A Study of International Experience and Practices in Ukraine

Peer Support in the Rehabilitation of Service Members and Veterans

Between Flexibility and Standardization

Pryncyp
LTAID Lithuanian Development Cooperation
Lithuania Co-create Future of Ukraine
MINISTRY OF NATIONAL DEFENCE REPUBLIC OF LITHUANIA
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Pryncyp

The Human Rights Center "Pryncyp" is a non-governmental organization founded in 2023 for the legal protection of service members and veterans. Our priority goal is the protection of the service member's dignity and transparency of processes along their journey. To this end, we are working in the following areas: legal education for service members, veterans, and their families about the existing mechanisms and opportunities during treatment and rehabilitation; analytical work to develop systemic solutions for reforming the system; advocacy for changes in this system in cooperation with government authorities.

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Abbreviations

MMC	Military Medical Commission
WHO	World Health Organization
NGO	Non-Governmental Organization
HCF	Healthcare Facility
PSI	Peer Support Intervention
CMU	Cabinet of Ministers of Ukraine
KNU	Taras Shevchenko National University of Kyiv
CBT	Cognitive Behavioral Therapy
MinVeterans	Ministry for Veterans Affairs of Ukraine
MRT	Multidisciplinary Rehabilitation Team
MSEC	Medical and Social Expert Commission (Disability Determination Service)
PTSD	Post-Traumatic Stress Disorder
RCT	Randomized Controlled Trial
SCI	Spinal Cord Injury
PM&R	Physical Medicine and Rehabilitation

Introduction

In the context of full-scale war, more and more service members and veterans face physical and psychological consequences of combat and require comprehensive rehabilitation. For them, this is not only about the restoration of physical functions, but also a path back to active social life, economic activity, and, where possible, to military service. In this process, a special role can be played by those who have already gone through a similar experience and are ready to support others by becoming a bridge to professional help. This approach is known as peer support.

In recent years, peer support has gained popularity in Ukraine. It often appears in civil society projects, grant applications, and even in public policies. The reasons behind this are clear: shared experience traditionally serves as a source of trust and empathy, and in high-risk professions its effect is especially strong. The brotherhood built during military service remains a unifying force even after the service; similarly, the experience of trauma can bring people together. However, popularity does not equal maturity. So far, Ukraine lacks data on how systematic, effective, and sustainable peer support interventions (hereafter referred to as PSI) are.

The goal of our study is to understand how peer support is applied in the rehabilitation of service members and veterans, and to develop recommendations for improving practices. We sought to answer the following key questions: in which cases does peer support add value in rehabilitation, where can it create risks, and how can those risks be prevented?

The priority focus of our study was the field of physical medicine and rehabilitation (hereafter referred to as PM&R) aimed at the recovery of service members and veterans after injuries and wounds. At the same time, in this report we also briefly address the application of peer support in mental health, given the prevalence of such programs in the military community.

Our report systematizes data obtained through several methods. First, we conducted a desk study of international and Ukrainian academic and «gray» literature regarding peer support implementation and effectiveness in rehabilitation. These findings served as the basis for the design of semi-structured in-depth interviews. We carried out purposive sampling of respondents for interviews, followed by snowball sampling. Additionally, open invitations to participate in the study were distributed through Pryncyp's social media channels. All respondents gave informed consent to participate in the interviews and to have them audio recorded; their personal data were anonymized.

A total of 23 respondents took part in the interviews, including:

• 14 peer support providers: non-governmental organizations (hereafter referred to as NGOs) and healthcare facilities (hereafter referred to as HCFs). This category included both respondents at the managerial level with experience in planning and organizing such programs, and those who directly provided support;

• 2 healthcare professionals (a physical therapist and a physician specializing in physical medicine and rehabilitation) collaborating with peer support specialists in healthcare facilities;

• 3 current or former service members who received peer support;

• 3 representatives of governmental structures, including the Ministry for Veterans Affairs of Ukraine (hereafter referred to as MinVeterans) and the Coordination Center for Mental Health of the Cabinet of Ministers of Ukraine;

• 1 representative of a Lithuanian non-governmental organization working with the peer support approach in rehabilitation.

