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Recovery assistants on their training and employment – a survey

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Summary

Aim. The aim of the study was to evaluate the opinions of graduates of courses preparing them for work as recovery assistants on the training they had completed. In addition, information was collected on the possible need for further education of these graduates. Furthermore, data was obtained on graduates taking up employment as recovery assistants (RA).

Material and methods. A survey method was used, employing a self-administered questionnaire. Forty-eight questionnaires were analysed.

Results. Between 79.2% and 97.9% of respondents considered the content of the course to be useful, depending on the module. 97.9% of respondents see a need for further education. 63.8% of respondents took up employment as a recovery assistant after the course, with 40% working full-time. 83.9% of respondents find working with patients satisfying. 87.1% of respondents see great value in working with patients. 73.3% of respondents stated that working as a recovery assistant has improved their mental health. Recovery assistants notice several significant changes in their patients as a result of their work. The most important of these are greater motivation to undergo treatment (79%) and planning for the future and undertaking various activities (72%).

Conclusions. The results indicate the validity of courses and training for recovery assistants, both at the basic and advanced levels. The introduction of assistants into therapeutic teams has a positive impact both on themselves and on the people with whom they work in carrying out their tasks. Further research is needed on the scope of work of RA and their role in therapeutic teams.

Key words: recovery assistants, training, course evaluation

This work was carried out within the "Cogito" Krakow Research Group.

Introduction

Experts by experience (Ex-In, *peers*) joined therapeutic teams in Europe, Australia and the United States at the beginning of the 21st century [1–3]. Forchuk et al. [2] described various models of peer *support* in one region of the United Kingdom. The authors distinguished three forms of support. The first is informal, collegial support. The second is support provided in clubs and psychosocial centres, usually in the form of various recreational activities. The third form is mutual support in the form of self-help. The authors prepared a list of activities carried out by recovery assistants in the above-mentioned areas. This list shows that the fewest recovery assistants work in clinical settings, such as 24-hour wards, day wards or community wards. On the other hand, a large part of the support provided by recovery assistants was through non-governmental organisations (NGOs). They were particularly involved in activities related to education, mental health promotion and early detection of disorders.

For over ten years, studies have been published on the effectiveness of recovery assistants' impact on patients in various therapeutic programmes. Their results are compared with those achieved by patients undergoing standard psychiatric treatment. The recovery assistants included in the study had previously undergone training based on the Ex-In training programme [4]. The results indicate that the group activities of recovery assistants significantly support the personal recovery process of patients. However, no impact of these activities on other measured treatment outcomes was found. Other studies have shown that the availability of support from recovery assistants was associated with a reduction in patients' use of outpatient forms of assistance. Moreover, it turned out that such support was particularly valuable in low-income countries [5].

Research on the evaluation of training for *peer support* assistants was conducted in Switzerland and Germany in 2021 [6]. The aim of this study was to assess the impact of Ex-In training on various indicators of recovery among training participants. The indicators assessed included level of hope, sense of self-efficacy, ability to introspect, resistance to stigmatisation, subjective sense of recovery, health-related quality of life, and employment status of training graduates. The study involved 103 people from Switzerland and Germany. Measurements were taken before the training and 16 months after the training. The results proved to be very valuable. The study reported a statistically significant increase in several parameters. This concerned the personal recovery process, resistance to stigma and introspection skills. The only indicator that did not improve was the participants' quality of life. In addition, the employment rate among participants increased significantly after completing the training.

In Poland, 'experts by experience' have been participating in educational programmes for many years, both at the undergraduate and postgraduate levels. However, their new role, referred to as recovery assistant (RA), has only become widespread since 2019 with the development of psychiatric care reform and the formal establishment of this function in Mental Health Centres [7–10]. The name 'recovery assistant' in Poland refers to people who previously functioned as 'experts by experience' (*Ex-In*, *peers*). Experts by experience have long performed a number of important social

functions. As part of their educational role, they taught various social groups about the experience of mental illness, gave interviews in the press, on the radio and on television, and wrote books in which they shared their experiences of the recovery process. In their political role, they have participated in various decision-making bodies (e.g. the Sejm Council for Psychiatry), engaged in dialogue with local politicians and publicly represented colleagues with similar experiences. Recovery assistants are also experts by experience, but they work directly in the field of therapy. They are involved in the treatment of people with mental disorders and perform therapeutic functions that support the course of treatment. This new, strictly professional role of people with mental illness is now recognised as a separate professional qualification. It is included in the Integrated Qualifications System (ZSK) [10].

