Commission has also long been a champion of this approach, and this work has been made possible thanks to the Commission's collaboration with the WHO Regional Office for Europe on the "Addressing mental health challenges in the European Union, Iceland and Norway" project.

Who this roadmap is for

The roadmap is for use by governments, mental health policy-makers, service providers, people who use services, lived/living experience workers and advocates. It is particularly relevant for organizations transitioning to recovery-oriented care models and those looking to integrate intentional lived/living experience practitioners into their services. Additionally, it provides guidance for training institutions and community leaders involved in mental health reform.

How to use this roadmap

This roadmap outlines essential actions for including lived/living experience in a variety of professional roles within mental health systems. It offers a flexible, best-practice approach wherein actions should be taken based on the user's starting-point and needs. It can also be used to advocate transformation of policy, practice and culture within local and national contexts. It emphasizes a collaborative approach, encouraging co-creation/co-production between stakeholders, including individuals with lived experience, clinicians and community organizations. The roadmap also sets out actions to address systemic barriers, foster inclusion, build capacity and promote sustainable frameworks for lived/living experience roles. Within each action area, there are several country case studies to show the application of action steps in practice.

Background

Lived/living experience is the wisdom arising from experiencing – and in many cases recovering from – a mental health adversity. It can bring a distinct and complementary expertise to mental health service design, delivery, policy and practice and the mental health workforce. This roadmap aims to support countries in applying this wisdom effectively.

The evolution of lived/living experience in mental health care is deeply rooted in the human rights and equity movements that stress dignity, self-determination and access to high-quality care. Recovery has been described as the new worldwide paradigm of the 21st century in mental health systems, and there is increasing recognition that the transformation of mental health systems to a recovery perspective requires collaboration among all stakeholders *(1)*. Recovery can be defined in a number of ways. Mental Health Europe defines it as a personal process aimed at leading a meaningful life, regardless of symptoms *(2)*. Anthony's *(3)* description of recovery is frequently used within the literature:

> *a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/ or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*

According to the WHO QualityRights training modules, the meaning of recovery can be different for each person. For many people, recovery is about regaining control of their identity and life, having hope for their life, and living a life that has meaning for them – through work, relationships, community engagement, spirituality or some or all of these *(4)*.

This concept of recovery in mental health differs from clinical recovery, which focuses on alleviating symptoms and restoring previous levels of functioning. Personal recovery is about managing mental health problems and achieving a fulfilling life as defined by the individual. However, the interconnectedness of health, economic stability, social interaction, housing, personal relationships and support systems in shaping mental health outcomes should not be neglected, as these are all intertwined within and across a person's life *(5)*. Recovery can therefore be considered an umbrella term that encompasses the range of elements that contribute to a person's wellness.

Grass-roots movements have played a pivotal role in advocating inclusion of lived/living experience in mental health care, where equity is a key guiding principle. Based on shared experience and mutuality, lived/living experience interventions such as peer support work have proved effective in creating culturally relevant and accessible care pathways for those often excluded from traditional systems *(6,7)*. Evidence also highlights that lived/living experience roles contribute significantly to personal recovery and professional development, strengthening recovery-oriented systems *(8)*. Moreover, the integration of lived/living experience practitioners has fostered cultural shifts within organizations, making mental health systems more inclusive and equitable *(9,10)*. The role of lived/living experience is crucial in promoting equitable mental health care, and should be highlighted to policy-makers and stakeholders *(11)*.

International human rights frameworks have further reinforced the importance of lived/

living experience in mental health systems. Notably, the United Nations Convention on the Rights of Persons with Disabilities *(12)* emphasizes the right of individuals with disabilities – including mental health conditions – to participate in decisions affecting their lives, and to access support that promotes independence and inclusion in society. Lived/living experience practitioners help to uphold these rights by:

- promoting autonomy: empowering individuals to define their recovery journeys;
- reducing stigma and discrimination: challenging societal and systemic discrimination through shared lived/living experience;
- enhancing accessibility: addressing barriers disproportionately affecting marginalized groups, such as language, culture, and socioeconomic status *(11)*; and
- inspiring hope: modelling recovery, which inspires hope in other experiencing mental health challenges and acts as a key catalyst of recovery *(13)*.

Since the adoption of the Convention on the Rights of Persons with Disabilities, WHO has worked continuously to support countries in its implementation. The WHO QualityRights initiative has been the backbone of these efforts, aiming to build capacity to fight stigma and discrimination, and to promote community-based services that respect and uphold human rights, while advocating for better policy and legislation. Key to making these services effective, helpful and acceptable to people is creating a service culture that embraces lived/living experience as essential to person-centred, rights-based and recovery-oriented mental health care. To date, the WHO QualityRights initiative has produced extensive training and guidance materials to facilitate these efforts *(4)* (Box 1).

Box 1. The WHO QualityRights initiative

The WHO QualityRights initiative aims to address the extensive and wide-ranging violations and discrimination experienced by people with mental health conditions around the world. Under the initiative, WHO has developed a comprehensive package of training and guidance materials *(4)* to build capacity and knowledge about how to implement a human rights and recovery approach in mental health, based on the United Nations Convention on the Rights of Persons with Disabilities and other international human rights standards. The target audience for these materials includes mental health workers; people with psychosocial, intellectual and cognitive disabilities; people using mental health services, their families, care partners and other supporters; nongovernmental organizations; organizations of people with disabilities; and others. The WHO QualityRights initiative ultimately aims to change mindsets and practices in a sustainable way, and to empower all stakeholders to promote rights and recovery in order to improve the lives of people with psychosocial, intellectual or cognitive disabilities. The full list of WHO QualityRights tools and other relevant guidance is found in the Annex.

Recovery-oriented care is a key principle of lived/living experience practice, emphasizing self-determination, hope and personal empowerment over clinical symptom management. It recognizes recovery as a unique journey shaped by individual values *(11)*. Empowerment and mutuality are central to lived/living experience practitioners, fostering relationships where everyone involved gains insight *(14,15)*. Lived/living experience as expertise also challenges traditional knowledge hierarchies, highlighting the importance of the perspectives of those who have faced mental health problems *(6)*.

Lived/living experience practitioners use this expertise to enhance understanding of the experiences of people using services and of the practices, relationships and cultures that sustain power imbalance; perpetuate hopelessness and helplessness; impose limitations and lack of opportunity; and keep the focus on disability and dysfunction rather than strengths and resources. By drawing on their own experiences of recovery, people in these roles can normalize individual journeys, break down hierarchical barriers, and encourage open conversations that promote recovery and – above all – introduce the hope that recovery is possible.

Lived/living experience roles require a context in which equity and human rights are protected and fulfilled. However, this varies considerably by country and region. There is also variation within countries and across demographic groups *(16)*. Marginalized groups – including migrants and refugees, people from LGBTQI+ communities, people with disabilities, people from minoritized ethnic and racial groups, and people with unstable housing or who are homeless – face additional barriers that require targeted interventions. Lived/living experience practitioners can transform mental health systems, but ongoing efforts are needed to ensure that everyone benefits.

Defining lived/living experience practitioners

The terminology related to lived/living experience practice can differ based on context, role expectations and level of involvement. Table 1 provides a snapshot of terminology found in the literature to illustrate differences in lived/living experience roles and their application in mental health systems. Recognizing the diversity in roles allows organizations and policy-makers to create frameworks that support collaboration while maintaining role clarity *(17)*. However, for ease and a common shared understanding of language, this roadmap uses the term "lived/living experience practitioner" to capture the broadness and diversity of roles.

Table 1. Different lived experience roles and their applications in mental health systems

Role	Application	Source
Experienced involvement worker	Formalized lived/living experience practitioner	Hegedüs et al. *(18)*
Peer consultant	Adviser on service design	Balková *(14)*
Recovery specialist	Practitioner offering recovery-oriented care	Tate et al. *(19)*
Consumer provider	Lived/living experience practitioner	Hamilton et al. *(20)*
Peer supporter	Lived/living experience practitioner	Kane et al. *(21)*
Peer mentor	Lived/living experience practitioner; often used in addiction recovery	Kowalski *(22)*
Lived/living experience practitioner	Practitioner with recovery expertise	Owen et al. *(23)*
Mental health peer or recovery specialist	Practitioner with lived experience of mental health and/or substance use problems	Tate et al. *(19)*
Peer support worker	Lived/living experience practitioner	Erasmus+ project to create Europe-wide working standards for peer support workers *(24)*
Recovery coordinator	Lived/living experience practitioner with organizational responsibilities	Ireland's Mental Health Engagement Framework 2024–2028 *(25)*
Expert by experience	Practitioner of mental health education or service delivery	Happell et al. *(26)*

In mental health systems, "peer supporter", "peer worker" and "peer educator" are sometimes used interchangeably as exemplars of lived/living experience practitioners. However, these terms represent different applications and aspects of these roles, and it is important to understand these distinctions. They highlight varying applications of lived/living experience through their responsibilities, skills and contributions; however, all are underpinned by the same principles and values. In some cases, these roles are not mutually exclusive *(10,23)*.

- **Peer supporters** offer emotional connection, hope, support and shared experiences to individuals facing mental health problems. This role can be informal or formal, and focuses on building trust through empathy and mutual understanding rather than structured interventions. Peer supporters provide emotional and personal support founded on shared experiences and mutual reciprocal relationships, where understanding and learning can be enhanced; solutions generated; and self-efficacy, confidence and hope improved *(7,16)*. Peer support is also applicable, and should be encouraged, in non-mental health contexts.
- **Peer support workers** apply lived/living experience within formal health-care systems, often as part of multidisciplinary teams. Through their presence, they act as role models for recovery, and offer a greater sense of hope and understanding of the potential for recovery for the individual. They also perform structured tasks like facilitating recovery-focused workshops, assisting with care planning and promoting engagement of service users. Their role includes navigating organizational policies, adhering to ethical frameworks, and participating in supervision and training programmes *(14,15)*. While drawing on their lived experience, peer support workers also have professional responsibilities, including maintaining boundaries and meeting performance standards *(27)*. In many cases, peer support workers also contribute a lived/living experience perspective to service planning, delivery and evaluation, working in equally valued partnerships with other members of the team to co-create decisions that reflect generative and inclusive conversations between professionals and people with lived/living experience.
- **Peer educators** act as a bridge between people who use services and knowledge-sharing initiatives. They facilitate shared learning, co-create and co-facilitate recovery education programmes, and promote mental health awareness in various settings. They use their lived experience to make theoretical concepts relatable, working in schools, workplaces or health-care organizations to promote mental health, reduce stigma and build capacity *(11)*. Some peer educators also facilitate the connection of recovery education participants to the recovery process (as "recovery educators"). Recovery education is built on adult education principles. These peer educators facilitate recovery-related learning and growth by offering safe spaces to reflect on and explore what recovery might mean at an individual level, and the individual's own role in it. Knowledge-sharing and psychoeducational programmes can be part of recovery education *(7)*.