In addition, data collection for our study included ethnographic observation in a hospital in a rear region of Ukraine. This method gave us the opportunity to see how the peer support model is implemented in real-life conditions.

Our study has several limitations. In both Ukraine and abroad, PSIs are heterogeneous and fragmented. This made it difficult to sum up findings and to develop typical recommendations. An additional challenge for us was terminological ambiguity in the Ukrainian language: the term «peer support» is used in very different contexts and with varied meanings, while PSI beneficiaries are often unfamiliar with it and identify support providers using alternative terms (such as mentor, instructor, trainer, etc.). This created difficulties in respondent selection and limited the sample size.

Most of our respondents were interested in developing and raising the standards of peer support programs. They also told us about known cases of clearly problematic PSIs in other organizations; however, we were not able to independently examine them due to lack of access to participants and ethical constraints. Thus, the results of the study primarily reflect the experiences and positions of those motivated to improve the approach, rather than the full spectrum of existing practices.

Despite these limitations, our study is the first systematic attempt to comprehensively analyze the state of peer support implementation in the rehabilitation of service members and veterans in Ukraine. We hope it will serve as a foundation for more evidence-based management decisions at the level of both individual organizations and public policy.

Section 1

Overview of International Experience

1.1 General Literature Review

1.1.1. DEFINITION AND LANDSCAPE OF PEER SUPPORT INTERVENTIONS

In global practice, peer support interventions (hereafter referred to as PSIs) are used as a form of mutual support to overcome life challenges. The term does not have a unified definition, but a key feature of PSIs is the shared experience of participants, which serves as a source of trust and empathy.

PSIs are applied in various social and medical contexts. The peer support model has been implemented most systematically in the field of mental health. It is here that it has demonstrated the greatest benefit for the veteran community – within programs assisting veterans with post-traumatic stress disorder (hereafter referred to as PTSD), substance use disorders, and other psychosocial problems[1]. At the same time, peer support approaches are becoming increasingly widespread in physical medicine and rehabilitation (hereafter referred to as PM&R), regardless of participants' veteran status. In this field, they originate from the movement for the rights and independent living of people with disabilities. Their aim is to promote health, social participation, and quality of life by involving individuals with lived recovery experience. Examples of such interventions include: mentorship programs in rehabilitation centers to develop self-management skills; community support during the return to work or study; or the creation of navigator networks – peer support specialists who help people with disabilities navigate service systems[2].

PSIs vary significantly in terms of goals, design, degree of formalization, and the roles of the specialists who deliver them. Some are integrated into existing healthcare and social service systems, while others are implemented as standalone NGO initiatives. This flexibility makes PSIs adaptable to local conditions, but it also significantly complicates standardization and inter-program comparison.

One of the methodologies proposed in the literature identifies four key characteristics of peer support specialists in the healthcare sector:

- Shared experience or life circumstances with the target group
- Added value of the intervention due to the "peer" status (greater trust in the service provider)
- Lack of formal medical or psychological education
- Targeted activity under the standardized protocols[3]

Thus, peer support combines a component of lived experience with the elements of programmatic inter-

1 — Deans C. Benefits and employment and care for peer support staff in the veteran community: A rapid narrative literature review. 2020. Journal of Military and Veterans Health, 28(4), 6–15. https://jmvh.org/article/benefits-and-employment-and-care-for-peer-support-staff-in-the-veteran-community-a-rapid-narrative-literature-review/

2 — Magasi S., Papadimitriou C. Peer Support Interventions in Physical Medicine and Rehabilitation: A Framework to Advance the Field. 2022. Archives of Physical Medicine and Rehabilitation. 2022 Jul;103(7S): S222–S229. doi: 10.1016/j.apmr.2020.09.400

3 — Simoni J.M., Franks J.C., Lehavot K., Yard S.S. Peer interventions to promote health: conceptual considerations. 2011. American Journal of Orthopsychiatry. 2011 Jul;81(3):351–9. doi: 10.1111/j.1939-0025.2011.01103.x

vention. At the same time, the roles of peer support specialists can vary widely: from "friendly" support to facilitation or case management[4]. Their status also varies: from salaried staff to external consultants or volunteers.