It is worth noting here the differences between the mission and role of a recovery assistant and their formal position in the institutional system. The mission and role of a recovery assistant differ significantly from their formal position in the institutional mental health care system. These differences mainly concern the scope of values and objectives of the work, as well as the level of legal regulations, qualifications, employment conditions, and target professional status.

The mission of a recovery assistant is to support people experiencing mental health crises in the recovery process, based on their own experience of crisis and the process of regaining balance. A key element of this role is a partnership based on hope, strengthening the agency, self-determination, and subjectivity of the person being supported. The recovery assistant acts as an 'equal in experience' who accompanies, motivates, shares practical knowledge gained from their own recovery journey, and helps to find resources, both personal and environmental.

However, the formal position of a recovery assistant in the institutional system does not fully reflect this mission. In many cases, this role functions as part of pilot or temporary projects, without a clear and permanent professional status. The qualifications of a recovery assistant are usually determined by completing specialised training or a certification course. However, there is no uniform, legally regulated education system. Certification requirements are regulated by the Integrated Qualifications System. From March 2024, it will be possible to undergo the certification process for this qualification. The Association for the Development of Psychiatry and Community Care has been authorised to certify this qualification. The full name of the qualification is: "Supporting people experiencing mental health crises in the recovery process by people with experience of psychosis (recovery assistant)". The inclusion of this qualification in the Integrated Qualification System was announced in the Minister of Health's announcement of 26 May 2022 (M. P. 2022, item 581) [11].

The differences between the mission and role of recovery assistants and their formal status within the institutional system are also evident in their employment conditions. Recovery assistants are often employed on a temporary basis, under civil law contracts or as part of externally funded projects. The lack of job stability, ambiguously defined responsibilities and differences in remuneration mean that the actual work of a recovery assistant is sometimes inconsistent with their mission and role. Assistants are often integrated into institutional structures without sufficient preparation of teams

to work in a partnership model, which can lead to the marginalisation of their voice or the instrumentalisation of their experience.

The target status of recovery assistants as a profession remains undefined in many systems. Although this role is increasingly recognised as an important element of modern community mental health care, there is a lack of clear legal regulations granting it the status of an independent profession with clearly defined competences, a career path and a place in the health care system. The discrepancy between the mission and the formal status causes tension, but at the same time points to the direction of further development – towards professionalisation while maintaining the unique, experience-based nature of this role.

In Poland, recovery assistants have been trained for several years. Courses preparing for the qualification of recovery assistant have been or are being held in several centres: in Wieliczka, Wroclaw, Warsaw, and Krakow. The courses differ in terms of participant qualification, scope and duration, trainer competencies, practical requirements in the next stage, and the content of the obtained certificate – in the Krakow course, it is only a certificate of completion, which is a necessary step towards obtaining the Certificate. This study refers to the experiences of the Krakow training environment for recovery assistants. Initially, the training was organised by the Association for the Development of Psychiatry and Community Care (SRP) in cooperation with the "Otwórzcie Drzwi" Association. Subsequently, the SRP established the Krakow Cogito Education Centre, which took over the role of organiser. Between January 2020 and July 2023, seven editions of the recovery assistant course were conducted, with a total of 110 participants. Currently (June 2025), the twelfth edition of this course is underway.

Before the start of the Krakow courses, a survey of expectations was conducted, covering two groups: professionals and patients. The expectations of both groups proved to be very high. What they had in common was a focus on in-depth knowledge of the disease, insight and the recovery process. Professionals also expected recovery assistants to have specific skills and qualities. Above all, they pointed to the need for candidates to have effective communication and cooperation skills. They also considered reliability and responsibility to be important qualities. Patients, on the other hand, in addition to the ability to share their own experiences and cooperate well with other patients and their families, perceived the recovery assistant as a companion, i.e. a person providing support. They also saw them as an intermediary between patients and medical staff [12].

Due to the short time that recovery assistants have been functioning as members of therapeutic teams, both their training process and subsequent experience of working with patients and therapeutic teams have been studied only to a limited extent.

Legal basis and organisation of courses

The vast majority of courses, except during the Covid-19 coronavirus threat, took place in Krakow. However, due to the pandemic, some editions were conducted entirely or partially online via the Zoom platform. Some editions of the course were completely free of charge for participants thanks to funding obtained for this purpose.

These funds came from various sources (including the Ministry of Family and Social Policy and the "Active Citizens – National Fund" programme). In the initial editions of the course, over 100 people applied for only 15 places. Many candidates were so highly motivated that they declared their willingness to participate even in paid training courses, so that after the grant funds were exhausted, paid editions were also organised. Undoubtedly, a factor influencing such high interest in the courses was the introduction of the mandatory employment of recovery assistants in Mental Health Centres. The legal basis for this is the Regulation of the Minister of Health of 9 October 2019, amending the regulation on the pilot programme in Mental Health Centres [13]. Paragraph 16 of this act was supplemented with paragraph 6, which reads: "Persons employed at the centre as part of its core activities include: (…) recovery assistants".

