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WORKING WITH LIVED EXPERIENCES IN MENTAL HEALTHCARE: ORGANIZATIONAL CHALLENGES

WERKEN MET ERVARINGSKENNIS IN DE GGZ: ORGANISATORISCHE UITDAGINGEN

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ABSTRACT

This study examines the integration of experiential knowledge, derived from the lived experiences of mental health service users and professionals, within mental health and addiction care organizations in the Netherlands. Over five years, four organizations participated in a case study aimed at enhancing the incorporation of lived experiences into their practices. The findings highlight the challenges and strategies involved in positioning experiential knowledge as a valuable and complementary resource alongside traditional professional and scientific knowledge. Key themes include the need for organizational commitment, the formalization and professionalization of lived experience roles, and the importance of creating supportive environments for the sharing and utilization of this knowledge. The study underscores the potential of experiential knowledge to enrich mental healthcare practices, though it requires significant investment in training, resources, and cultural shifts within organizations.

KEYWORDS

experiential knowledge, lived experience, organizational change, professionalization, mental health

SAMENVATTING

Deze studie onderzoekt de integratie van ervaringskennis, vanuit de doorleefde ervaringen van cliënten en professionals, binnen ggz en verslavingszorg organisaties in Nederland. Gedurende vijf jaar hebben vier organisaties deelgenomen aan een casestudy gericht op het verbeteren van de integratie van ervaringskennis in de praktijk. De bevindingen benadrukken de uitdagingen en strategieën die betrokken zijn bij het positioneren van ervaringskennis als een waardevolle en aanvullende bron naast traditionele professionele en wetenschappelijke kennis. Belangrijke thema's zijn de behoefte aan organisatorische betrokkenheid, de formalisering en professionalisering van ervaringsdeskundige rollen, en het belang van het creëren van ondersteunende omgevingen voor het delen en het gebruik van deze kennis. De studie onderstreept het potentieel van ervaringskennis om zorgpraktijken te verrijken, hoewel het significante investeringen in opleiding, middelen en culturele verschuivingen binnen organisaties vereist.

TREFWOORDEN

Ervaringskennis, doorleefde ervaringen, organisatieverandering, professionalisering, geestelijke gezondheidszorg

INTRODUCTION

Working with service users' lived experiences in mental health organizations is part of a broader recovery agenda that emphasizes person-centred care, personal recovery, social inclusion, and empowerment more than traditional clinical medical outcomes (World Health Organization, 2015). Over the past 25 years, user- and survivor-led collaborations have featured internationally in major mental health policy and practice guidelines (World Health Organization, 2022). The lived experiences of service users have been acknowledged amidst large transitions such as the shift from institutional care to community care in Western countries (Casey, 2021; Castro, 2018).

The rise of experiential knowledge as a relevant source of knowledge was due to its ability to better relate to users' needs (Baillergeau & Duyvendak, 2016). Working with this knowledge is seen as a pathway to complement the often standardized evidence-based practice in transitioning towards tailored approaches.

The integration of experiential knowledge into mental healthcare systems is grounded in several theoretical perspectives that explore its role, value, and challenges. Central to this integration is the concept of knowledge pluralism, which recognizes the coexistence of different types of knowledge—scientific, professional, and experiential—as equally valid yet distinct contributions to understanding and addressing mental health issues (Flyvbjerg, 2001). Experiential knowledge, derived from lived experiences of mental health challenges, represents a form of embodied knowledge (Polanyi, 1966), which is deeply personal, contextual, and often tacit. This knowledge contrasts with the generalized and decontextualized nature of evidence-based practices dominant in clinical settings (Greenhalgh et al., 2014; Leemeijer, 2024).

Theoretical discussions emphasize the transformative potential of experiential knowledge in reshaping traditional power dynamics within healthcare systems. Drawing from Foucault's (1980) concept of power/knowledge, experiential expertise challenges the authority of clinical knowledge by bringing forth narratives that highlight the subjective and relational dimensions of recovery. This shift aligns with the principles of recovery-oriented practice (Anthony, 1993), which prioritize individual agency, meaning-making, and holistic care over symptom reduction and diagnostic categorizations.