1.1.2. BENEFITS AND EFFECTIVENESS OF PEER SUPPORT

1.1.2.1 MENTAL HEALTH

Despite the wide use of PSIs in mental healthcare, the evidence base for their effectiveness is limited. Overall, studies indicate a positive impact of specific interventions on target groups. However, diversity in the design and implementation of PSIs makes comparison and generalization difficult. Some programs have undergone formal effectiveness evaluations, but they often have methodological limitations: small sample sizes, lack of control groups, predominance of qualitative methods, and a variety of outcome indicators. The general consensus in the scientific literature is that systematic evidence is insufficient. Nevertheless, there are several established assessments based on the available limited data.

In mental health, the literature highlights the following benefits of PSIs for their consumers: improved access to services; expanded social support; reduced stigma and discrimination; increased satisfaction with support; engagement of hard-to-reach groups; more active participation in treatment; and higher rates of completing treatment or psychological care courses[5].

Studies specifically focusing on veterans are fragmented but generally support these trends. For example, an Australian evaluation of a six-day outdoor therapy program involving peer support specialists showed reductions in veterans' symptoms of depression, anxiety, and stress, as well as increases in confidence, life satisfaction, and psychological well-being[6].

In the United States, a report on an inpatient PTSD treatment program involving peer support specialists found that veterans felt the greatest support from other veteran patients. However, it was the combination of support from fellow patients, peer support specialists, and healthcare professionals that contributed to a more positive overall perception of treatment[7]. Another U.S. study showed that veterans undergoing cognitive behavioral therapy (hereafter referred to as CBT) with peer support specialists had higher completion rates compared to those working with mental health professionals without shared experience[8]. A qualitative study in Scotland confirmed that participation of peer support specialists facilitated veterans' initial contact with mental health centers and helped reduce barriers to seeking help[9].

4 — Mercier J.M. et al. Peer Support Activities for Veterans, Serving Members, and Their Families: Results of a Scoping Review. 2023. International Journal of Environmental Research and Public Health. 2023 Feb 18; 20(4):3628. doi: 10.3390/ijerph20043628

5 — Deans C. Benefits and employment and care for peer support staff in the veteran community: A rapid narrative literature review. 2020. Journal of Military and Veterans Health, 28(4), 6–15. https://jmvh.org/article/benefits-and-employment-and-care-for-peer-support-staff-in-the-veteran-community-a-rapid-narrative-literature-review/

6 — Bird K. Research evaluation of an Australian peer outdoor support therapy program for contemporary veterans' wellbeing. 2015. International Journal of Mental Health, 44(1–2), 46–79. https://doi.org/10.1080/00207411.2015.1009752

7 — Jain S., McLean C., Adler E.P., Rosen C.S.. Peer Support and Outcome for Veterans with Posttraumatic Stress Disorder (PTSD) in a Residential Rehabilitation Program. 2016. Community Mental Health Journal. 2016 Nov;52(8):1089–1092. doi: 10.1007/s10597-015-9982-1.

8 — Nelson C.B. et al. Predictors of CBT-pretreatment intervention engagement and completion: Evidence for peer support. 2019. Psychological Services. 2019 Aug;16(3):381–387. doi: 10.1037/ser0000268

9 — Weir B. et al. Military veteran engagement with mental health and well-being services: a qualitative study of the role of the peer support worker. 2019. Journal of Mental Health. 2019 Dec;28(6):647–653. doi: 10.1080/09638237.2017.1370640.