The main assumption of the professional role of a recovery assistant is the skilful use of one's own experience of mental crisis in working with people with mental illness. This competence is formulated in this way in the official description of the Integrated Qualifications System. Therefore, the decisive criterion for admission to the course was having experienced such a crisis. From the organisers' perspective, it was also important for candidates to have already worked through (i.e. discussed and reflected on) their own psychotic crisis. Therefore, the second key condition for admission to the course was to have experience of psychotherapy. Apart from these two main guidelines, other additional criteria changed in subsequent editions of the course. These changes depended on the requirements of specific projects (e.g. restrictions in force at a given time). All admission criteria for the course were verified in two stages. First, candidates submitted an application form and then underwent individual interviews. These interviews were conducted in pairs: a psychologist and a person with experience of mental crisis. Similarly, all training modules within the course were delivered by such two-person teams of instructors. This approach was based on many years of experience in education conducted in tandem by a professional and a person with experience of psychosis. Over time, this principle has become established as the standard. The concept of this model of education about psychotic disorders has also been developed in other courses, such as the community therapist course and the psychotherapy course. As mentioned, the course programme was developed on the basis of a survey of needs and expectations conducted in 2019 among both people with experience of mental crisis and members of therapeutic teams [12]. In addition, the opinions of future course trainers, their reflections and professional experience were taken into account. The course programme initially consisted of 10 modules: Integration and Communication 1, Communication 2, Cognitive Distortions, Ethics, Knowledge about Illness, Cooperation 1, Cooperation 2, Recovery, Insight and Stereotypes, and Summary. However, due to emerging needs, it was decided to expand the programme with an additional module on Self-advocacy.

This research was inspired by two main reasons. On the one hand, it was prompted by conversations with course participants – their feedback and numerous questions about further development opportunities (such questions also arose after the completion of individual editions of the course). On the other hand, the motivation for undertaking the research was the natural need to evaluate our own work and the commitment of the course leaders.

Research objectives

The aim of this study is to conduct a multidimensional analysis of the experiences of participants in Krakow recovery assistant courses, with particular emphasis on the education process, the further educational and professional careers of graduates, and their functioning in the professional role of recovery assistant in the realities of the Polish mental health care system. The study is exploratory and descriptive in nature and attempts to fill the existing research gap concerning the practical dimension of the education and work of recovery assistants in Poland.

In particular, three main research objectives (questions) were set:

1. Evaluation of the training in the opinion of participants. The first objective of the study is to obtain a subjective assessment of the Krakow recovery assistant course by its participants. The analysis included, among other things, the perceived adequacy of the training programme for the future professional role, the evaluation of individual modules, the competence of the training staff, and the usefulness of the acquired knowledge and skills. An important element of this objective is also to identify the strengths of the course and areas requiring modification or further development from the perspective of people with experience of mental health crises who are preparing to take on a professional role.
2. Further educational and professional prospects of participants. The second objective of the study is to track the further educational and professional development of graduates of the recovery assistant course. This includes analysing the extent to which the acquired qualifications are used in practice, taking up employment as a recovery assistant or in related areas, as well as continuing education (e.g. participation in further training, courses or the certification process within the Integrated Qualifications System). The aim is also to identify factors that facilitate or hinder entry into the labour market and retention in the professional role of recovery assistant.
3. Experiences related to working as a recovery assistant. The third objective of the study is to describe and analyse the participants' experiences related to working as a recovery assistant. Particular attention was paid to the ways in which the professional role is performed in different institutional contexts, relationships with members of therapeutic teams, patients and other stakeholders in the system. As part of this objective, the perceived tensions between the mission of a recovery assistant and the formal basis of this role were also examined, including issues related to the scope of responsibilities, professional autonomy, job stability, institutional support and opportunities for further professional development.

The implementation of the above objectives is aimed not only at evaluating current training practices, but also at formulating conclusions relevant to the further development of the training of recovery assistants and their effective and consistent integration into the structures of the mental health care system.

Method

A survey method was used, employing a self-administered questionnaire. All graduates of the Krakow courses were asked to complete the questionnaire. The questionnaire was sent by email to 110 people, 48 of whom completed it. Respondents submitted their answers via a Google form. The survey was conducted from July to August 2023.