To use experiential expertise, peer workers have been employed in mental healthcare, and their contributions to supporting others have gradually gained more recognition (Grundman et al., 2020).

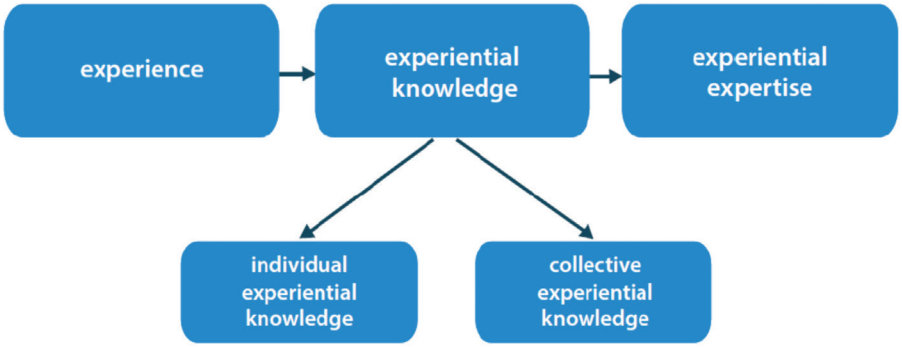

Figure 1: Process model from experience to experiential expertise (Castro, 2018).

There is also growing awareness that a considerable number of professionals have been exposed to trauma and distress in their personal lives (Zerubavel & Wright, 2012). This overall trend has led to advances in legislation and government policies supporting shared decision-making and empowerment of service users (Casey, 2021).

The use of experiential knowledge in mental healthcare is based on acknowledging the unique character of this kind of knowledge, which is grounded in the experience of living with a mental illness (Van Haaster et al., 2013). Its uniqueness stems from what it is like to experience distress and be dependent on the care and support of others, as well as on reflections on the organization of care, public responses to mental illness, and, most importantly, the strengths required to give new meaning to the changes in one's life. Sharing these experiences can lead to a 'collective' knowledge base (Boertien & Van Bakel, 2012) and 'experiential expertise' allowing the latter to position it alongside professional and theoretical knowledge to bridge potential gaps. The following process model presents the evolution from 'lived experience' to 'experiential expertise' emphasizing this is part of a larger process in organizations (Figure 1).

While the recognition of the first-person perspective has grown over the years, studies demonstrate that the mental healthcare system has yet to meaningfully incorporate experiential knowledge. For example, tensions have been described between peer workers and established staff about how much lived experience is enough to fulfill a role as a lived experience practitioner and what experiences are considered valuable (Roennfeldt & Byrne, 2020). Scholars have been

critical of the co-optation of peer workers (Van Os et al., 2021) and its instrumental use in cutting services and expenses, reproducing neoliberal values of productivity, risk reduction, and efficiency (Aadam & Petrakis, 2019; Beresford & Brosnan, 2021; Davidson et al., 2006; Wigmore & Stanford, 2017). The interplay between marketization logic, medicalization, and professionalization has also led to new cost control and management strategies (Saks, 2020). There is a need for a better understanding of how to position experiential knowledge within mental healthcare organizations to harness its values and contributions.

The aim of the current study was to research the conditions needed to implement experiential knowledge in three mental healthcare organizations and one addiction care organization.

METHODS

Research setting

In this case study, we examined how to further develop and integrate experiential knowledge and expertise in four different organizations. While the organizations differed from one another, they were all in the process of acknowledging and integrating lived experiences in a professional context. Therefore, with this study we identified the lessons learned from an organization perspective when implementing this type of expertise in mental health and addiction care organizations. All organizations were part of the PEPPER Consortium which stands for Practical, Existential, Political-critical, Personal, Ethical, and Relational and consists of a collaboration of providers and universities aiming to incorporate the lived experience perspective into the 'standard of care' (Weerman et al., 2019). The consortium invested in research, policy development, and education such as training and peer supervision groups for 60 nursing professionals and social workers with lived experiences in addition to regular peer support. Psychologists and psychiatrists, managers and directors in the participating organizations collaborated to work on the changes needed for integrating experiential knowledge based on personal lived experience as the lived experience of (family) caregivers.