Lived/living experience practitioners as a whole make several unique contributions to mental health care systems, including the following.

- By sharing their recovery stories and lived/living experience, practitioners reduce stigma – dismantling stereotypes about mental health conditions, and promoting acceptance and inclusivity within communities and organizations *(1,28,29)*.
- Lived/living experience practitioners improve engagement through their relatability, fostering trust and encouraging individuals to seek and sustain engagement in mental health services *(11,30)*.
- Evidence supports the effectiveness of lived/living experience practitioners in improving recovery outcomes such as self-efficacy and overall quality of life *(7,31)*. Instilling hope for recovery is considered a particularly important outcome of lived/living experience practice. For example, Balková *(15)* demonstrated how lived/living experience practitioners in Czechia contribute to holistic recovery approaches.

Despite growing recognition of lived/living experience in mental health systems, defining the work remains challenging in many countries owing to its inherent diversity and the influence of cultural and systemic factors *(14,21,32,33)*. Various frameworks of lived/living experience practice prioritize distinct aspects – such as advocacy, activism or structured service delivery *(17)*. Furthermore, lived/living experience practitioners' dual identities as professionals and individuals with lived/living experience create tensions between authenticity and organizational expectations *(27,34)*. These complexities hinder establishment of standardized role descriptions, which are necessary for integration into multidisciplinary teams and effective policy development. Therefore, inclusive dialogue among stakeholders is essential to reconcile the differing interpretations and to collaboratively define roles that consistently honour the core values of lived/living experience practitioners in practice *(35)*.

One successful example is found in Ireland, where lived/living experience roles have received recognition within the Health Service Executive, which has established a formally recognized peer support worker grade code. This includes a clearly defined role, ensuring organizational readiness, addressing employment considerations, implementing robust recruitment and training processes, and developing strategic plans for their integration into mental health services. The framework sets out clear role descriptions, line management, supervision and remuneration *(36,37)*.

How this roadmap was co-created

In line with contemporary best practice in mental health, WHO is committed to supporting co-creation of policies and health service organization with people who use mental health services and their family members and supporters *(4)*. In 2023, the WHO Regional Office for Europe entered into a contribution agreement with the European Commission, funded by the European Union under the EU4Health programme. This agreement – the "Addressing mental health challenges in the European Union, Iceland and Norway" project – falls under the Commission's European Mental Health Capacity Building Initiative, as laid out in the 2023 communication on a comprehensive approach to mental health *(38)*. The focus of the Regional Office's work under this agreement is to provide tailored capacity-building in policy-making and service delivery for the 29 participating countries, including in the integration of lived/living experience expertise into policy and services. To achieve this, the Regional Office contracted Mental Health Europe, and received in-kind support from the Department of Health in Ireland – institutions with significant experience in partnering with people with lived/living experience of mental health challenges, their family members and supporters.

A taskforce was established to co-create the roadmap, with representation from countries across Europe, including Belgium, Germany, Hungary, Ireland, Lithuania, Romania, Slovakia, Spain and the United Kingdom of Great Britain and Northern Ireland. The taskforce adopted Mental Health Europe's definition of co-creation to guide the work *(2)*:

> *a collaborative approach involving all actors in mental health working together on an equal basis to develop and implement policies, services, programmes and communication that foster positive mental health according to a psychosocial model and human rights-based approach.*

The roadmap was co-created following a project management methodology and through extensive consultation with a diverse group of stakeholders, including individuals with lived/living experience, mental health professionals, nongovernmental organizations, policy-makers, family members and other supporters. Central to this process was the principle of equity – ensuring that every voice was heard and valued. The roadmap reflects the shared insights, priorities and expertise of all involved.

The process of co-creating the roadmap commenced in August 2024 and finished in April 2025. Seven taskforce meetings were held during that period. To support the work of the taskforce project plan, two subgroups were established – one to support the senior researcher in defining the research strategy, and one to support planning of consultation events.

The first group consisted of six taskforce members including the senior researcher, supported by a research assistant. It held 12 bi-monthly meetings. The search strategy was co-created to include a broad range of search terminology (including terms related to population, mental health, training and

education, policy, models of participation, service delivery, and geography) and inclusion and exclusion criteria. Literature searches were conducted across a broad range of publication types, consisting of both peer-reviewed and non-peer-reviewed literature. Searches were conducted in databases including PubMed, ERIC, Wiley, PsycINFO (EBSCO Host) and Web of Science Core Collection, and in a range of grey literature sources (such as those by Mental Health Europe and WHO); open Google Search terms were also developed. A range of additional material was identified in consultation with national focal points from participating countries. From an analysis of all relevant research identified, this subgroup categorized the findings by theme, and identified a number of actions deemed essential to support the integration of lived/living experience roles into mental health systems. These actions served as the basis of the roadmap. The first draft was produced in December 2024 and circulated to taskforce members for comment. Thereafter, the roadmap was refined and updated by the senior researcher.

In parallel, the second subgroup planned two consultation events (in person and online) held in February 2025. This subgroup met three times and consisted of 10 taskforce members. The revised roadmap was circulated to the people who had signed up for the consultation process in January 2025. In total, 65 people were involved across the two consultation events, with representation from people with lived/living experience, family members, policy-makers and service providers from across the 29 participating European countries, Brazil, Hong Kong Special Administrative Region, China, and New Zealand. The in-person consultation took place in Brussels, Belgium, over two days, with 25 people in attendance. A further four-hour online consultation was held later, with 40 people attending. All feedback was collated and refined through a thematic analysis conducted by the senior researcher, project manager and operational lead, who incorporated it into the roadmap. Throughout this process, the taskforce gave ongoing feedback and input into the development and drafting of the roadmap as it evolved.

This roadmap is envisaged as the first phase in a three-phase process. Phases 2 and 3 will concentrate on co-creating and piloting a Europe-wide certified/accredited training programme for the integration of lived/living experience into mental health systems.

Roadmap actions

Integrating lived/living experience practitioners into mental health systems across countries participating in the "Addressing mental health challenges in the European Union, Iceland and Norway" project requires a targeted and practical approach. This section outlines key actions for critical areas of development to ensure the successful and sustainable incorporation of lived/living experience into health care. Each action includes a clear objective and essential action steps to guide implementation. Although developed under the collaboration between the WHO Regional Office for Europe the European Commission, the roadmap is intended to be of use in all countries – both within and outside the WHO European Region.

Action 1. Strengthening policy

Objective

National mental health policies and strategies should contain provisions related to inclusion of lived/living experience in health-care settings, and should be aligned with recovery-oriented care principles.

Action steps

Stakeholders should:

1. engage policy-makers to integrate lived/living experience practitioners into legislative and strategic frameworks, including workforce planning and budgeting;
2. define lived/living experience practitioners' roles, responsibilities and boundaries within policy guidelines to reduce role ambiguity and enhance organizational clarity;
3. promote co-creation in policy development, ensuring that lived experience informs mental health-care system decisions; and
4. review and develop policy from a contemporary understanding of the role of lived/living experience expertise and recovery-oriented care practice.

As highlighted in the 2025 WHO guidance on mental health policy and strategic action plans *(39)*, historically, people with mental health conditions and psychosocial disabilities have been excluded both from making decisions about their own health and life, and from broader decision-making processes within society. The Convention on the Rights of Persons with Disabilities acknowledges that people with mental health conditions and psychosocial disabilities have enormously valuable knowledge, perspectives and contributions. As such, their meaningful participation is integral to all aspects of mental health reform, including governance and policy development, implementation and evaluation. The creation of lived/living experience practitioner roles reflects such involvement, and ensures that all actions to transform mental health services are aligned with the perspectives and needs of those with lived experience.

Integrating lived/living experience practitioners into national mental health strategies is a vital step towards incorporating peer roles and securing sustainable funding. Policies that define such roles, establish funding streams and prioritize co-creation are essential to embed them as a core component of mental health systems *(11,40,41)*. Without

this vital step, lived/living experience practitioners will have ambiguous roles within health-care systems, few formalized supports and little opportunity to participate in health-care system development. For more detailed information for ensuring lived/living experience is integrated into all policy actions, see the WHO Guidance on mental health policy and strategic action plans *(39)*.

Based on a survey by WHO Regional Office for Europe and the European Commission in 2023, many countries in Europe are only beginning to integrate lived/living experience into policy. While 25 of the 29 countries (86%) reported involving people with lived/living experience in policy development, their participation may be superficial. In fact, 11 countries (38%) reported limited buy-in from individuals with lived experience and their carers. Additionally, more than half of the countries surveyed (16 countries; 67%) indicated a need for support in building capacity within the mental health workforce. While most countries have partly implemented mental health interventions into primary health-care settings, efforts to enhance the general health-care workforce's capacity are lagging. Specifically, 12 out of 29 countries have not yet started this implementation. Barriers to policy implementation include inadequate accessibility and coverage of the health and care workforce (15 countries; 52%) and insufficient infrastructure to meet system needs (13 countries; 45%). Inadequate infrastructure and lack of coverage can affect care continuity and limit service user engagement. The findings indicate key areas for additional support, such as expanding the mental health workforce and improving the competencies of general health-care workers *(42)*.

As an additional concern, mental health plans and policies in Europe often lack specific, measurable targets and details on implementation steps, responsibilities and funding sources *(43)*. Many also provide limited information on data systems and evaluation processes. While progress has been made in developing these policies and plans, operationalization and data collection for evaluation are often inadequate. To improve knowledge generation and demonstrate impact, mental health policies and plans should include specific, measurable targets as well as assigned responsibilities, funding and evaluation plans.