1.1.2.2. PM&R

Studies of PSIs in PM&R indicate their ability to facilitate the transition of people with functional limitations to an active and independent life, improve their mental well-being, promote community participation and reintegration, and activate patients, that is, help them recognize their own role in the treatment process, develop knowledge, skills, and confidence to manage their health.

The value of peer support in PM&R is recognized internationally. The Commission on Accreditation of Rehabilitation Facilities (CARF International) requires verification of peer support integration in the delivery of rehabilitation services for spinal cord and brain injuries[10]. The United Nations Convention on the Rights of Persons with Disabilities obliges states to promote the implementation of peer support and mentoring as components of education and integration processes[11].

The World Health Organization (WHO) in its report on spinal cord injury (SCI)[12] notes that people with such injuries value support from others with similar experiences, both in informal settings (for example, when interacting with other patients in a hospital) and in organized mentoring and training programs. WHO encourages PSIs for people with SCI, emphasizing that they can improve outcomes.

WHO highlights the benefits of engaging peer support specialists for: increasing the confidence of people who have recently experienced SCI; promoting psychological adaptation; teaching self-management and mobility skills; providing information and advice on maintaining health and preventing secondary conditions (e.g., pressure sores or urinary tract infections); and initiating referrals to healthcare professionals when needed.

PSIs for people with functional limitations are implemented by non-governmental organizations or as part of community-based rehabilitation (CBR) programs. PSIs are also integrated into specialized rehabilitation services in healthcare facilities. WHO encourages these practices, emphasizing the importance of proper training and supervision for peer support specialists to ensure PSI effectiveness.

Despite international recognition, the evidence base regarding PSIs in PM&R is as limited as in mental health. At least six systematic literature reviews (including studies on people with brain and spinal cord injuries and veterans with post-deployment syndrome) highlight the complexity of evaluating PSI effectiveness and developing best practices. The main reason for this is the significant differences between interventions in terms of parameters such as setting, duration, intensity, focus, the role of peer support specialists, and outcome assessment approaches[13]. Moreover, the literature sometimes shows conflicting results for PSIs.

For example, a systematic review of two randomized controlled trials (hereinafter referred to as RCTs) on PSIs after traumatic brain injury found positive effects on patients and their caregivers in areas of social support, coping, behavioral control, and physical quality of life.

10 — Magasi S., Papadimitriou C. Peer Support Interventions in Physical Medicine and Rehabilitation: A Framework to Advance the Field. 2022. Archives of Physical Medicine and Rehabilitation. 2022 Jul;103(7S): S222–S229. doi: 10.1016/j.apmr.2020.09.400

11 — United Nations Convention on the Rights of Persons with Disabilities 2010 (ratification). https://zakon.rada.gov.ua/laws/show/995_g71#Text

12 — Bickenbach J. et al. International perspectives on spinal cord injury. 2013. World Health Organization. The International Spinal Cord Society. https://www.who.int/publications/i/item/international-perspectives-on-spinal-cord-injury

13 — Magasi S., Papadimitriou C. Peer Support Interventions in Physical Medicine and Rehabilitation: A Framework to Advance the Field. 2022. Archives of Physical Medicine and Rehabilitation. 2022 Jul;103(7S): S222–S229. doi: 10.1016/j.apmr.2020.09.400

At the same time, there were negative effects such as an increase in depression symptoms among some patients, as well as a decrease in subjective perception of social support and integration among caregivers. Some participants also reported increased anxiety and worse family functioning. Researchers suggest that these effects may be associated with a deeper awareness of the consequences of injury, gained through interaction with a peer support specialist. However, no clear reasons were established[14].

Another review of six RCTs on PSIs among people with traumatic brain injury showed that only two studies demonstrated significant improvements in quality of life, and none showed statistically significant effects on community integration[15].