Organization 1 is a large mental health care organization providing specialized and general mental health services for individuals of all ages, with a focus on prevention, treatment, and recovery. Organization 2 is a large mental health care institution offering a wide range of outpatient, inpatient, and specialized psychiatric services, with a strong emphasis on recovery-oriented care and community support. Organization 3 supports individuals with psychiatric or psychosocial

challenges through housing, guidance, and day-structure programs, aiming to promote independent living and social participation. Organization 4 specializes in addiction treatment and social care, offering integrated support for substance abuse, behavioral issues, and homelessness, with a focus on sustainable recovery and reintegration.

These organizations provide services to more than 45,000 clients in 75 different locations in the northeastern and central parts of the Netherlands. The workforce consisted of approximately 547 to 1221 full-time equivalent healthcare professionals working in the participating organizations. At the time of the study, only a small percentage (1–2%) of all working professionals were trained and qualified to complement their work with insights from lived experiences.

The research team consisted of four academic researchers (authors 1, 4, 5, and 6) and two executives (authors 2 and 3) from organizations 2 and 4, respectively. The first author collected the data, the fourth author led the learning community, and the fifth and sixth authors were involved as supervising co-researchers. The second and third authors were involved as co-researchers in the implementation process. All authors disclose having either personal lived experience and/or having lived experience as a family caregiver caring for someone with mental illness or disability.

Methods

The four organizations were conceived as similar cases concerning the process of integrating experiential knowledge and expertise; each representing a demarcated unit of analysis (Abma & Stake, 2014). For this multiple case study, a mixed-methods design was conducted consisting of a case study and responsive evaluation in every organization to describe its context and stimulate the dialogue (Padgett, 2016). The responsive evaluation was set up to stimulate a dialogue among stakeholders (executives and researchers) and generate mutual understanding within the organizations. Parallel a steering group and learning community with the executives (directors and managers) of the four organizations was established with a mixed group of participants to foster a process of action–reflection–learning.

Data collection and analysis

The following data was collected between 2017 and 2022: written policy documents, interviews, observations, and reflections during different meetings as well as a questionnaire. See Table 1 for the detailed list.

Table 1: Data collection.

Data sources	Organizations	Period	Specifications
Desk-search on policy documents (mission, vision, action plans)	1, 2, 3, 4	1: Strategic policy 2017-2021 and Strategic policy 2021-2025 2: Multiple years policy 2020-2023 3: Policy on experiential expertise 2021 4: Strategic policy 2020-2023	Desk-search at the onset of the study in 2017 and input was given on new policy in each organization
In-depth qualitative interviews with executives and managers	1, 2, 3	1: 5-11-2018; 3-11-2019; 22-1-2020 2: 3-11-2017; 30-10-2019 3: 7-6-2019; 29-1-2020	Qualitative semi-structured interviews were conducted of appr. 60 minutes
Observations and reflections during periodic meetings of a learning community of executives and managers	1, 2, 3, 4	2017-2022	All researchers were part of a learning community in their organizations and participated in monthly meetings. Additionally, the first researcher (SK) conducted participating observations in bi-monthly peer supervision meetings of organization 1
Questionnaire about organization perspective	1, 2, 3, 4	2021	A structured questionnaire was used

The researchers (authors 1, 2, 3 & 6) conducted data analysis and sensemaking and discussed with the executives (author 4 & 5) that functioned as a learning community, as aimed for an emancipatory research approach (Weerman et al., 2019). A thematic analysis was used to identify, analyze, and reflect on possible patterns or categories that emerged during discussions and interviews (Braun & Clarke, 2006). All data was triangulated by using this approach involving familiarization, coding, and generating recurring themes, reviewing and eventually defining them.

See Table 2 for an example of the analysis scheme developed over time per theme. It shows several condensed meaning units capturing the essential meaning of a quote given during interviews or group reflections. In addition to the analysis of available documents in the desk search, researchers and co-researchers in the learning community collectively reflected on and discussed findings, which helped in the process of sense-making and analysis as well as steering the implementation.