Case study 1 – Ireland

Ireland's National Framework for Recovery in Mental Health (2024–2028) *(44)* focuses on creating recovery-oriented services by embedding values like hope, self-determination and empowerment into every aspect of care – from recruitment to service planning. Communication plans ensure that service users, families, carers and staff work together with a shared understanding of these principles. Recovery education, such as wellness recovery action planning, supports individuals in managing their mental health and achieving their goals.

Lived/living experience practitioners play a vital role in this process, working one-on-one with service users to build confidence, navigate transitions and connect them to community resources. Co-production is an integral step in Ireland's plan to promote service-user-centred mental health recovery, and lived/living experience practitioners play a crucial role by bridging the gap between the service user/person who uses the service and professionals *(37,38)*. Training courses that provide these practitioners with formal qualifications are available through Dublin City University and Atlantic Technological University, with grants available for enrolment *(45,46)*.

Case study 2 – Norway

Norway has taken a structured approach to integrating peer support into its mental health system, creating a clear roadmap for its development. Community mental health centres serve as the backbone of care, incorporating mobile teams and crisis services to ensure accessibility *(47)*. Peer recovery services have emerged within municipalities to improve mental health and substance abuse treatment, recognizing the unique value of lived experience in service delivery *(48)*. Reducing stigma within mental health services has been a central focus of national policy and lived/living experience practitioners' integration.

Lived/living experience practitioners, known as *erfaringskonsulenter* (lived experience consultants), are embedded in multidisciplinary teams to foster inclusivity and challenge stereotypes about mental health. This engagement has shifted public perceptions and reduced discriminatory practice within health-care settings, demonstrating the contribution of lived experience expertise to society. Erfaringssentrum, Norway's national association for peer support workers, has played a key role in professionalizing the field by fostering collaboration, advocating workplace inclusion and organizing national conferences *(49)*. The KBT Competence Center for Lived Experience and Service Development offers training accredited by the Norwegian Agency for Quality Assurance in Education, ensuring that peer workers gain formal qualifications and have structured career pathways *(50)*. This multilevel approach – from policy and education to service implementation – demonstrates Norway's commitment to integrating peer support into mainstream mental health care.

Action 2. Building capacity for organizational readiness

Objective

Mental health organizations should be prepared to include lived/living experience practitioners by fostering inclusive practices; addressing systemic barriers; and ensuring that lived/living experience practitioners are supported through training, supervision and equitable career pathways.

Action steps

Stakeholders should:

1. set up anti-stigma activities in health-care organizations to foster respect and collaboration between lived/living experience practitioners and traditional staff;
2. standardize lived/living experience practitioners' roles and training to ensure consistency and professionalism in practice;
3. strengthen supervision and support structures to promote ethical practice;
4. foster inclusive workplace cultures through training and practice support to achieve full integration of lived/living experience practitioners into multidisciplinary teams; and
5. build career development pathways to attract and sustain a motivated and skilled workforce.

Organizational structures and culture significantly affect the experiences and well-being of lived/living experience practitioners *(29,51–53)*. To keep these practitioners effective and motivated, organizations must foster inclusive workplace cultures that are equitable, value lived experience through remuneration, establish clear career pathways for progression *(54–56)*, offer comprehensive training, and provide supportive supervision.

One of lived/living experience practitioners' most significant contributions is their potential to reduce stigma within mental health systems and broader society. Stigma and discrimination related to mental health conditions are widespread and harmful. Reducing stigma and discrimination benefits families, communities and economies, and has the potential to save lives. Reducing stigma among health-care staff requires ongoing organizational initiatives and community engagement (see Box 2 for WHO's approach) *(57)*. Clinical staff often express scepticism, driven by a lack of understanding, about lived/living experience practitioners; this has led to efforts in countries including Ireland and Spain to educate health-care teams on the value of the role *(32)*. In addition, supporting service users to engage and understand their own mental health story reduces self-stigma and increases their autonomy and capacity for recovery *(58)*. Memria in Norway launched a pilot project with the Norwegian Human Rights Fund, where they collect and publish stories of human rights defenders told by people, in their own voices, about the work they do, the risks they take, and why they are compelled to fight for the rights of others. This storytelling approach has improved public attitudes and reduced discrimination in health care *(59)*.

Standardization of training is essential for consistency and professionalism. It can help avoid role ambiguity and enhance organizational clarity *(32,61)*. Training curricula that address the dual identity of lived/living experience practitioners – blending lived experience with professional responsibilities – are critical *(16)*. Training that promotes professional development while maintaining the authenticity of peer roles can be achieved through modules on co-creation and boundary management *(62,63)*. The Experienced Involvement certification programme exemplifies effective training standardization focusing on recovery-oriented care, ethical frameworks and practical skills for multidisciplinary environments *(15,18)*. The Nordic and Baltic Cooperation for Peer Support Workers is a funded partnership to develop and share new educational materials for peer support across Denmark, Estonia, Iceland, Lithuania, Norway and Sweden *(64)*. Organizations can ensure that lived/living experience practitioners are adequately prepared for their roles by adopting standardized training and certification processes that align with recovery principles and ethical standards *(27)*. See Action Area 4 for more details on training.

Ethical practice by lived/living experience practitioners is multifaceted, encompassing relational dynamics, formalized frameworks and stigma reduction efforts *(27,65)*. These dimensions can be addressed through standardized training and strong supervision and community engagement, allowing these practitioners to flourish as

Box 2. Mosaic toolkit to end stigma and discrimination in mental health

The WHO Regional Office for Europe published the Mosaic toolkit to end stigma and discrimination in mental health in order to support policy-makers, people with lived experience, health professionals, civil society and others to develop and initiate evidence-based anti-stigma activities in their local contexts. The toolkit offers practical guidance based on three key principles: leadership or co-leadership by individuals with lived experience, social contact and inclusive partnerships. To implement these principles, the toolkit offers a four-step process model: identifying aims, planning and preparing the activities through needs assessment and stakeholder mapping, launching and learning from the activities, and reflecting on the results to inform future activities. To illustrate the process and principles, the Mosaic toolkit includes 11 global case studies and a spotlight on policies and actions across the European Union *(60)*.

a transformative force in mental health systems. Effective supervision requires ethical frameworks specific to lived/living experience practitioners, which can guide practice and address unique challenges. The National Association of Peer Supporters in the United States of America has developed standards encompassing 12 core values and emphasizing guidelines for supervisors, alongside a distinction between peer and non-peer supervision *(66)*. See Action Area 5 for more details on supervision.

Creating recovery-focused and inclusive services requires both cultural and practical shifts within organizations. Resistance from traditional health-care staff often stems from a lack of understanding of peer roles *(27,67)*. To combat this, targeted training and awareness campaigns are needed. In Ireland and Spain, lived/living experience practitioners have faced challenges gaining acceptance within clinical teams, indicating the necessity for organizational training *(32)*. Collaboration with traditional staff can be improved through team-building and co-creation *(68)*; integrating lived/living experience practitioners into multidisciplinary teams fosters mutuality *(69)*. The multidisciplinary team is essential, whether in hospitals or communities, as supporting recovery involves teamwork and changing front-line attitudes. All these strategies help reduce stigma and enhance workplace dynamics, leading to a more inclusive culture.

Daily practices should also change, incorporating recovery principles. This shift demands two key approaches: educating teams to apply recovery concepts in real-life situations, and leveraging everyone's skills at the front line to foster innovative recovery solutions. Team recovery integration plans can be used for this purpose – they are designed to help teams focus on recovery, empowering them to implement recovery concepts by leveraging the skills of both service providers and users, and fostering innovative methods to promote recovery and supportive environments *(70)*.

Structured career pathways are essential for sustaining a motivated and skilled workforce. These pathways should offer specialization and leadership development opportunities, facilitating career advancement *(56,71,72)*. Ongoing professional development is vital for retaining lived/living experience practitioners, and enhancing their contributions *(73)*. These measures also improve retention, and reinforce their value within health-care systems. Equitable renumeration is a persistent issue *(54)*, as is the financial sustainability of these positions within health-care organizations. Adequate and stable funding is essential for sustaining the integration of lived/living experience practitioners *(74)* and for ensuring the scalability of their contributions *(7)*.

Case study 3 – Finland

In Finland, the involvement of lived/living experience practitioners in mental health services has increased in recent years. In addition to experts with experience through nongovernmental sector activities, an effort has been made to expand such activity in the public sector, aiming to provide client-oriented services and implement a mental health policy emphasizing participation of the service user/person who uses the service. There are many lived/living experience practitioner groups, and information is readily available online *(75)*. Finland's peer support and experts by experience group model combines community-based, professionalized and integrated approaches *(76)*. Many training courses are available for lived/living experience practitioners and experts by experience – some facilitated by the Global Alliance of Mental Illness Advocacy Networks-Europe, Vertaistoimijat and Kokemustiedon Keskus. It is unclear whether it is a requirement for these practitioners to be formally trained to provide support, but it is likely *(77,78)*.

Case study 4 – Sweden

In Sweden, lived/living experience practitioner models and training programmes emphasize recovery, empowerment and collaboration in mental health services. Initiatives and research campaigns in recovery colleges and patient schools focused on peer-supported education, where individuals with lived mental health experiences share their journeys, teach coping skills, and foster confidence to reduce stigma and promote self-management *(79).* The model is flexible and collaborative, with key features like role development, relationship-building and separation from clinical duties. Training programmes prepare lived/living experience practitioners through a five-week course complemented by sessions for organizations and staff, ensuring smooth integration into mental health services. Coordinators oversee recruitment and support, while experienced mentors provide coaching to strengthen professional growth and well-being *(80)*. The *Personligt Ombud*, a Swedish case management initiative, exemplifies this approach by helping service users define goals, access resources and make life changes *(81)*. Peer support workers, introduced through the National Cooperation for Mental Health, have improved communication with service users, and have changed mental health services in a positive manner *(82)*.

Action 3. Promoting co-creation, collaboration and integration

Objective

Through application of co-creation principles, lived/living experience and other forms of expertise should be integrated into the design, delivery and evaluation of mental health services.

Action steps

Stakeholders should:

1. establish platforms for collaboration between lived/living experience practitioners, clinicians and service users in service design and delivery;
2. build capacity and provide training for people with lived/living experience to engage in meaningful co-creation of services;
3. use successful co-creation models to guide implementation and scale best practices;
4. train health-care staff to recognize and value the role of co-creation in creating inclusive and person-centred mental health services; and
5. implement evaluation frameworks to assess the outcomes of co-created initiatives and refine practices based on stakeholder feedback.