Studies also report examples of poorly organized PSIs; for instance, when peer support specialists did not support patient goals, had their own psychological difficulties, or lacked empathetic listening skills. One study comparing knowledge about pressure sore prevention between mentors and their clients found that both groups lacked knowledge for effective prevention of this secondary condition.

It is also known that some patients may decline participation in PSIs due to the belief that negative experiences of others will harm their own recovery, stigma or shame about seeking support, or concerns about confidentiality. Participation in such programs is more common among patients with more severe injuries or longer hospital stays[16].

1.1.3. IMPACT ON PEER SUPPORT SPECIALISTS

Data on the impact of PSIs on the peer support specialists themselves are also limited. Qualitative studies indicate that providing support can have a therapeutic effect for specialists by promoting reflection on personal experience, enhancing self-esteem, and fostering a sense of social value. At the same time, this work can be emotionally exhausting, especially in the absence of clearly defined boundaries.

According to a large study of peer support specialists' perspectives in mental health, the benefits of this role include: increased well-being, a sense of social contribution, development of new knowledge and skills, expanded social connections, and monetary compensation (when the role is paid). A barrier to sustained participation in PSIs is limited career development. Specialists also highlighted their support needs, including training, supervision, and a supportive organizational culture. They emphasized the uniqueness of the peer support approach, which is based on sharing personal, often traumatic, experience, and differs from traditional psychological assistance. For PSIs to be effective, organizations must recognize this specificity. Studies focused specifically on veterans also confirm the importance of organizational support for PSI implementation[17].

Although psychological risks for peer support specialists and the need for systematic supervision and preven-

14 — Wobma R., Nijland R.H., Ket J.C., Kwakkel G. Evidence for peer support in rehabilitation for individuals with acquired brain injury: A systematic review. 2016. Journal of Rehabilitation Medicine. 2016 Nov 11;48(10):837–840. doi: 10.2340/16501977-2160

15 — Levy B.B., Luong D., Perrier L., Bayley M.T., Munce S.E.P. Peer support interventions for individuals with acquired brain injury, cerebral palsy, and spina bifida: a systematic review. 2019. BMC Health Services Research. 2019 May 8;19(1):288. doi: 10.1186/s12913-019-4110-5

16 — Wasilewski M. et al. Peer support for traumatic injury survivors: a scoping review. 2023. Disability and Rehabilitation, 14(33), pp. 2199–2232. doi: 10.1080/09638288.2022.2083702

tion of secondary traumatization are recognized, detailed data measuring the level of psychological risk in this group are virtually absent. One study analyzing the work of peer support specialists with veterans with mental disorders documented mental health and burnout trends similar to those observed in mental health professionals[18].

A comparative analysis of two groups of PM&R specialists (those formally employed and those acting as volunteers) found that formally employed specialists were generally better informed about available resources, less likely to report lack of knowledge as a barrier, and more often helped clients access the necessary services[19].

1.1.4. RECOMMENDATIONS FOR THE DESIGN AND IMPLEMENTATION OF PEER SUPPORT INTERVENTIONS

The diversity of PSIs and the lack of systematic evidence about their effectiveness make it difficult to develop proper practices in this field. There are no unified approaches to implementing PSIs. However, some respected researchers propose framework models that can serve as guidance.

1.1.4.1. MENTAL HEALTH

Australian researchers have developed guidelines for PSIs in high-risk professions (military, first responders), where employees often face traumatic events[20]. Later, the model was adapted for the field of mental health[21] and veteran programs. A synthesis of practices is presented in Table 1[22].

17 — Deans C. Benefits and employment and care for peer support staff in the veteran community: A rapid narrative literature review. 2020. Journal of Military and Veterans Health, 28(4), 6–15. https://jmvh.org/article/benefits-and-employment-and-care-for-peer-support-staff-in-the-veteran-community-a-rapid-narrative-literature-review/

18 — Park S.G. et al. Predictors of Employment Burnout Among VHA Peer Support Specialists. Psychiatric Services. 2016. Oct 1;67(10):1109–1115. doi: 10.1176/appi.ps.201500239.