Table 2: Example of an analyzing scheme.

Condensed meaning units (citations of interviews)	Data	Themes
Our organization wants to contribute to a mentally resilient community by acknowledging human variety and emphasizing mutuality… (..) Our care is focused on recovery from day 1, with the environment of the service user, and with respect to his/her needs.	*Mission-vision paper* (organization 1)	Positioning
We need this kind of expertise throughout the entire organization, so not only in the provision of care, but also a policy officer, a lived experience advisor and in all other roles you could think of.	*Learning community* (organization 2)	Human resources
We decided to organize a seminar with two external experts who claim that training is not needed in order to use ones lived experiences. This has puzzled us, but eventually we came to the conclusion that professionalization does require training.	*Steering group* (all organizations)	Professionalization, formalization

As part of the responsive evaluation, feedback was used to further refine and discuss new themes, and to validate the findings. These discussions allowed for deeper understanding, adjustments to the thematic categories, and ensured the results aligned with both the data and the goals of the emancipatory research approach. The themes that emerged repeatedly helped to deepen the team's understanding and further led to the identified categories.

Critical reflection

While the participatory approach and involvement of stakeholders with lived experience are strengths, the composition of the research team may also introduce a certain positive discrimination bias. This could influence data interpretation and thematic analysis, as researchers might unconsciously prioritize findings that align with their own perspectives or emphasize the positive aspects of lived experience integration.

Moreover, the selection of organizations all being part of the PEPPER Consortium may limit the generalizability of the findings. These organizations were already invested in integrating experiential knowledge, potentially creating a favourable bias in terms of outcomes and processes. Additionally, the relatively small percentage of professionals trained in experiential knowledge raises questions on the possible larger impact in the organizations.

Ethical considerations

According to the Medical Ethics Review Committee of VU University Medical Center (registered with the US Office for Human Research Protections as IRB00002991; FWA number: FWA00017598) the Medical Research Involving Human Subjects Act did not apply to our research. Approval was also obtained for the activities and the publication of findings from the ethical commission of the participating organizations. Sensitive data has been transferred by email with encryption. Besides informed consent and confidentiality, the ethical principles of participatory research were taken into consideration (Abma et al., 2019; Banks & Brydon-Miller, 2018).

RESULTS

The central finding of this study is that the potential of experiential knowledge requires concrete actions and efforts at all levels within mental healthcare organizations, backed up by executives who invest in open, safe, creative, and destigmatizing spaces to sensitize lived experiences.

The implementation of experiential knowledge can be clustered in the following themes: 1) positioning of lived experiences, 2) human resources management and 3) professionalization.

Positioning of lived experiences

As part of participating in a consortium that aimed to expand the use of experiential knowledge, all organizations committed to the positioning of experiential knowledge as a valid source of knowledge. At the onset of the research, in mid-2017, a quantitative survey (n=1728) in the whole PEPPER consortium consisting of 5 organizations in total was conducted (Weerman, et al., 2019). While this also included care organizations outside mental health, we presumed that a focus on psychiatric distress would be too restricted. Therefore the questionnaire included all types of disruptive life circumstances.

With a response percentage of 35%, it indicated that 46.9% of all professionals self-reported personal lived experiences with psychiatric, somatic, addiction, psychosocial, and/or financial problems. An even higher percentage of 82.6% reported being familiar with the aforementioned problems in the family line. This underlined that organizations have a large human capital of 'experiential knowledge', but also raised the question of how to translate this potential. Then most professionals used lived experiences either implicitly or not at all.

Through additional mission and vision documents, stakeholders were informed about the potential of experiential knowledge broadly. Oftentimes this was embedded in recovery-oriented approaches to care based on values such as mutuality, professional proximity, inclusion, empowerment, diversity, and an overall process of democratization.