Co-creation emphasizes all stakeholders' shared ownership and active participation in the design, delivery and evaluation of mental health services. This approach is rooted in principles of inclusivity, mutuality and empowerment, aligning closely with the ethos of lived/living experience practitioners *(53,83).* Unlike traditional hierarchical approaches, co-creation emphasizes equality, mutual learning and the integration of diverse perspectives. Effective co-creation involves creating spaces where service users, lived/living experience practitioners, family members, other supporters and clinicians can innovate and contribute equally to decision-making processes. This requires addressing power imbalances and ensuring that all parties are recognized as having valuable expertise *(32, 83)*.

However, there is a danger of performing tokenistic inclusion rather than practising actual inclusion. Tokenistic inclusion involves

using lived experience as a symbolic gesture rather than a foundation for structural change. True integration of lived experience requires shifting power, listening deeply and being willing to change the system itself, not just decorate it with new language. Co-optation (or co-option) refers to the process through which a dominant group seeks to absorb, neutralize or pacify a weaker opposition it perceives as a threat to its authority. This process can take many forms, such as the dominant group adopting ideas or language of marginalized communities, gradually reshaping the meaning of key ideas or terms, until words like "empowerment" or "peer" lose their original significance or come to mean the opposite *(84)*. When systems coopt the language or stories of lived experience without respecting their depth or context, those insights risk being watered down into sanitized narratives friendly to the status quo. For example, ideas like peer support – which are meant to challenge existing power structures – can be professionalized and bureaucratized until they lose their radical, community-based roots. Lived experience often brings with it critique and challenge, especially of how traditional mental health systems have caused harm. When these voices are coopted, that critical edge gets smoothed over or ignored, and reform becomes more about image than substance. People with lived experience often come into these roles with hope for meaningful change. When they realize that their voices are being used but not truly heard, it leads to disillusionment, burnout and mistrust – not only in individuals but across entire communities *(84)*.

Co-creation and collaborative models represent a paradigm shift in mental health care, emphasizing equality, inclusivity and shared ownership. The diverse applications highlight the adaptability and impact of these approaches in fostering recovery-oriented systems. By addressing challenges such as power dynamics and sustainability, while leveraging opportunities for innovation, co-creation can continue transforming mental health systems and can ensure that lived/living experience remains at the heart of care. A four-year longitudinal study examined three co-created public service innovations in Canada, Scotland (United Kingdom) and Sweden. It found that, for all case studies, a philosophy that valued lived/living experience practitioners as equals with professional knowledge had more flexibility and adaptability to local contexts, and resulted in developing new mindsets and co-creation processes *(53)*.

The key principles of co-creation are:

- inclusivity and shared ownership: ensuring that all voices – particularly those of individuals with lived experience – are represented in decision-making processes;
- mutuality and collaboration: building partnerships that value the unique contributions of lived/living experience practitioners and service users; and
- recovery-oriented focus: recognizing the holistic nature of recovery and aligning services with recovery principles, such as autonomy, empowerment and personal growth.

Various resources have been developed to support training on and implementation of co-creation *(2,85,86)*. According to one study *(53)*, several strategic actions can support co-creation, including the following.

- Stakeholder power dynamics need to be balanced. Traditional hierarchies within health-care systems often limit the influence of lived/living experience practitioners and service users. In Ireland, lived/living experience practitioners have reported difficulties asserting their perspectives within multidisciplinary teams, necessitating organizational training to promote mutuality and collaboration.

- Trust needs to be built in co-creation processes. Trust is a critical factor in successful co-creation. Resistance from traditional staff, combined with systemic stigma, can undermine collaborative efforts.
- Sustainability needs to be ensured. Co-creation requires sustained investment in training, supervision and infrastructure.

Co-creation has been applied successfully in various contexts. In New Zealand, the Whānau Ora initiative integrates lived/living experience practitioners into family-centred health services, emphasizing holistic well-being and cultural responsiveness. This model demonstrates the potential of co-creation to address the unique needs of diverse populations *(87)*. Similarly, refugee mental health programmes in Greece employ lived/living experience practitioners from refugee communities to co-create support services *(88)*. This approach enhances cultural relevance and trust, leading to better engagement and outcomes *(7)*.

Co-creation has much potential, but it can be challenged by stakeholder power dynamics and trust deficits. Building effective co-creation models requires sustained investment in relationship-building, facilitated dialogue and capacity-building for all participants. Opportunities lie in leveraging these processes to foster innovation and ensure that mental health services are responsive to the needs of diverse populations.

Action 4. Standardizing training and certification

Objective

Consistent and high-quality training and certification programmes should be co-created, equipping lived/living experience practitioners with the skills, knowledge and ethical grounding required for effective and professional recovery-oriented practice.

Action steps

Stakeholders should:

1. co-create a certified core training curriculum;
2. develop modules on recovery-oriented care principles, lived experience practice, ethical frameworks, using one's narrative as a recovery tool, boundary management, self-care, supervision and co-creation, among others, to prepare lived/living experience practitioners for multidisciplinary environments;
3. collaborate with academic institutions, mental health organizations and stakeholders to ensure that training programmes are co-created, reflect best practice and are accessible to all lived/living experience populations; and
4. ensure that ongoing professional development opportunities are provided to address emerging challenges and support career progression.

Building on Action 2 (Building capacity for organizational readiness), standardized training models ensure consistency and professionalism among lived/living experience practitioners, equipping them with the essential skills and ethical frameworks for promoting recovery *(27,52,89)*. Training approaches vary widely, based on local cultural and systemic contexts, but should always aims to promote ethical practice. Ethical practice is fundamental for lived/living experience practitioners, who often encounter challenges such as boundary management, power dynamics and stigma. Establishing tailored ethical frameworks can ensure the integrity and sustainability of their contributions, and should in particular

cover relational ethics: the importance of trust, respect and mutuality in fostering connections between these practitioners and service users *(66)*. However, the deeply personal nature of these interactions requires careful attention to boundaries and disclosure practices *(89)*.

While a valuable tool, self-disclosure can lead to role confusion or emotional harm if used inappropriately. Personal narrative training is one approach that can reduce the possibility of self-disclosure misuse. Mental health recovery narratives are firsthand personal accounts of the lived/living experience of recovery from mental health problems. They refer to specific actions or events, and often include personal accounts of struggles, adversities, successes, survival and identified personal strengths *(90)*. Lived/living experience practitioners should balance sharing relatable experiences with maintaining professional boundaries *(91)*. Dual relationships, in which they share personal connections with those they support, pose significant ethical challenges. Supervisory frameworks are essential to address potential conflicts of interest *(92)*. In intentional and professional lived/living experience practitioner roles, sharing personal narratives should only be used when it will benefit the other person in the engagement. Sharing personal narratives for their own therapeutic or personal growth benefit needs to occur in a self-care or other setting *(89,91)*.

It is important to separate training and certification programmes into theoretical and practical skill areas. One study *(92)* reviewed types of mental health peer support work components, and identified various themes related to recruitment, preparation, staff training, practice and record keeping. A further review identified 20 training topics that could be included in the curriculum for initial training programmes. Core topics – those that are essential for completion of the curriculum – include an introduction to the historical, local and international perspective of peer support and peer support workers; the role of peer support work in recovery; and approaches and models used in peer support work. Elective or context-specific topics could include:

- developing role-specific skills and competencies such as motivational interviewing
- understanding service settings and mental health needs across the life-course
- administrative skills such as recording and documenting care plans and incidents
- other work skills such as time management *(93)*.

Some countries have already established competency frameworks for peer support workers in mental health services. The National Health Service in England, United Kingdom, published a competence framework *(94)*, while the Erasmus+ project published a guide for implementing further training concepts for peer support workers, based on the European Qualifications Framework for Levels 4 and 5 *(24)*. The UPSIDES intervention and training manual was developed following a four-step framework on intervention adaptation for implementation in diverse cultural and socioeconomic settings. This training focuses on practical skills using role-playing exercises; working in teams, including role reflection with colleagues (InterVision) or with a highly experienced coach (supervision); necessary resources and tools for networking; and continuous awareness-raising about lived/living experience expertise *(61)*.

Accessibility and equity in certification remain critical challenges in professionalizing lived/living experience. For example, while popular, the Experienced Involvement training programme is led by various organizations, and the training and certification may not hold equal standing for those looking to move countries. A tiered or scaffolded approach like that seen in Ireland would be beneficial, whereby lived/living experience

practitioner employment and grades are linked to a defined set of qualifications and experience *(95)*.

Continuous professional development is also essential. Given the evolving landscape of mental health care, lived/living experience practitioners must continually enhance their skills. Emerging areas of focus include digital health, intersectional care and advocacy. Additionally, leadership programmes are vital for preparing experienced lived/living experience practitioners to take on roles in management, training and policy advocacy *(39, 96)*.

Case study 5 – Austria

A trialogue model is used in Austria for peer support groups. Users, carers and mental health workers meet regularly to have an open discussion with the aim of communicating about and discussing the experiences and consequences of mental health problems and ways to resolve them *(97)*. A pilot training course for mental health lived experience practitioners was run between 2013 and 2015 in European countries including Austria.

In addition, peer support workers are deemed experts by experience. Austria also participated in the European project PEER2PEER, which shared the Scottish (United Kingdom) approach to lived/living experience practitioners for mental health among partner organizations *(98)*. The project helped partners understand their role, using the Scottish Recovery Network's experience. Teaching tools were tailored to the specific contexts of Austria, Spain and Romania, where two pilot training courses were held. Of 135 students, 18 work as lived/living experience practitioners, either as volunteers or paid employees.

Case study 6 – Iceland

Iceland offers several peer support models and training programmes focused on empowerment, recovery and community engagement. Klúbburinn Geysir *(99)* helps individuals rebuild their lives by working alongside staff, emphasizing strengths over illness. Virknihús Engagement Center provides rehabilitation programmes, including employment support and counselling *(100)*. Bataskóli Recovery School offers courses on mental health and recovery for individuals and their families *(101)*. Hugarafl, a peer-run organization, promotes personal recovery, human rights and mental health education *(102)*.