The first part of the questionnaire concerned the evaluation of the course and its individual modules. We asked graduates to rate the usefulness of the content in their future work and life, the commitment of the lecturers, the attractiveness of the content and its accessibility on a scale of 1 to 6 (1 being very low and 6 being very high). The survey also included open-ended questions: "What would you change/improve in this module?" and the opportunity to enter other comments. Graduates were also asked to give an overall assessment of the training – asking whether they would recommend the course to others – and were given the opportunity to provide a longer, descriptive answer summarising the course.

The second part of the survey consisted of questions about the potential further education of recovery assistants. Graduates were asked whether they saw a need to expand their knowledge and whether they would be willing to participate in more advanced training. They were also asked what topics should be included in such a course. The aim of this part was also to determine what kind of help graduates need most and whether they would like to participate in support groups. They were also asked about their further educational plans.

The last, third part of the survey was devoted to issues related to working as a recovery assistant. Graduates were asked whether they work in this profession and, if not, why. Those working in the profession were asked where they work, how long and how many hours they work, and what their responsibilities are. They were asked to assess their level of job satisfaction and the level of difficulty of working with patients and their families, as well as with the therapeutic team. With regard to working with patients and their families, they were asked about the sense of purpose in their work. They were also asked how taking up this job had affected their health and whether they had had to take sick leave due to a deterioration in their health caused by their work duties. We were also interested in whether graduates had encountered ignorance about their profession and, if so, from whom. Those working as recovery assistants were also asked an open-ended question: whether they see the meaning and purpose of their work and what effects of their work they can describe.

Results

The results concerning the evaluation of the training, the need for education and development, the employment of trainees, cooperation with staff and families, knowledge about recovery assistants, the sense of purpose of the work, the impact of the work on the health of RAs, and the observed effects of their activities are presented below.

Training evaluation

The results from the first part of the survey are presented below.

Table 1. **Module evaluation: Communication 1, Communication 2, Cognitive Distortions, and Ethics**

Modules: Communication 1 and Communication 2						
	1	2	3	4	5	6
A) Usefulness at work and in later life 1 – not useful at all; 6 – very useful	0	2.1	6.4	4.3	19.1	68.1
B) Commitment of teachers 1 – very low; 6 – very high	0	0	0	4.3	10.9	84.8
C) Attractiveness of the provided content 1 – low; 6 – high	2.1	2.1	0	6.3	29.2	60.4
D) Accessibility of the provided content 1 – low; 6 – high	0	0	0	2.1	25	72.9
Module: Cognitive Distortions						
A) Usefulness at work and in later life 1 – not useful at all; 6 – very useful	0	0	6.3	0	18.8	75
B) Commitment of teachers 1 – very low; 6 – very high	0	0	0	4.2	14.6	81.3
C) Attractiveness of the provided content 1 – low; 6 – high	0	4.2	2.1	8.3	10.4	75
D) Accessibility of the provided content 1 – low; 6 – high	0	0	0	4.2	22.9	72.9
Module: Ethics						
A) Usefulness at work and in later life 1 – not useful at all; 6 – very useful	0	2.1	8.3	10.4	22.9	56.3
B) Involvement of teachers 1 – very low; 6 – very high	0	2.1	8.3	12.5	16.7	60.4
C) Attractiveness of the provided content 1 – low; 6 – high	2.1	2.1	8.3	18.8	29.2	39.6
D) Accessibility of the provided content 1 – low; 6 – high	4.2	0	4.2	12.5	27.1	52.1

Source: own study.

When it came to the usefulness of the content in future work, the ratings ranged from 79.2% (for the Ethics module) to 97.9% (for the Knowledge about Illness module). These percentages include responses from graduates who found the content useful or

very useful. The lecturers were assessed in terms of their commitment – the results range from 71.4% (for the Self-advocacy module) to 97.9% (for the Knowledge about module). These are the percentages of graduates who selected the answer "high" or "very high" engagement of the lecturers. We also asked about the attractiveness of the content provided during the course.

Table 2. **Evaluation of modules: Knowledge about Illness, Cooperation 1 and Cooperation 2**

Module: Knowledge about Illness						
	1	2	3	4	5	6
A) Usefulness at work and in later life 1 – not useful at all; 6 – very useful	0	0	0	2.1	10.4	87.5
B) Commitment of teachers 1 – very low; 6 – very high	0	0	2.1	0	6.3	91.7
C) Attractiveness of the provided content 1 – low; 6 – high	2.1	0	0	2.1	16.7	70.2
D) Accessibility of the provided content 1 – low; 6 – high	0	0	0	2.1	17	80.9
Modules: Cooperation 1 and Cooperation 2						
A) Usefulness at work and in later life 1 – not useful at all; 6 – very useful	2.1	0	2.1	4.3	19.1	72.3
B) Commitment of teachers 1 – very low; 6 – very high	0%	0%	0	4.2	18.8	77.1
C) Attractiveness of the provided content 1 – low; 6 – high	2.1	0	0	4.2	25	68.8
D) Accessibility of the provided content 1 – low; 6 – high	0	0	0	6.3	20.8	72.9

Source: own study.