> *Our organization wants to contribute to a mentally resilient community by acknowledging human variety and emphasizing mutuality… (..) Our care is focused on recovery from day 1, with the environment of the service user, and concerning his/her needs.* (Strategic policy 2017-2021, organization 1)

This example reflects an effort to democratize care practices and embrace lived experiences as a source of strength within mental health systems. By situating experiential knowledge as a relevant, valid, and complementary source next to scientific and professional knowledge, this type of knowledge received acknowledgment, also for the established workforce. This was supported by the involved executives formulating a personal statement promoting the strength of 'personal

lived experiences' and led to intensive discussions about traditional notions of mental ill health, emphasizing vulnerability.

> *Some entirely devaluated it (lived experiences) as a resource. We have had a heated conversation after which we eventually agreed to state: vulnerability in the bin!* (learning community meeting, June 2021)

The example highlights a shift in the perception of lived experiences within mental healthcare and how they were integrated into professional practices. The phrase *vulnerability in the bin* symbolizes the rejection of framing lived experiences solely as a marker of weakness. Instead, it reflects an ideological turning point where lived experiences were redefined as a resource with potential value for care practices.

Ideological arguments and discussions on the surplus value of lived experiences and its risks were constantly enriched by concrete actions and reflections on learning experiences.

A 1-year training was set up targeting the established mental healthcare professionals (such as social workers and nurses), and the recruitment and training of other staff members with lived experience took place. Each year a group of approximately 5-6 professionals from the research organizations participated. These trainings ran parallel to the research process.

Also, some professionals opened up about their lived experiences in a role as (family) caregivers. To deal with hierarchy and established power relations the whole implementation needed to be strongly back-upped by highly motivated managers and directors who supported the implementation of lived experiences, and who promoted the involved lived experience practitioners as pioneers and innovators.

> *Disruptive acts are needed in organizations as ours, which is why I decided to open up about my own lived experiences with psychosis during one of our organization building days.* (interview with an executive from organization 2)

The coming out of established professionals with lived experiences evoked criticism from peer workers because they feared losing their granted positions. Others, such as psychiatrists and psychologists had the tendency to further distance themselves from the appearing lived experience perspective of professionals. Even though the lived experience of a professional may differ from

a service user and experiential expert, this unfolded as a conflict at first, but over time led to the overall awareness and relevance to sensitize professionals for a lived experience perspective rather than discriminating or excluding a (sub)population. Some of the executives embodied a living example themselves, by speaking up about their mental distress during a work conference in 2018 and inspiring others to open up. Traditional professionals' readiness was tested, while in some cases the use of lived experiences did not comply with the framework of their professional identity. A thorough reflection on existing discussions about the transformation of lived experiences further stimulated the reflection and revealed a diversity of the use of lived experiences (Weerman et al., 2019). All these actions and conservations on the position of lived experience practitioners within the organization were key to fostering a learning process and revealed the importance of an action-oriented approach.

Human resources management

Initially, the development of a new function description versus an addendum in addition to the existing functions of nurses, social workers, and humanistic counselors, was discussed.

In all organizations a role differentiation (addendum) was developed, to complement the core profession.

Also, all organizations had set up peer supervision and recovery departments to facilitate lived experience practitioners and traditional professionals with experiential knowledge, after the training. Regulating and integrating experiential knowledge into mental health organizations seemed controversial in itself, as existing dynamics may remain dominant.

To counter these existing hierarchies, experiential knowledge needed not only to be authorized in formal documents, a rich variation of personal recovery narratives on all layers of the organization showcased. E.g., posters that portrayed professionals with lived experiences were largely printed and exposed in organization 2, thereby narrating a diversity of recovery stories of professionals with lived experiences (see Illustration 1).

In some organizations, this exposure initially led to a lack of response. Eventually in one of the organizations, it not only led to silence and ignorance, it also evoked counter-responses from some clinicians claiming that the posters were self-indulging and too much exposure, and therefore regarded as unprofessional. This influenced the sense of safety on both sides: on the one hand,

Illustration 1: Posters' exposition in organization 2.

some clinicians seemed intimidated by the poster's actions, while on the other hand professionals with lived experience felt devalued.