Case study 7 – France

The role of lived/living experience practitioners has been developing slowly in France, but is now gaining more attention, mainly due to political agendas and new government policies *(103,104)*, Policies and programmes that rely on these practitioners include mutual assistance groups, the Accompanied Response for All programme, the Housing First programme and national calls for pilot projects to improve health and autonomy. GHU Paris shares information on the differences between professional and voluntary peers; again, general mental health training courses are available, and lived/living experience practitioners are considered experts through experience *(105,106)*. The WHO Collaborating Centre for Research and Training in Mental Health in Lille has created a training curriculum for peer workers, which has operated since 2012. It is offered at Bobigny Paris 13 University and Bordeaux University as a one-year programme, as part of a degree course. Peer workers also undergo vocational training in psychiatric and rehabilitation centres that have recruited peer workers *(107)*.

Action 5. Enhancing supervision and support

Objective

Lived/living experience practitioners should be provided with robust clinic/practice supervision models that address their unique needs, support their well-being and ensure adherence to professional standards.

Action steps

Stakeholders should:

1. develop clinical/practice supervision guidelines that emphasize reflective and strengths-based practices;
2. train direct line management and supervisors to understand lived/living experience practitioners' dual roles and support them in using their lived experience effectively, as well as managing challenges like self-disclosure and relational boundaries;
3. ensure that clinical/practice supervision is considered an essential requirement of lived/living experience roles, and that everyone has equitable access to supervision; and
4. establish peer-to-peer supervision networks to create spaces for mutual support and shared learning among lived/living experience practitioners.

Again, building on Action 2 (Building capacity for organizational readiness), it is essential to understand that lived/living experience practitioners occupy a unique position. They bridge the gap between service users and traditional mental health service professionals. This dual role often creates tension. On the one hand, lived/living experience practitioners are expected to maintain their authenticity by drawing from firsthand experiences; on the other hand, they are bound by organizational expectations and professionalism. The requirement to navigate these dual identities can lead to internal conflicts, such as balancing personal self-disclosure with maintaining appropriate boundaries. These practitioners frequently highlight the challenge of maintaining authenticity while adhering to professional boundaries standards *(27,40,74,108)*.

Reflective supervision is emphasized to help lived/living experience practitioners navigate the complexities of their dual identities *(15)*. The non-hierarchical nature of lived/living experience roles can sometimes obscure underlying power imbalances. These practitioners must have a clearly defined role, particularly within formal health-care settings: everyone must be clear about how the role contributes to the overall development of recovery-oriented services. All practitioners are facilitators of an individual's recovery journey, but in guiding service users through that journey, they may inadvertently create a dynamic where the service user feels dependent or disempowered. Reflective supervision effectively addresses these dynamics, ensuring that lived/living experience practitioners remain rooted in mutuality and respect. Peer Support Services Technical Assistance Center (PeerTAC) in New York have developed a comprehensive self-directed workbook. This training includes understanding what peer support is, and how that translates into peer support services. What peer supervision is, the context within which it thrives, and how it may be performed. The workbook also explores the myths and reality of supervising peers, the necessary knowledge and resources when acting as a peer supervisor and finally the unique challenges of peer supervision in multi-professional settings for supervisors *(109)*.

While the provision of supervision by others without lived experience can be very effective, there is a need ultimately to develop the capacity of lived/living experience practitioners to provide supervision. As a rule, people with lived experience should be supervised by people with lived experience *(66)*.

Lived/living experience practitioners are particularly susceptible to burnout and secondary trauma due to the emotionally intensive nature of their roles. These risks can lead to high attrition rates and reduced effectiveness without adequate self-care, peer support and organizational support *(56,74,110)*. Reflective supervision tailored to lived/living experience practitioners' unique needs is critical for sustaining their effectiveness and well-being, helping them to address challenges such as boundary management and secondary trauma. Furthermore, there is growing recognition of the utility of training supervisors in trauma-informed practice *(108,111)*. Structured support networks, such as group supervision sessions, can enhance resilience and mitigate feelings of isolation *(56,74)*. Providing access to mental health resources and wellness programmes further ensures that these practitioners can manage the emotional demands of the role effectively *(112,113)*.

Case study 8 – Netherlands (Kingdom of the)

Many lived/living experience practitioners and expert-by-experience facilitators for recovery exist throughout the Netherlands (Kingdom of the). The Enik Recovery College has multiple locations and stands out for its unique approach to recovery, which focuses on personal development and self-exploration rather than traditional treatment methods. What sets it apart is the flexibility in the programme: it offers a range of workshops, weekly training and full-time retreats that allow individuals to choose the approach that best suits their needs. The College fosters a learning environment where participants gain new knowledge and engage in ongoing self-examination to understand their own experiences and vulnerabilities better. The equal role of facilitators – peers with lived experience – creates a collaborative atmosphere, leading to a more open and relatable experience.

Training courses and opportunities are available to facilitate peer worker training through recovery colleges like the Enik Recovery College *(114)*. Furthermore, the Comprehensive Approach to psychosocial Rehabilitation approach is well established in the Netherlands (Kingdom of the) and other European countries, and training programmes also provide modules on group coaching *(115)*. A peer mentor programme for young adults in rural areas has also been developed *(116)*. In 2013, the National Institute Trimbos and GGZ Nederland developed a competency profile for peer specialists, followed by an educational curriculum in 2015. Dutch care authorities aim to establish an officially recognized profession and role for peer specialists in health-care settings *(117)*.

Case study 9 – Poland

Poland's Mental Health Buddies Network provides peer-to-peer emotional support and practical guidance. Trained university volunteers act as peer buddies/mentors, helping peers navigate everyday challenges, encouraging them to seek professional psychological help, and offering non-judgmental companionship. They also focus heavily on mental health education, including hosting awareness campaigns and events to combat stigma and teach effective communication. The Mental Health Buddies Network programme also provides training for volunteer lived/living experience practitioners *(118)*.

Case study 10 – Estonia

The model of lived/living experience practitioners in Estonia is a recovery-oriented, collaborative and education-driven approach run by nongovernmental organizations such as the Heaolu Ja Taastumise Kool *(119,120)*. Lived/living experience practitioners are known in Estonia as counsellors; they are people who have experienced a mental health problem and have recovered well from it. Practitioners are required to complete seven modules over a total of 182 hours, including 30 hours of supervision by a clinical professional and 20 hours supervised by the training institution *(121)*.

Action 6. Expanding access through accessible and digital tools

Objective

Digital platforms should be used to increase the accessibility and reach of lived/living experience practitioners, particularly in remote areas and for underserved populations.

Action steps

Stakeholders should:

1. develop digital mental health programmes that enable lived/living experience practitioners to provide virtual support;
2. train lived/living experience practitioners in digital engagement techniques to enhance their effectiveness in online environments;
3. implement online training modules to expand access to lived/living experience practitioner education, especially for individuals in geographically isolated regions; and
4. use digital platforms to create forums for international collaboration, allowing lived/living experience practitioners and policy-makers to share best practices and innovations.

Digital technology offers ample opportunity to expand the reach and accessibility of lived/living experience practitioners.

The coronavirus disease (COVID-19) pandemic accelerated the adoption of telehealth, creating new avenues for these practitioners *(122)*. Peer support specialists can deliver services via telephone calls, videoconference-based services, SMS text messages, smartphone applications and social media, as well as through emerging technologies such as virtual reality and video games *(123)*.

Digital platforms enable lived/living experience practitioners to provide remote support, reaching individuals in underserved or geographically isolated areas *(41)*. They can offer a diverse and safe online community to complement health-care interventions – much more so if these technologies and communities are co-created. For example, Finland has implemented virtual peer support groups that allow individuals in rural regions to access services without travelling *(124)*. The United Kingdom's service Togetherall provides a combination of psychosocial, educational, recovery-oriented and self-care approaches via an anonymous online platform *(125)*. Integrating lived/living experience practitioners into digital health initiatives is also a promising avenue for increasing scalability and accessibility. This would enable individuals to access mental health support remotely, while ensuring that their voices are represented in technological design and empirical evidence about recovery and mental health *(126,127)*.

Conclusion

In a contemporary approach to mental health service delivery that focuses on recovery, autonomy and rights of the individual, integrating lived/living experience practitioners into health-care and social systems is crucial to realizing that recovery-oriented mental health care. Lived experience has been described as the wisdom that arises from experiencing and often recovering from a mental health challenge, with recovery being defined as a personal process leading to a meaningful life. Lived/living experience practitioners bring unique perspectives and expertise, enhance the inclusivity of services, and bridge gaps between traditional health-care structures and service users. Despite growing recognition of its importance, integration of lived/living experience roles faces systemic challenges, including resistance from traditional staff, policy constraints and funding inconsistencies. At the same time, it also presents opportunities for innovation in digital health and community-based approaches. Understanding the transformative potential of lived/living experience practitioners and their expertise is critical to envisioning a future where mental health systems are accessible to everyone. In this context, the purpose of this co-created roadmap is to set out a path forward with recommended actions from an evidenced-based perspective that will support health systems and organisations to integrate lived/living experience practitioners as equal and essential expertise in developing recovery oriented services and in delivering opportunities for better well-being for those using those services. The implementation of this roadmap will help the creation of truly person-centred services that all can be proud of and are worthy of those who provide and use those services.

References[1]

1. Piat M, Sabetti J, Bloom D. The transformation of mental health services to a recovery-orientated system of care: Canadian decision maker perspectives. Int J Soc Psychiatry. 2010;56(2):168–77 (https://doi.org/10.1177/0020764008100801).[1]

2. Toolkit: co-creating in mental health. Brussels: Mental Health Europe; 2022 (https://www.mentalhealtheurope.org/library/co-creation-toolkit/).

3. Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosoc Rehabil J. 1993;16(4):11–23 (https://doi.org/10.1037/h0095655).

4. QualityRights materials for training, guidance and transformation. In: World Health Organization [website]. World Health Organization; 2025 (https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools).

5. Norton MJ, Swords C. Social recovery: a new interpretation to recovery-orientated services – a critical literature review. J Ment Health Train Educ Pract. 2021;16(1):7–20 (https://doi.org/10.1108/JMHTEP-06-2020-0035).

6. Borg M, Davidson L. The nature of recovery as lived in everyday experience. J Ment Health. 2008;17(2):129–40 (https://doi.org/10.1080/09638230701498382).

7. Repper J, Carter T. A review of the literature on peer support in mental health services. J Ment Health. 2011;20(4):392–411 (https://doi.org/10.3109/09638237.2011.583947).