The ratings for the attractiveness of the course content were quite high. They ranged from 66.7% (for the Self-advocacy module) to 95.8% (for the Knowledge about Illness module). The above values represent the percentage of graduates who considered the content to be "attractive" or "very attractive".

Table 3. **Assessment of modules: Recovery, Insight and Stereotypes**

Module: Recovery						
	1	2	3	4	5	6
A) Usefulness at work and in later life 1 – not useful at all; 6 – very useful	0	0	2.1	2.1	14.6	81.3
B) Commitment of teachers 1 – very low; 6 – very high	0	0	0	4.2	20.8	75

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C) Attractiveness of the provided content 1 – low; 6 – high	0	2.1	4.2	2.1	20.8	70.8
D) Accessibility of the provided content 1 – low; 6 – high	0	0	0	4.2	25	70.8
Module: Self-advocacy (for those who took this module during the course)						
A) Usefulness at work and in later life 1 – not useful at all; 6 – very useful	0	3.6	0	7.1	21.4	67.9
B) Commitment of teachers 1 – very low; 6 – very high	0	7.1	7.1	14.3	17.9	53.6
C) Attractiveness of the provided content 1 – low; 6 – high	7.4	0	7.4	18.5	18.6	48.1
D) Accessibility of the provided content 1 – low; 6 – high	7.1	0	10.7	7.1	17.9	57.1
Module: Insight and stereotypes						
A) Usefulness at work and in later life 1 – not useful at all; 6 – very useful	0	2.1%	0%	4.3	27.7	56
B) Involvement of teachers 1 – very low; 6 – very high	0	0	0	4.3	25.1	69.6
C) Attractiveness of the provided content 1 – low; 6 – high	0	2.1	0	4.3	25.5	68.1
D) Accessibility of the provided content 1 – low; 6 – high	0	0	0	0	31.9	68.1

Source: own study.

The last aspect assessed in this part of the survey was the accessibility of the presented content. Here, the ratings ranged from 75% (for the Self-advocacy module) to 100% (for the Insight and stereotypes module). The percentage calculations took into account the answers "accessible" and "very accessible".

The need for education and development

The next part of the survey concerned the need for further education and other forms of support for course graduates. As many as 97.9% of respondents said they saw such a need, and 95.8% would like to participate in an additional course to expand the knowledge acquired in the basic course for recovery assistants. In addition, 97.9% of respondents see the need to organise a support group or Balint group for working recovery assistants, and 93.8% declare their willingness to participate in such forms of support.

It is extremely important to note that during the course (and also after its completion), many participants discover new skills and take advantage of various opportunities for further education and professional development. The survey shows that they undertake education in fields such as occupational therapy, environmental therapy, psychology, social work, and others. The course leaders noticed that during the classes, the participants' horizons broaden – they discover their potential and competences, and therefore want to develop further, especially in professions related to helping others. This seems particularly valuable, as graduates then join therapeutic teams, bringing new perspectives to them.

Work

The third part of the survey concerned the work of recovery assistants undertaken by course graduates. At the time of the survey, 63.8% of respondents had taken up employment as recovery assistants. Those who did not take up employment were asked about the reasons for their decision. The given reasons included: too low pay, lack of a Mental Health Centre near their place of residence, and fears of excessive mental strain. A large proportion of the respondents were still in training and planned to take up employment after completing it. It is worth noting that the vast majority of those who took up employment work in Mental Health Centres.

Working recovery assistants were also asked about their working hours. Surprisingly, the largest group (40%) work full-time; 6.7% work three-quarters of full-time hours, 20% work half-time, and the rest work other part-time hours. The survey also included a question about the scope of duties of working recovery assistants. The answers indicate a very wide and varied range of activities – primarily tasks carried out directly with patients, such as: conducting classes in the patient club, individual conversations with patients staying at the facility, individual and group outings with patients, conducting their own therapeutic activities (including occupational therapy), working at the Registration and Coordination Point, and participating in trips with patients. In addition, duties performed in cooperation with staff were also mentioned, e.g.: assisting therapists and psychologists during classes, participating in home visits as part of Community Treatment Teams, talking to medical staff about the current health status of individual patients, participating in patient case discussions and team intervision. An important part of the recovery assistants' activities was also cooperation with patients' families, e.g. participation in family sessions or conducting educational activities for families.