> *In the end, our head reached out, by preventing the removal of the posters and stating that apparently, mental healthcare organizations are not completely prepared to deal with this confrontation.* (interview with a professional, organization 2)

Another challenge faced was creating volume and allocating sufficient resources: only a small percentage of the established professionals came to the fore with their lived experiences. Even though all involved executives aimed to position experiential knowledge in their organization as a complementary resource, this apparently was not easily accomplished. Some professionals started doubting and needed additional support and resources, such as coaching.

> *We need this kind of expertise throughout the entire organization, so not only in the provision of care but also a policymaker, a lived experience advisor and in all other roles you could think of.* (interviews with executives organizations 3, 4)

After differentiating the input of experiential knowledge in varying roles in care service provision, management, and policy, it appeared sometimes difficult to assess the level of competence and functioning in those using experiential knowledge. Subsequently, only specific lived experience practitioners were financially covered by Dutch healthcare regulations, which led to discussions and polarization. Some organizations, however, received local funding from the government

which was less restrictive and supported all types and levels of professionals. An adequate embedment of peer workers and professionals with lived experiences in the organization was part of the challenge, while specifically claiming 'discretionary space'. There was an ongoing overall need to inform colleagues throughout the organization, e.g. about the desirable conditions.

> *We questioned whether peer workers should operate solely or as part of a team. We like to use the metaphor of an orchestra to refer to the latter.* (learning community, organization 3)

One of the most prominent challenges was the policy implementation by the concerned management. This required more effort and time than expected and even though some of the organizations seemed ahead, they sometimes backlashed due to personnel changes. Some managers were hesitant towards the positioning and professionalization or limited informed. Especially in larger organizations, there were difficulties in communicating and involving all layers, including middle management.

> *You can't expect professionals to follow novel policy from a paper, and yet, we need to work both top-down and bottom-up when it comes to this implementation process.* (interview with executive from organization 1)

Concrete plans on the team level allowed the organizations to work with experiential knowledge firmly on all layers of the organization. Inviting people to share their lived experiences facilitated a conditional safe space to talk about charged topics, but also led to discussions about the extent to which one should strive for openness. Sharing lived experiences with mental illness or addiction was easily associated with being 'non-professional'. Some organizations incorporated 'reflection time' in their daily team routine to pay attention to the lived experience perspective. Ultimately the goal was to create a culture in which experiential knowledge was recognized and appreciated.

At first, it seemed that there was little investment necessary for established professionals (nurses, and social workers) to be able to work with this type of knowledge. However, the process of harnessing experiential knowledge, its emotional labor, and (political) actions, required time and resources in terms of support and training. Also concrete actions and experiences were key to fostering a learning process throughout the organizations, both for professionals with experiential knowledge and the ones without such expertise.

Professionalization

Investment in ongoing professionalization and formalization of experiential knowledge was considered relevant since merely "having lived experiences" was not sufficient in the complex context of these mental health organizations. Lived experienced practitioners could be exposed to heavy duties on the one hand, while on the other hand, the organization was not able to receive financial compensation for non-trained lived experienced practitioners. Cooperating with traditional professionals was beneficial in this regard. Yet, this also led easily to interprofessional tensions and seemingly conflicted with the intention of working with lived experiences.

To legitimize the use of lived experiences as a valid source of knowledge by established mental health professionals, such as social workers, nurses, psychologists, and psychiatrists, the process of professionalization recycled in the organizations both bottom-up and top-down between the concerned professionals, lived experience practitioners, policymakers, executives and client representatives. These dialogues were held in multidisciplinary teams and management teams, whereby stakeholders navigated how to make more space for experiential knowledge and how to further professionalization. This resulted in a few professionals with lived experiences, acting as 'ambassadors' and fulfilling a social changemaker role in their organization. Together with managers and other colleagues, they made efforts to bridge the so-called knowledge gap.