8. Myrick K, Del Vecchio P. Peer support services in the behavioral healthcare workforce: state of the field. Psychiatr Rehabil J. 2016;39(3):197–203 (https://doi.org/10.1037/prj0000188).

9. Crowther A, Taylor A, Toney R, Meddings S, Whale T, Jennings H et al. The impact of recovery colleges on mental health staff, services and society. Epidemiol Psychiatr Sci. 2019;28(5):481–8 (https://doi.org/10.1017/S204579601800063X).

10. Walker G, Bryant W. Peer support in adult mental health services: a metasynthesis of qualitative findings. Psychiatr Rehabil J. 2013;36(1):28–34 (https://doi.org/10.1037/h0094744).

11. Addo R, Ginder V, Nedegaard R. The role of peer support in recovery from psychiatric symptoms: a moderation analysis. Community Ment Health J. 2022;58(6):1141–5 (https://doi.org/10.1007/s10597-021-00923-5).

12. Convention on the Rights of Persons with Disabilities (CRPD). New York: United Nations; 2008 (https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd).

1 All references accessed on 12–14 May 2025.

13. Leamy M, Bird V, Le Boutillier C, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. Br J Psychiatry. 2011;199(6):445–52 (https://doi.org/10.1192/bjp.bp.110.083733).

14. Balková M. Engaging peer consultants in mental health services: narrative research. Int J Soc Psychiatry. 2022;68(2):411–9 (https://doi.org/10.1177/00207640211000371).

15. Balková M. A qualitative study of the experience of peer workers in the Czech Republic. Community Ment Health J. 2022;58(3):429–36 (https://doi.org/10.1007/s10597-021-00832-7).

16. Abraham S, Perez P. Bridging the gap with peer support: Patricia's recovery story. J Psychosoc Nurs Ment Health Serv. 2018;56(3):7–11 (https://doi.org/10.3928/02793695-20171027-01).

17. Krumm S, Haun M, Hiller S, Charles A, Kalha J, Niwemuhwezi J et al. Mental health workers' perspectives on peer support in high-, middle- and low income settings: a focus group study. BMC Psychiatry. 2022;22(1):604 (https://doi.org/10.1186/s12888-022-04206-5).

18. Hegedüs A, Burr C, Pfluger V, Sieg D, Nienaber A, Schulz M. Peer support worker training: results of the evaluation of the Experienced Involvement training programme in Switzerland and Germany. Int J Mental Health Nurs. 2021;30(2):451–60 (https://doi.org/10.1111/inm.12805).

19. Tate MC, Roy A, Pinchinat M, Lund E, Fox JB, Cottrill S et al. Impact of being a peer recovery specialist on work and personal life: implications for training and supervision. Community Ment Health J. 2022;58(1):193–204 (https://doi.org/10.1007/s10597-021-00811-y.

20. Hamilton AB, Chinman M, Cohen AN, Oberman RS, Young AS. Implementation of consumer providers into mental health intensive case management teams. J Behav Health Serv Res. 2015;42(1):100–8 (https://doi.org/10.1007/s11414-013-9365-8).

21. Kane L, Portman RM, Eberhardt J, Walker L, Proctor E, Poulter H et al. Peer supporters' mental health and emotional wellbeing needs: key factors and opportunities for co-produced training. Health Expect. 2023;26(6):2387–95 (https://doi.org/10.1111/hex.13836).

22. Kowalski MA. Mental health recovery: the effectiveness of peer services in the community. Community Ment Health J. 2020;56(3):568–80 (https://doi.org/10.1007/s10597-019-00514-5).

23. Owen D, Watson E, Repper J. The role of lived experience within health and social care systems. Nottingham: Imroc; 2024 (Imroc Briefing Paper No. 26; https://www.imroc.org/publications/26-the-role-of-lived-experience-within-health-and-social-care-systems).

24. Erasmus+ "European profile for Peer Support Workers" [website]. Grone-Bildungszentrum für Gesundheits- und Sozialberufe GmbH; 2022 (https://www.grone.de/erasmus-european-profile-for-peer-support-workers/).

25. Mental Health Engagement Framework 2024-2028. Dublin: Health Service Executive; 2024 (https://www.hse.ie/eng/services/list/4/mental-health-services/mental-health-engagement-and-recovery/guidance-and-support-documents/).

26. Happell B, O'Donovan A, Sharrock J, Warner T, Gordon S. Understanding the impact of expert by experience roles in mental health education. Nurse Educ Today. 2022;111:105324 (https://doi.org/10.1016/j.nedt.2022.105324).

27. Aylott LME, Tiffin PA, Brown S, Finn GM. Great expectations: views and perceptions of professionalism amongst mental health services staff, patients and carers. J Ment Health. 2022;31(1):139–46 (https://doi.org/10.1080/09638237.2020.1818195).

28. Bajraktarov S, Kalpak G, Jovanovic N. Community mental healthcare: new developments and innovative strategies. Curr Opin Psychiatry. 2020;33(5):491–500 (https://doi.org/10.1097/YCO.0000000000000629).

29. Reis G, Bromage B, Rowe M, Restrepo-Toro ME, Bellamy C, Costa M et al. Citizenship, social justice and collective empowerment: living outside mental illness. Psychiatr Q. 2022;93(2):537–46 (https://doi.org/10.1007/s11126-021-09968-x).

30. Shalaby RAH, Agyapong VIO. Peer support in mental health: literature review. JMIR Ment Health. 2020;7(6):e15572 (https://doi.org/10.2196/15572).

31. Forchuk C, Martin ML, Sherman D, Corring D, Srivastava R, O'Regan T et al. An ethnographic study of the implementation of a transitional discharge model: peer supporters' perspectives. Int J Ment Health Syst. 2020;14(1):18 (https://doi.org/10.1186/s13033-020-00353-y).

32. Baxter L, Burton A, Fancourt D. Community and cultural engagement for people with lived experience of mental health conditions: what are the barriers and enablers? BMC Psychol. 2022;10(1):71 (https://doi.org/10.1186/s40359-022-00775-y).

33. Hurley J, Cashin A, Mills J, Hutchinson M, Kozlowski D, Graham I. Qualitative study of peer workers within the 'Partners in Recovery' programme in regional Australia. Int J Mental Health Nurs. 2018;27(1):187–95 (https://doi.org/10.1111/inm.12308).

34. Gupta V, Golding L, Eames C, Greenhill B, Qi R, Allan S et al. Understanding the identity of lived experience researchers and providers: a conceptual framework and systematic narrative review. PsyArXiv Preprints; 2022 (https://doi.org/10.31234/osf.io/gjh2c).

35. Lorenz-Artz K, Bierbooms J, Bongers I. Introducing peer-supported open dialogue in changing mental health care. Front Psychol. 2023;13:1056071 (https://doi.org/10.3389/fpsyg.2022.1056071).

36. Toolkit to support peer support workers working in the Health Service Executive. Dublin: Health Service Executive; 2019 (https://www.hse.ie/eng/services/list/4/mental-health-services/mental-health-engagement-and-recovery/guidance-and-support-documents/).

37. Naughton L, Collins P, Ryan M. Peer support workers: a guidance paper. Dublin: Health Service Executive; 2015 (https://www.hse.ie/eng/services/list/4/mental-health-services/mental-health-engagement-and-recovery/guidance-and-support-documents/).

38. Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on a comprehensive approach to mental health. Brussels: European Commission; 2023 (COM(2023) 298 final; https://health.ec.europa.eu/publications/comprehensive-approach-mental-health_en).

39. Guidance on mental health policy and strategic action plans: module 2: key reform areas, directives, strategies, and actions for mental health policy and strategic action plans. Geneva: World Health Organization; 2025 (https://iris.who.int/handle/10665/380466). Licence: CC BY-NC-SA 3.0 IGO.

40. Payne M. Peer support in mental health: a narrative review of its relevance to social work. Egypt J Soc Work. 2017;4(1):19–40 (https://doi.org/10.21608/ejsw.2017.8725).

41. Van Genk C, Roeg D, Van Vugt M, Van Weeghel J, Van Regenmortel T. Current insights of community mental healthcare for people with severe mental illness: a scoping review. Front Psychiatry. 2023;14:1156235 (https://doi.org/10.3389/fpsyt.2023.1156235).

42. Mental health systems capacity in European Union Member States, Iceland and Norway. Copenhagen: WHO Regional Office for Europe; 2024 (https://iris.who.int/handle/10665/378308). Licence: CC BY-NC-SA 3.0 IGO.

43. Guerrero Z, Kågström A, Aliev A, Tomášková H, Yon Y, Lazeri L et al. Mental health plans and policies across the WHO European Region. Glob Ment Health (Camb). 2024;11:e110 (https://doi.org/10.1017/gmh.2024.88).

44. A National Framework for Recovery in Mental Health. Dublin: Health Service Executive; 2024 (https://www.hse.ie/eng/services/list/4/mental-health-services/mental-health-engagement-and-recovery/guidance-and-support-documents/).

45. Certificate in peer support working in mental health. In: Dublin City University [website]. Dublin City University; 2025 (https://www.dcu.ie/courses/undergraduate/school-nursing-psychotherapy-and-community-health/certificate-peer-support).

46. Peer support practice. In: Atlantic Technological University [website]. Atlantic Technological University; 2025 (https://www.atu.ie/courses/certificate-peer-support-practice).

47. Ruud T, Friis S. Community-based mental health services in Norway. Consort Psychiatr. 2021;2(1):47–54 (https://doi.org/10.17816/CP43).

48. Sørly R, Sivertsen K, Stalsberg Mydland T. An exploration of recovery competence among Norwegian peer workers in substance abuse services. Soc Work Ment Health. 2022;20(1):44–59 (https://doi.org/10.1080/15332985.2021.1968988).

49. Strifeldt M. About the Norwegian association of peer support workers [website]. Erfaringssentrum; 2021 (https://erfaringssentrum.no/about-the-norwegian-association-of-peer-support-workers/).

50. KBT Competence Center for Lived Experience and Service Development [website]. KBT Competence Center for Lived Experience and Service Development; 2025 (https://kbtkompetanse.no/en/we-offer/vocational-school-for-peer-support/).