Working recovery assistants were asked to assess their work with patients, staff and patients' families in the following areas: degree of satisfaction, level of difficulty and, in the case of work with patients and families, also the sense of meaning in their work. The results are as follows. When it comes to working with patients, 83.9% of respondents feel "very high" or "high" satisfaction with this work. The level of difficulty of working with patients was assessed as follows: 19.3% of respondents considered it to be "very low" or "low", 51.6% considered it to be "medium", and 29.0% considered it to be "high" or "very high". A sense of meaning in working with patients was declared "very high" or "high" by 87.1% of respondents.

Cooperation with the therapeutic team and families

As regards cooperation with the therapeutic team, 64.5% of respondents consider it “satisfactory” or “very satisfactory”, while 6.4% rate their cooperation with staff as “not very” or “very not very” satisfactory. The level of difficulty of working with staff is rated as “very low” or “low” by 32.3% of respondents, as “average” by 54.9%, and as “difficult” or ”very difficult” by 12.9%.

In their assessments of various aspects of working with patients’ families, 50% of respondents rated their satisfaction with this work as “high” or “very high”, and the remaining 50% as “average” (no one indicated “low” or “very low”). The level of difficulty of working with families was considered “very low” or “low” by 42.1% of respondents, “average” by another 42.1%, and “high” by 15.8%. When it came to the sense of meaning in working with families, 77.3% of respondents rated it as “high” or “very high”, 18.2% as “medium” and 4.5% as “very low”.

Impact of work on mental health of RAs

The survey also asked how working as a recovery assistant affected the mental health of the respondents. It was to be expected that, given the heavy workload associated with this job, mental health might deteriorate. Interestingly, 73.3% of respondents said that working as a recovery assistant had improved their mental health, and 80% said that they had not needed to take sick leave (due to their work).

Knowledge about the tasks of a recovery assistant

Graduates were also asked whether, while working as recovery assistants, they had encountered ignorance about their profession, and if so, from whom. The vast majority of working graduates admitted that they encounter a great deal of ignorance about the role of a recovery assistant in the health care system. Importantly, this ignorance applies to various professional groups. Both occupational physicians, whom graduates report to at the beginning of their professional careers, often do not know what the duties of a recovery assistant are, and colleagues in medical facilities often do not have information about the role of a recovery assistant. This applies to psychologists, psychiatrists, nurses, and social workers alike. A lack of knowledge about the qualifications of a recovery assistant was also found among those to whom this role is most dedicated – patients and their families.

Sense of purpose

The last question in this part of the survey concerned the meaning and purpose of working as a recovery assistant. All respondents agreed that they see a deep meaning and purpose in their role as recovery assistants. The essence of the responses is reflected in the statements of the graduates: “I serve as an example that illness does not have to be the end of the world, that you can get through it and do quite well. It is

not theory that convinces patients to change, but a 'living' example" and *"*I see great meaning and purpose in my work. It gives me a great sense of fulfilment. I love what I do. It gives me strength and great joy. I feel tired, but it doesn't destroy me, it gives me the strength to rest well. My patients are radiant, smiling, singing. They get out of bed – without violence, with dignity and respect".

Observed impact on therapy

Participants were also asked to list the visible changes resulting from the work of recovery assistants. The course graduates also described a number of positive changes observed in patients thanks to the work of recovery assistants. The most frequently mentioned changes were greater patient motivation to undergo treatment (79.3% of responses) and their making plans for the future and various activities (72.4%). In addition, 58.6% of assistants noticed that their patients began to actively participate in available therapeutic activities, and 51.7% of respondents said that they contributed to improving the atmosphere at the treatment facility. In addition, 44.8% of recovery assistants noticed that patients began to regularly attend visits to a doctor or psychotherapist, and 41.4% noticed an improvement in the regularity of their medication use. Approximately 31.0% of respondents admitted that thanks to them, patients created their own crisis plans, while 13.8% of respondents encouraged their patients to become involved in assessment activities.

Discussion

Due to the limited number of publications on recovery assistants and the almost complete lack of research conducted in this group in Poland, the presented results should be approached with caution. The role of a recovery assistant is a new social role for people with experience of psychosis and, at the same time, a new formal basis for this function in psychiatry.

Training of recovery assistants

The lack of specific tasks for recovery assistants has contributed to difficulties in planning courses to prepare for this role. There are still differences between the institutions offering courses, and there are no uniform eligibility criteria for candidates for such training. Currently, several institutions in Poland are involved in the training of recovery assistants [14, 15]. The Polish Institute of Open Dialogue Foundation runs a course that is conducted entirely online. Another place where recovery assistants are trained is the EX-IN Polska Association, which is linked to the European Experienced-Involvement movement, promoting cooperation between "experts by experience" and families and professionals. EX-IN courses are held in Wroclaw. In Warsaw, such courses are run by the POMOST Association in cooperation with the Academy of Special Education.