> *It might be somewhat awkward, we can handle almost anything but when it comes to personal topics, there seems to be a knowledge gap among professionals.* (interview with executive organization 2)

All organizations searched for creative ways to improve the expertise, skills, and competence level of their entire workforce. They decided to structurally invest in training and peer supervision for professionals, while some also continue to work with voluntary peer support workers. This led to challenging discussions in the organization: what is the necessity of training and does training improve the work or, conversely counterproductive leading to alienation and distancing from experiences? (see Illustration 2)

> *We decided to organize a seminar with two external experts who claimed that training is not needed to use one's lived experiences. This has puzzled us, but eventually, we concluded that professionalization does require training. (statement steering group, 2021)*

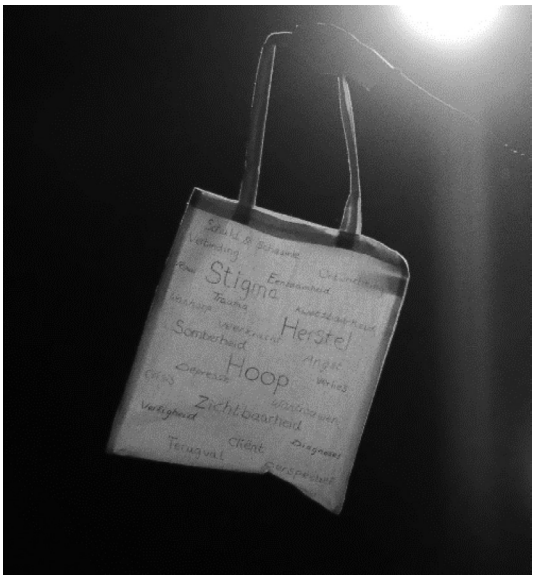

Illustration 2: 'A bag full of lived experiences' to promote the dialogue in teams, organization 1, may 2021.

The organizations profited in some regards from the standard and guidelines of the Dutch novel quality system which was released in 2022 and initiated by the professional body of lived experience practitioners and the Dutch Ministry of Health, Welfare, and Sport. It consisted of a generic module, national register, quality standard, and national learning plan on six education levels. This facilitated a further implementation of experiential knowledge. Yet, all directors and managers were also wary of formalization as echoed in the learning communities and steering group.

> *The most important realization I have had is that installing a formal structure might not lead to any desired result. We have been struggling with production and outcome pressures, struggling to connect to the reason why we are here. When peer workers came to the fore with critical questions and were supported by new structures and procedures, we also created opposition. We need to return to in-depth talking and dialogues about what we mean with inclusion, anti-stigma, recovery, and such before it will lead to instrumentalization.* (learning community organization 2)

Altogether the need for a discretionary space and professional autonomy commonly promoted by the peer workforce became partially part of the organizational structures. For all organizations, the way forward was an emphasis on experiential knowledge as a valid source to draw from, by different actors and in different contexts.

DISCUSSION

This study reveals the complexities of integrating experiential knowledge into mental health and addiction care organizations. The findings underscore that while many professionals within these organizations have personal experiences of mental distress, only a small percentage explicitly utilize this knowledge in their practice. This hesitancy reflects gaps in training and organizational support, as well as a lack of formal acknowledgment of the value of lived experiences.

Resistance is evident at multiple levels, from individual professionals to organizational structures, and is shaped by entrenched beliefs about professionalism, hierarchy, and the role of experiential knowledge in care delivery. One core issue is the association of professionalism with objectivity and detachment. Experiential knowledge, rooted in personal lived experiences, challenges these traditional notions by emphasizing relational and emotional dimensions of care. Many professionals may perceive this as a threat to their professional identity, leading to hesitation or outright rejection of integrating lived experiences into their practice. This dynamic underscores the need for cultural shifts that reframe professionalism to include the value of vulnerability and shared humanity.

Secondly, resistance is also fuelled by existing power dynamics within organizations. Traditional professionals, such as psychiatrists and psychologists, may feel their authority is challenged by the growing recognition of experiential knowledge. Peer workers and professionals with lived experience often find themselves navigating tensions, as their contributions may be undervalued or even dismissed. Addressing these dynamics requires strong leadership to foster mutual respect and collaboration between traditional and experiential perspectives.