19 — Wasilewski M. et al. Peer support for traumatic injury survivors: a scoping review. 2023. Disability and Rehabilitation, 14(33), pp. 2199–2232. doi: 10.1080/09638288.2022.2083702

20 — Creamer M.C. et al. Guidelines for peer support in high-risk organizations: an international consensus study using the Delphi method. J Trauma Stress. 2012 Apr;25(2):134–41. doi: 10.1002/jts.21685

21 — Campos F. et al. Directrices prácticas para programas de apoyo entre personas con enfermedad mental [Practical guidelines for peer support programmes for mental health problems]. Revista de Psiquiatría y Salud Mental. 2016 Apr-Jun;9(2):97–110. doi: 10.1016/j.rpsm.2014.06.002.

22 — Deans C. Benefits and employment and care for peer support staff in the veteran community: A rapid narrative literature review. 2020. Journal of Military and Veterans Health, 28(4), 6–15. https://jmvh.org/article/benefits-and-employment-and-care-for-peer-support-staff-in-the-veteran-community-a-rapid-narrative-literature-review/

Table 1. Synthesis of the Best Practices for PSIs in the Field of Veteran Mental Health

PSS: peer support specialist
MHP: mental health professional

Goals and principles	Selection of PSSs	Training and certification of PSSs	Role of MHPs	Role of PSSs	Organizational issues	Client access to PSSs	Support for PSSs
Empathic listening Simple psychological interventions Advocacy of clients' interests in disputes Identifying clients who may be at risk Facilitating access to professional help Encouraging treatment adherence Supporting clients' functioning Promoting physical and mental health	Defined process of application and selection Approval by the target group representatives MHP approval Must be a representative of the veteran community	Standardized training and opportunities for continuing education Supervision Information about available support services Active listening skills Basic psychological techniques Trauma-informed approach Recovery system Self-care and boundary-setting Time to develop PSS identity	Participation in training and supervision for PSSs Peer support program management	No clinical functions Discussion of each case with MHPs Confidentiality Availability of direct referral to MHPs Adapting services to clients' needs Balancing organizational goals with independence Supporting relationships based on shared experience and reciprocity Ongoing support as long as it is useful	PSS code of conduct Organizational support for the unique role of PSSs Training staff on the role of PSSs Integration with other veteran programs Defined duration and frequency of the program Clear goals linked to outcomes External independent evaluation PSS leadership Access to veteran organizations	PSS as the first point of contact Possibility to choose PSPs from a pool Availability outside of regular hours on a rotation basis	Regular consultations with other PSSs Regular supervision with MHPs Access to information from MHPs at any time Access to mental health support Support with setting boundaries during self-disclosure

1.1.4.2. PM&R

American researchers proposed a PSI model for PM&R[23]. The key components of the model are summarized in Table 2 and described afterward.

Table 2. Key Aspects of Developing and Implementing PSIs in PM&R

	PSI Elements	**Key Aspects**
Theory-driven components	Goals / theoretical foundation of the program	Training Social support Self-sufficiency Strengthening confidence in group interaction, advocacy
	Target group	Heterogeneous Limited to a specific medical condition Social and cultural factors
	Point of intervention	Inpatient care Outpatient care / day rehabilitation Community-based care
	Services	Emotional support Role modeling Informational support Self-management skills
	Method	Group Individual In-person Remote
	Intervention dosage	Frequency Intensity Duration
	Results	Short-term Long-term Process effectiveness
Contextual factors	Characteristics of peer support specialists	Availability of lived experience Interpersonal skills Leadership abilities

23 — Magasi S., Papadimitriou C. Peer Support Interventions in Physical Medicine and Rehabilitation: A Framework to Advance the Field. 2022. Archives of Physical Medicine and Rehabilitation. 2022 Jul;103(7S): S222–S229. doi: 10.1016/j.apmr.2020.09.400.