51. Bower P, Roberts C, O'Leary N, Callaghan P, Bee P, Fraser C et al. A cluster randomised controlled trial and process evaluation of a training programme for mental health professionals to enhance user involvement in care planning in service users with severe mental health issues (EQUIP): study protocol for a randomised controlled trial. Trials. 2015;16(1):348 (https://doi.org/10.1186/s13063-015-0896-6).

52. Kent M. Developing a strategy to embed peer support into mental health systems. Adm Policy Ment Health. 2019;46(3):271–6 (https://doi.org/10.1007/s10488-018-0912-8).

53. Mulvale G, Green J, Robert G, Larkin M, Vackerberg N, Kjellström S et al. Adopting, implementing and assimilating coproduced health and social care innovations involving structurally vulnerable populations: findings from a longitudinal, multiple case study design in Canada, Scotland and Sweden. Health Res Policy Sys. 2024;22(1):42 (https://doi.org/10.1186/s12961-024-01130-w).

54. Harrison J, Lange A, Chapleua A. Mental health peer career pathways and impact: the results of lived experience on recovery. Ment Health Hum Resilience Int J. 2021;5(1):000142 (https://doi.org/10.23880/mhrij-16000142).

55. Huber MA, Metze R, Veldboer L, Stam M, Van Regenmortel T, Abma T. The role of a participatory space in the development of citizenship. J Soc Intervention. 2019;28(1):39 (https://doi.org/10.18352/jsi.583).

56. Scanlan JN, Still M, Radican J, Henkel D, Heffernan T, Farrugia P et al. Workplace experiences of mental health consumer peer workers in New South Wales, Australia: a survey study exploring job satisfaction, burnout and turnover intention. BMC Psychiatry. 2020;20(1):270 (https://doi.org/10.1186/s12888-020-02688-9).

57. Gray M, Davies K, Butcher L. Finding the right connections: peer support within a community-based mental health service. Int J Soc Welfare. 2017;26(2):188–96 (https://doi.org/10.1111/ijsw.12222).

58. Lawn S. Integrating service user participation in mental health care: what will it take? Int J Integr Care. 2015;15:e004 (https://doi.org/10.5334/ijic.1992).

59. Schlesinger K. Storytelling as a tool to advance awareness of human rights [blog post]. Norwegian Human Rights Fund; [undated] (https://nhrf.no/blog/storytelling-as-a-tool-to-advance-awareness-of-human-rights).

60. Mosaic toolkit to end stigma and discrimination in mental health. Copenhagen: WHO Regional Office for Europe; 2024 (https://iris.who.int/handle/10665/379124). Licence: CC BY-NC-SA 3.0 IGO.

61. Nixdorf R, Kotera Y, Baillie D, Garber Epstein P, Hall C, Hiltensperger R et al. Development of the UPSIDES global mental health training programme for peer support workers: perspectives from stakeholders in low, middle and high-income countries. PLoS One. 2024;19(2):e0298315 (https://doi.org/10.1371/journal.pone.0298315).

62. Rebeiro Gruhl KL, LaCarte S, Calixte S. Authentic peer support work: challenges and opportunities for an evolving occupation. J Ment Health. 2016;25(1):78–86 (https://doi.org/10.3109/09638237.2015.1057322).

63. Wall A, Lovheden T, Landgren K, Stjernswärd S. Experiences and challenges in the role as peer support workers in a Swedish mental health context – an interview study. Issues Ment Health Nurs. 2022;43(4):344–55 (https://doi.org/10.1080/01612840.2021.1978596).

64. Nordic and Baltic cooperation for Peer Support Workers [website]. Peer-Partnerskabet; 2025 (https://peerpartnerskabet.dk/projekter/nordic-and-baltic-cooperation-for-peer-support-workers/).

65. Shankland M, Ferrand A, Ganache I, Côté MA, Pomey MP. Ethical foundations of the accompanying patient's role for an enhanced patient experience: a scoping review. J Pers Med. 2022;13(1):77 (https://doi.org/10.3390/jpm13010077).

66. National practice guidelines for peer specialists and supervisors. Washington, DC: National Association of Peer Supporters; 2019 (https://www.peersupportworks.org/national-practice-guidelines/).

67. Lequin P, Suter C, Mazallon R, Brodard R, Abrahamyan Empson L, Robalo B et al. Integration of a peer practitioner in a hospital unit for patients with psychotic disorders: an exploratory qualitative study. Front Psychiatry. 2023;14:1244433 (https://doi.org/10.3389/fpsyt.2023.1244433).

68. Gillard S, Holley J, Gibson S, Larsen J, Lucock M, Oborn E et al. Introducing new peer worker roles into mental health services in England: comparative case study research across a range of organisational contexts. Adm Policy Ment Health. 2015;42(6):682–94 (https://doi.org/10.1007/s10488-014-0603-z).

69. Phipps M, Barnes T, Morrison J. Lived experience of peer-clinician collaboration in a mental health service. Int J Mental Health Nurs. 2023;32(2):615–9 (https://doi.org/10.1111/inm.13101).

70. Repper J, Perkins R. The team recovery implementation plan: a framework for creating recovery-focused services. Nottingham: Imroc; 2013 (Imroc Briefing Paper No. 6; https://www.imroc.org/publications/the-team-recovery-implementation-plan-a-framework-for-creating-recovery-focused-services).

71. Jenkins GT, Shafer MS, Janich N. Critical issues in leadership development for peer support specialists. Community Ment Health J. 2020;56(6):1085–94 (https://doi.org/10.1007/s10597-020-00569-9).

72. Nash E, Taplin S, Rust LJ, Percival R. Staff experiences of working alongside peer support workers in forensic mental health community teams: a qualitative study. J Forensic Pract. 2022;24(4):354–63 (https://doi.org/10.1108/JFP-05-2021-0030).

73. Reeves V, Loughhead M, Halpin MA, Procter N. Organisational actions for improving recognition, integration and acceptance of peer support as identified by a current peer workforce. Community Ment Health J. 2024;60(1):169–78 (https://doi.org/10.1007/s10597-023-01179-x).

74. Zeng G, McNamara B. Strategies used to support peer provision in mental health: a scoping review. Adm Policy Ment Health. 2021;48(6):1034–45 (https://doi.org/10.1007/s10488-021-01118-6).

75. Peer support groups at service centres [website]. Helsinki; 2025 (https://www.hel.fi/en/health-and-social-services/peer-support-groups-at-service-centres).

76. Kivistö M, Martin M, Hautala S, Soronen K. Facilitators and challenges of integrating experts by experience activity in mental health services: experiences from Finland. Community Ment Health J. 2023;59(3):540–51 (https://doi.org/10.1007/s10597-022-01039-0).

77. Peer support [website]. Global Alliance of Mental Illness Advocacy Networks-Europe; 2025 (https://www.gamian.eu/peersupport/).

78. Expert by experience and peer supporter [website]. Kokemustiedon Keskus; 2025 (https://kokemustiedonkeskus.fi/en/projects-and-training/training/expert-by-experience-and-peer-supporter/).

79. Al-Adili L, Malmqvist M, Reinius M, Helispää Rodriguez I, Stenfors T, Brommels M. Implementation of a recovery college embedded in a Swedish psychiatry organization: qualitative case study. J Particip Med. 2024;16:e55882 (https://doi.org/10.2196/55882).

80. Riktlinjer för utbildning, implementering och anställning – Metodhandbok [Guidelines for training, implementation and employment – methodology manual]. Stockholm: Nationell Samverkan för Psykisk Hälsa; 2019 (https://nsph.se/butik/informationsmaterial/metodhandbok-peer-support/) (in Swedish).

81. Klockmo C, Marnetoft SU, Nordenmark M. Moving toward a recovery-oriented approach in the Swedish mental health system – an interview study of Personligt Ombud in Sweden. Vulnerable Groups & Inclusion. 2012;3(1):18879 (https://doi.org/10.3402/vgi.v3i0.18879).

82. Grim K, Bergmark M, Argentzell E, Rosenberg D. Managing peer support workers in Swedish mental health services – a leadership perspective on implementation and sustainability. J Psychosoc Rehabil Ment Health. 2023;10(3):313–29 (https://doi.org/10.1007/s40737-022-00311-6).

83. Slay J, Stephens L. Co-production in mental health: a literature review. London: New Economics Foundation; 2013 (https://neweconomics.org/2013/11/co-production-mental-health).

84. Penney D, Prescott L. The co-optation of survivor knowledge: the danger of substituted values and voice. In: Russo J, Sweeney A, editors. Searching for a rose garden: challenging psychiatry, fostering mad studies. Ross-on-Wye: PCCS Books; 2016: 35–45.

85. Coproduction in mental health toolkit [website]. Bath: National Development Team for Inclusion; 2025 (https://www.ndti.org.uk/resources/coproduction-in-mental-health-toolkit).

86. Norton M. Co-production in mental health: implementing policy into practice, first edition. London: Routledge; 2022 (https://www.taylorfrancis.com/books/9781003241423).

87. History of Whānau Ora. In: Horouta Whānau Ora [website]. Horouta Whānau Ora; 2025 (https://www.horoutawhanauora.com/history-of-whanau-ora/).

88. Community based intervention for mental health care of asylum-seekers and refugees in Greece [website]. Association for Regional Development and Mental Health; 2023 (https://www.epapsy.gr/en/cpw-community-based-intervention-for-mental-health-care-of-asylum-seekers-and-refugees-in-greece/).

89. Otte I, Werning A, Nossek A, Vollmann J, Juckel G, Gather J. Challenges faced by peer support workers during the integration into hospital-based mental health-care teams: results from a qualitative interview study. Int J Soc Psychiatry. 2020;66(3):263–9 (https://doi.org/10.1177/0020764020904764).

90. Rennick-Egglestone S, Ramsay A, McGranahan R, Llewellyn-Beardsley J, Hui A, Pollock K et al. The impact of mental health recovery narratives on recipients experiencing mental health problems: qualitative analysis and change model. PLoS One. 2019;14(12):e0226201 (https://doi.org/10.1371/journal.pone.0226201).

91. Ben-Dor IA, Kraus E, Goldfarb Y, Grayzman A, Puschner B, Moran GS. Perspectives and experiences of stakeholders on self-disclosure of peers in mental health services. Community Ment Health J. 2024;60(7):1308–21 (https://doi.org/10.1007/s10597-024-01287-2).