Another contributing factor to resistance is the absence of sufficient structural support for experiential knowledge. While organizations recognize its potential, many lack clear frameworks or policies to embed it into everyday practice. Professionals with lived experiences often operate in ambiguous roles, with limited resources and unclear career pathways. They face stigma and are exposed to different social dynamics. A lack of institutional backing can lead to frustration and

reinforce scepticism among traditional staff, who may question the sustainability and legitimacy of these roles.

Leadership played a pivotal role in addressing these challenges. Executives and managers were instrumental in creating safe and brave environments for sharing lived experiences, which is essential for overcoming stigmatization and power imbalances.

Support from executives and management in our study seems indispensable given the unfamiliarity and sometimes unpopularity of voicing lived experiences and established power relationships. Apart from the positioning and resources, it appeared to be crucial to keep an eye on the underlying intentions and motivation to prevent ending up in a process of bureaucratization and technical operation (Aadam & Petrakis, 2019). The process required a proper balance between regulations, measurements, formalization, and management on the one hand as well as meaning-making, motivation, and emotion-work on the other hand. This is in line with literature on change management and implementation strategies in general (Argyris & Schön, 1978), and the implementation of new programs within mental health care in particular (Weidema et al., 2012, 2015).

However, the study also found that the process of formalizing experiential knowledge could risk reducing its relational and transformative nature to a bureaucratic function. Balancing formal structures with flexibility and meaning-making processes is crucial.

A notable insight is the power of creative methods, such as storytelling, in facilitating organizational change. Experiential knowledge can be used to stimulate such dialogues between those who are seen, and those who remain unseen, as well as holding these paradoxes (Groot & Abma, 2021). As the authors point out: 'A successful boundary object evokes emotions among those who created the objects and those encountering these objects. It personally moves people and creates an impulse for change and connects different life worlds. The more provocative the object, the more people feel triggered to foster change.' (Groot & Abma, 2021). An investment in a cultural change using art appeared to be helpful to go beyond the rational and touch upon the affective dimensions of change, such as the case with the exposure of the posters. These approaches provide a medium for expressing the unsayable and foster deeper emotional connections, stimulating dialogue and cultural shifts within organizations.

Despite these promising developments, significant barriers remain. Resistance from traditional professionals, concerns about professionalism, and limited resources hinder the broader adoption

of experiential knowledge. Moreover, the implementation process often relied heavily on the personal motivation of key individuals, raising questions about sustainability.

Practical implications

To address the variety of factors relevant to the implementation of experiential knowledge in mental health and addiction care, we offer a series of recommendations meant to guide executives, managers, and policymakers. These recommendations were distilled from conversations in the steering group by the end of the research period.

- Start with a mission and vision: acknowledge experiential knowledge as a unique and valid source of knowledge that should be visible in the organization through artworks to foster dialogue and available for every service user.
- Identify the (potential) value of lived experiences in the teams.
- Stimulate all mental health professionals to be more open about their lived experiences and stimulate the dialogue between service users, all types of professionals, and other staff.
- Facilitate peer support and recovery-oriented and trauma-informed/sensitive environments in and outside the organization.
- Educate and invest in experiential knowledge on all levels (policy, human resources management, clinical practice, outpatient services).
- Include lived experience practitioners in the Board of Directors and the Supervisory Board.

Limitations

This study is based on a qualitative analysis and describes the organizational perspective during a further implementation of experiential knowledge. The participating mental health and addiction care services were in the process of transformation to work in a more relational way supporting personal recovery. It's uncertain if the results of this study can be generalized or transferred to other countries and/or more traditional contexts. However, the insights may hold resonance and be partially transferable to related contexts.

CONCLUSIONS

Integrating experiential knowledge into mental health and addiction care requires a comprehensive approach that combines technical, emotional, and cultural strategies. This study highlights the

importance of leadership, ongoing professionalization, and creative methods in fostering a supportive environment for lived experiences. While experiential knowledge offers significant potential to enhance recovery-oriented care, its implementation demands sustained commitment, resources, and a willingness to challenge traditional power structures. Future research should explore how these findings can be adapted to other contexts and how experiential knowledge can be scaled while preserving its authenticity and transformative value.

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