The courses run by the Cogito Educational Centre in Krakow draw on the educational expertise of professionals and experts by experience who have been conducting

training for many years in cooperation with the Association for the Development of Psychiatry and Community Care and the "Otwórzcie Drzwi" Association. The Krakow course begins with a careful selection of candidates, which guarantees that the requirements for participants are met. The course consists of 11 modules delivered exclusively in a classroom setting. The 12th edition of the basic course for recovery assistants is currently underway. At the end of June 2025, recovery assistants with several years of experience will be able to expand their knowledge thanks to the launch of the first edition of the advanced course. The "Otwórzcie Drzwi" Association has made efforts to ensure that recovery assistants have easy access to the materials discussed in the courses. Scripts have been developed for both the basic and advanced courses, containing content from individual modules. They are currently published by Dla Nas Publishing House and available on the websites of both Associations.

Training institutions increasingly require candidates to complete an internship at facilities providing services to people with mental illness. Only then, together with a certificate of course completion, are graduates issued a document confirming their qualifications.

The conclusions from the research on the Krakow course are very optimistic. The authors of the programme and the trainers conducting subsequent editions are satisfied with the high evaluation of individual modules – both in terms of their usefulness at work and in further life, the commitment of the trainers, the attractiveness and accessibility of the content. The opinions of course graduates are also valuable, as they allow for continuous improvement of the course quality. Unfortunately, the lack of similar studies of other courses in Poland makes it impossible to compare their results with those of the Krakow courses.

Implications related to the employment of recovery assistants

In a study of a group of 35 adults participating in one of the editions of a course preparing them for the role of recovery assistant [16], the authors focused on the dimensions of mental well-being of future recovery assistants. The results indicate that people undergoing training for this role experience lower levels of distress during recovery than during a mental health crisis (the period of psychiatric hospitalisation was taken as a reference point). For many people, the experience of a mental crisis is undoubtedly traumatic, and only by working through this experience – often over many years – can they satisfactorily return to the demands of everyday life and take up employment. The results also suggest that people who experience a greater difference in their subjective assessment of distress between the crisis period and the recovery period have a higher level of mental well-being. It can be concluded that these individuals appreciate their recovery more, see it as a source of hope, and that the prospect of finding employment in a place where they do not have to hide their mental illness has a positive impact on their well-being. In addition, a relationship between the level of well-being and self-efficacy was found [16]. In turn, qualitative research conducted in four Mental Health Centres on recovery assistants showed that their work in psychiatric facilities may be associated with psychological stress, which may lead

to a relapse [17]. The study collected interviews from 14 people working as recovery assistants in various settings, from inpatient wards to community treatment teams. Situations related to, for example, a patient's suicide or aggressive behaviour caused particular emotional strain and stress. The strategies used by the recovery assistants to cope with psychological strain were also described – they indicated supervision and psychotherapy as helpful.

Our research shows that obtaining the qualification of a recovery assistant has a positive impact not only on the patients they support, but also that participation in the training process contributes to the mental well-being of those taking the course. Over 60% of respondents in the Krakow study found employment as recovery assistants. Many of them rate their job satisfaction as high or very high – both with patients, their families and staff. They derive the greatest satisfaction from working with patients, slightly less from working with staff, and the least from working with patients' families. At the same time, when working with families, as with patients, the respondents feel a very high sense of purpose. With adequate preparation for this role, despite the burdens associated with the nature of the work, the vast majority of graduates reported an improvement in their mental health as a result of taking up the job.

However, there is still a great deal of ignorance about recovery assistants and the scope of their role among therapeutic teams, as well as among patients and their families themselves. Graduates encounter such ignorance among psychologists, psychiatrists, nurses, and social workers alike. Similarly, patients and their families often do not know what the role and work of a recovery assistant entails.

However, the results concerning the sense of meaning and purposefulness of the work performed by recovery assistants and the examples cited by graduates of changes occurring in the patients they work with are very encouraging.

The future of recovery assistants in Poland

While the initial stages of introducing the qualification of recovery assistant in Poland fell on fertile ground, the further development of this qualification and its future remain uncertain. First of all, the obligation to employ them in Mental Health Centres – which was the basis for employing and thus training assistants – is established only by regulation, not by law. This raises concerns about the future of this qualification.