92. Kotera Y, Newby C, Charles A, Ng F, Watson E, Davidson L et al. Typology of mental health peer support work components: systematised review and expert consultation. Int J Ment Health Addiction. 2025;23(1):543–59 (https://doi.org/10.1007/s11469-023-01126-7).

93. Charles A, Nixdorf R, Ibrahim N, Meir LG, Mpango RS, Ngakongwa F et al. Initial training for mental health peer support workers: systematized review and international Delphi consultation. JMIR Ment Health. 2021;8(5):e25528 (https://doi.org/10.2196/25528).

94. The competence framework for mental health peer support workers [website]. Royal College of Psychiatrists; 2025 (https://www.rcpsych.ac.uk/improving-care/nccmh/competence-frameworks/the-competence-framework-for-mental-health-peer-support-workers).

95. Peer support workers. In: Health Service Executive [website]. Health Service Executive; 2024 (https://www.hse.ie/eng/staff/jobs/eligibility-criteria/peer-support-workers.html).

96. Franke CCD, Paton BC, Gassner LAJ. Implementing mental health peer support: a South Australian experience. Aust J Prim Health. 2010;16(2):179 (https://doi.org/10.1071/py09067).

97. Amering M, Mikus M, Steffen S. Recovery in Austria: mental health trialogue. Int Rev Psychiatry. 2012;24(1):11–8 (https://doi.org/10.3109/09540261.2012.655713).

98. Peer to peer: a route to recovery of people with mental illness through peer support training and employment [website]. European Platform for Rehabilitation; 2025 (https://www.epr.eu/peer-to-peer-a-route-to-recovery-of-people-with-mental-illness-through-peer-support-training-and-employment/).

99. Klúbburinn Geysir [The Geysir Club] [website]. Klúbburinn Geysir; 2025 (https://klubburinngeysir.is/) (in Icelandic).

100. Rehabilitation at Virknihús Engagement Center [website] Reykjavik City; 2025 (https://reykjavik.is/en/engagement-and-rehabilitation/virknihus-engagement-center).

101. Batamiðað nám um geðheilsu og bætt lífsgæði [Recovery-oriented learning about mental health and improved quality of life] [website]. Bataskóli Íslands; 2025 (https://www.bataskoli.is) (in Icelandic).

102. Hvað er Hugarafl? [What is Mindpower?] [website]. Hugarafl; 2025 (https://hugarafl.is/hvad-er-hugarafl/) (in Icelandic).

103. Villani M, Kovess-Masféty V. Les programmes de pairs aidants en santé mentale en France: état de situation et difficultés de mise en place [Peer support programmes in mental health in France: current situation and implementation difficulties]. L'Encéphale. 2018;44(5):457–64 (https://doi.org/10.1016/j.encep.2018.01.003) (in French).

104. The CoFoR Project (Recovery Training Centre) [website]. TransForm; 2021 (https://transform-integratedcommunitycare.com/casestudy/the-cofor-project-recovery-training-centre/).

105. GHU Paris Psychiatrie & Neurosciences [GHU Paris Psychiatry & Neurosciences] [website]. GHU Paris Psychiatrie & Neurosciences; 2024 (https://www.ghu-paris.fr/fr) (in French).

106. Gardien E, Laval C. The institutionalisation of peer support in France: development of a social role and roll out of public policies. Alter. 2019;13(2):69–82 (https://doi.org/10.1016/j.alter.2018.09.002).

107. WHOCC (Lille – France): World Health Organization Collaborating Centre for Research and Training In Mental Health (English presentation). Etablissement Public de Santé Mentale Lille-Métropole; 2024 (https://www.epsm-lille-metropole.fr/le-ccoms).

108. Stefancic A, Bochicchio L, Tuda D, Harris Y, DeSomma K, Cabassa LJ. Strategies and lessons learned for supporting and supervising peer specialists. Psychiatr Serv. 2021;72(5):606–9 (https://doi.org/10.1176/appi.ps.202000515).

109. The supervision of peer support specialists. New York: Peer Support Services Technical Assistance Center; 2018 (https://peertac.org/wp-content/uploads/2024/06/PTAC-030_Supervision_Guide_06.07.24-3.pdf).

110. Klingemann J, Sienkiewicz-Jarosz H, Molenda B, Świtaj P. Peer support workers in mental health services: a qualitative exploration of emotional burden, moral distress and strategies to reduce the risk of mental health crisis. Community Ment Health J. 2025;61(4):629–38 (https://doi.org/10.1007/s10597-024-01370-8).

111. Castles C, Stewart V, Slattery M, Bradshaw N, Roennfeldt H. Supervision of the mental health lived experience workforce in Australia: a scoping review. Int J Mental Health Nurs. 2023;32(6):1654–71 (https://doi.org/10.1111/inm.13207).

112. Byrne L, Roennfeldt H, Wolf J, Linfoot A, Foglesong D, Davidson L et al. Effective peer employment within multidisciplinary organizations: model for best practice. Adm Policy Ment Health. 2022;49(2):283–97 (https://doi.org/10.1007/s10488-021-01162-2).

113. Prat Vigué G, Cano Prieto I, Del Río Sáez R, Vilanova Masana R, Simó Algado S. Training peer support workers in mental health care: a mixed methods study in central Catalonia. Front Psychiatry. 2022;13:791724 (https://doi.org/10.3389/fpsyt.2022.791724).

114. Werken bij Enik [Working at Enik] [website]. Enik Recovery College; 2025 (https://www.enikrecoverycollege.nl/over-ons/werken-bij-enik/) (in Dutch).

115. CARe Academy [website]. The CARe Network; 2025 (https://thecare-network.com/care-academy-3/).

116. Commandeur I. Developing a peer mentoring program to promote mental health in young adults living in rural North-Holland [Master's thesis]. Vrije Universiteit Amsterdam; 2022 (https://research.vu.nl/en/publications/developing-a-peer-mentoring-program-to-promote-mental-health-in-y). Licence: CC BY-NC-SA.

117. Netherlands. In: PowerUs [website]. PowerUs; 2025 (https://powerus.eu/countries/netherlands/).

118. Rosińska M. Mental Health Buddies Network (Sieć Przyjaciół Zdrowia Psychicznego). In: Humanity in Action [website]. Humanity in Action; 2025 (https://humanityinaction.org/action_project/mental-health-buddies-network-siec-przyjaciol-zdrowia-psychicznego/).

119. Well-Being and Recovery College Estonia [website]. Heaolu ja Taastumise Kool; 2025 (http://heakool.ee/eng/).

120. Peer counselling for those with mental illness [website]. Tallinn; 2022 (https://www.tallinn.ee/en/peer-counselling-those-mental-illness).

121. Kogemusnõustaja koolituskava [Experience adviser training plan]. In: Riigi Teataja [website]. Riigi Teataja; 2019 (https://www.riigiteataja.ee/akt/129122015035?leiaKehtiv) (in Estonian).

122. Mirbahaeddin E, Chreim S. Transcending technology boundaries and maintaining sense of community in virtual mental health peer support: a qualitative study with service providers and users. BMC Health Serv Res. 2024;24(1):510 (https://doi.org/10.1186/s12913-024-10943-y).

123. Fortuna K, Hill J, Chalker S, Ferron J. Certified peer support specialists training in technology and delivery of digital peer support services: cross-sectional study. JMIR Form Res. 2022;6(12):e40065 (https://doi.org/10.2196/40065).

124. Peer support groups – Autumn 2022 signup [website]. Substance Abuse and Mental Health Association; 2022 (https://www.samha.fi/en/peer-support-group-signup-2022/).

125. Research and evidence [website]. Togetherall; 2025 (https://togetherall.com/en-gb/about-us/evidence/).

126. Rowlands H, Aylwin-Foster E, Hotopf M, Rayner L, Simpson A, Lavelle G et al. A qualitative exploration of the psychosocial needs of people living with long-term conditions and their perspectives on online peer support. Health Expect. 2023;26(5):2075–88 (https://doi.org/10.1111/hex.13814).

127. Slade M, Longden E. Empirical evidence about recovery and mental health. BMC Psychiatry. 2015;15(1):285 (https://doi.org/10.1186/s12888-015-0678-4).

Annex: Tools and guidance on mental health

WHO QualityRights training and guidance tools

Human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329538).

Mental health, disability and human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329546).

Freedom from coercion, violence and abuse: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329582).

Legal capacity and the right to decide: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329539).

Recovery and the right to health: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329577).

Strategies to end seclusion and restraint: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329605).

Recovery practices for mental health and well-being: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329602).

Supported decision-making and advance planning: WHO QualityRights Specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329609).

Advocacy for mental health, disability and human rights: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329587).

Civil society organizations to promote human rights in mental health and related areas: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329589).

One-to-one peer support by and for people with lived experience: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329591).

Peer support groups by and for people with lived experience: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/bitstream/handle/10665/329594/9789241516778-eng.pdf)

WHO guidance and technical packages on community mental health services

Overall guidance

Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341648).

Seven technical packages

Community mental health centres: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341642).

Community outreach mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341644).

Comprehensive mental health service networks: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341646).

Hospital-based mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341647).

Mental health crisis services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341637).

Peer support mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341643).

Supported living services for mental health: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341645).

WHO QualityRights tools for assessing and transforming services and promoting rights

WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities. Geneva: World Health Organization; 2012 (https://iris.who.int/handle/10665/70927).

Transforming services and promoting human rights: WHO QualityRights training and guidance: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329611).

WHO guidance for policy, planning and law reform

Mental health, human rights and legislation: guidance and practice. Geneva: World Health Organization and the United Nations (represented by the Office of the United Nations High Commissioner for Human Rights); 2023 (https://iris.who.int/handle/10665/373126).

Guidance on mental health policy and strategic action plans. Geneva: World Health Organization; 2025 (https://www.who.int/publications/i/item/9789240106796)

WHO Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors (forthcoming, 2025)

WHO Mosaic toolkit to end stigma and discrimination in mental health

Mosaic toolkit to end stigma and discrimination in mental health. Copenhagen: WHO Regional Office for Europe; 2024 (https://iris.who.int/handle/10665/379124). Licence: CC BY-NC-SA 3.0 IGO.

The Heiloo Declaration: peer and lived experience leadership

Heiloo Declaration: peer and lived experience leadership [website]. Global Leadership Exchange; 2024 (https://gle.world/peer-and-lived-experience-leadership-match-the-netherlands/).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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