In addition, political changes in Poland do not provide certainty as to the direction in which the reform of psychiatric care is heading [8]. Reports from studies on the attitude of psychiatric facility staff towards recovery assistants are also worrying. Studies published to date indicate that the expectations associated with the introduction of recovery assistants into therapeutic teams were mainly linked to concerns on the part of both staff and patients. Our study shows that these concerns proved largely unfounded, and the vast majority of respondents were well received by the therapeutic teams.

The conclusions regarding the further education of graduates after completing the course and their professional development are optimistic. Both the research and observations during the course, as well as information obtained after each edition, show that the vast majority (over 90% of respondents) see the need for further development.

For many of these people, the course is not only a dose of knowledge and experience, but also an inspiration for further education. This is particularly valuable given that all graduates have experienced profound mental crises and many of them had not considered further education at all before the course. During the course, they found confidence in themselves and their abilities, as well as motivation and enthusiasm for further learning. It is also significant that many graduates point out, usually during the summary in the last module, that the course also had a therapeutic dimension for them – thanks to being in a safe space and a friendly group of peers. There is also a high demand among recovery assistants to participate in our nationwide online Balint group and a desire to continue their education in the second-level course currently being offered, aimed at people with several years of experience working in therapeutic teams.

An important effect of the training courses is to broaden the knowledge and understanding of people undergoing treatment, and thus better prepare them for the role of recovery assistant. Our experience and observations also show that training participants derive "therapeutic" benefits. Of particular importance may be the resharing (after an individual psychotherapy process) of one's crisis experience with colleagues – gaining understanding and support within the group. Participants who have undergone individual psychotherapy alone learn the value of the group and experience that issues related to psychosis and traumatic experiences are not isolated. Very often, the training group remains in contact afterwards, remaining in this unique network of support and friendship.

Strengths and weaknesses of the study

The strengths of this study include the analysis of a large group of graduates of Krakow recovery assistant courses conducted over several years (editions 1–7). This allowed us to capture the diverse experiences of the participants, both those who had completed the training relatively recently and those who already had longer professional experience. The study also provided unique data on the subjective assessment of the training process and the first professional experiences of recovery assistants in the reality of the Polish mental health care system, which have rarely been described in the literature to date.

At the same time, a significant limitation of the study is the fact that survey responses were obtained from less than half of the training graduates (43%). It should be emphasised that participation in the study was not mandatory, and the decision to conduct it was only made at the stage of the seventh edition of the course. As a result, the study was largely retrospective in nature and also included graduates of earlier editions (1–6) who had not been previously informed about the planned participation in the study or prepared for possible participation in the evaluation after completing the course.

An additional factor affecting the response rate was the time that had elapsed since the completion of the training for some of the graduates, changes in the personal and professional situations of the participants, and the limited possibility of ongoing contact with all those covered by the study. It should also be noted that low responsiveness is

a well-known limitation of survey research, especially in voluntary studies conducted without reminders or incentives to participate.

All of the above factors should be considered as weaknesses of the study, which may affect the representativeness of the obtained results and limit the possibility of generalising them. At the same time, however, the collected data constitute important exploratory material, allowing for the formulation of preliminary conclusions and the identification of directions for further, more systematic research. The experience gained from the implementation of this project emphasises the need to plan evaluation studies at the training design stage and to inform participants about the planned long-term monitoring of their educational and professional outcomes.

Conclusions

The obtained results indicate the validity of the courses and training of recovery assistants, both at the basic and advanced levels. The introduction of recovery assistants into therapeutic teams has a positive impact both on themselves and on the people with whom they work in carrying out their tasks. Recovery assistants have been recognised as full members of interdisciplinary therapeutic teams. They are mentioned in the literature as members of interdisciplinary therapeutic teams alongside psychiatrists, nurses, psychologists, therapists, community therapists, and social workers. However, their role is specific, as they "work" with their experience of illness and recovery. The value of the role of a recovery assistant is based on four pillars: 1) strategic use of knowledge gained from their own experiences of mental crisis and the recovery process, 2) serving as a role model, 3) acting on behalf of people experiencing mental health crises, 4) maintaining respectful, empathetic relationships, an unconditionally positive attitude, partnership, and reciprocity.

It turns out that earlier concerns, often resulting from ignorance, are not confirmed in the daily professional work of assistants.

Due to the fact that a recovery assistant is not a separate profession, but only a qualification – and taking into account the differences in the training of recovery assistants – it is reasonable to intensify work aimed at clarifying the scope of duties performed by these persons. Transforming the qualification into a fully-fledged profession in the future would contribute to greater clarity regarding the tasks of recovery assistants and give hope that this profession will become a permanent fixture in the Polish mental health care system, both in psychiatry and in support centres. It is also necessary to deepen research on the evaluation of the work and activities of recovery assistants from the perspective of a trialogue: professionals, patients and their families.

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