	PSI Elements	Key Aspects
Компоненти, зумовлені теоретичним підґрунтям	Training for peer support specialists	Key competencies (see explanation below) Communication skills Confidentiality compliance Ability to set boundaries
	Supervision	Role and qualifications of the supervisor Professional or peer support specialist Frequency Structure
	Supervision setting (location)	Level of organizational integration Physical location Receptivity of the organizational context

Theoretical Foundation and Program Goals

Peer support programs are often implemented without a clear theoretical model, that is, without an understanding of how specialist's actions lead to client outcomes. This complicates planning, evaluation, and scaling of PSIs. A theoretical model performs several important functions. It allows one to:

- Identify the issue the intervention seeks to address
- Outline the target audience most likely to benefit
- Define the key PSI components
- Account for contextual factors that may influence implementation and outcomes (social, organizational, cultural)
- Describe mechanisms of action: how exactly support leads to changes in client behavior, self-perception, or health

Table 3 provides examples of how different approaches (for example, social learning theory or self-sufficiency theory) determine the PSI content, format, and expected outcomes.

Table 3. Theory-Driven PSI Elements in PM&R[24]

Program goals	Theoretical foundation	Target group	Program activities	Results
Improve knowledge of symptoms or disease	Theory of dynamic social impact, social learning theory	Patients with: — Knowledge gaps — Difficulties managing symptoms — Risk of developing new conditions	Group or individual educational sessions	+ Symptom management + Symptom knowledge - Complications - Service costs
Improve adaptation and understanding that the patient is not alone with the disease	Stress and coping theory	Patients with recent injury or complication who struggle to adapt to a new lifestyle	— Informational support — Emotional support — Motivation Friendly visits	+ Life satisfaction + Acceptance - Depression - Anxiety - Fear of the unknown
Improve ability to manage specific aspects of disability	Social cognitive theory and self-sufficiency theory	Patients with: — Low self-efficacy — Low confidence — Self-management deficits	Interventions aimed at developing new skills	+ Self-efficacy + Patient activation (depending on the skills in focus)
Strengthen collective action against social barriers	Empowerment theory	Patients who are: — Socially marginalized — Stigmatized	— Communication training — Confidence training — Disability rights training — Collective action	Social change Critical thinking + Confidence
Change in health-related behavior	Theory of social control under group influence, diffusion of innovations theory, social network theory	Patients who need to change health-related behavior	Peer support specialists as role models for behavior change	+ Adoption of target health-related behavior

24 — Magasi S., Papadimitriou C. Peer Support Interventions in Physical Medicine and Rehabilitation: A Framework to Advance the Field. 2022. Archives of Physical Medicine and Rehabilitation. 2022 Jul;103(7S): S222–S229. doi: 10.1016/j.apmr.2020.09.400

Target Group

The PSI effectiveness depends significantly on its alignment with the needs of a specific target audience. This requires considering not only medical indicators but also social context, such as patients' living conditions, access to resources, and cultural factors. For example, a program created for a large urban rehabilitation center would need adaptation for implementation in a rural setting. Peer support specialists must be flexible in order to take these differences into account in their work.

Point of Intervention

PSI may be implemented at different stages: During inpatient rehabilitation, at the stage of returning to the community, or independent living. Each of these stages has its advantages and challenges. The choice of intervention point should be based on program goals and target group accessibility. It also affects the intervention format: During inpatient rehabilitation, in-person support at the healthcare facility may be more appropriate, whereas after discharge, home- or community-based interventions may be more effective. Working in the community gives peer support specialists greater autonomy and a focus on developing client independence.

When determining the intervention point, it is important to consider the characteristics of the target group. For example, in one study, patients with SCI reported that at the acute stage of injury, communication with a peer support specialist was premature for them. In contrast, patients preparing for amputation highly valued the opportunity to interact with a mentor at the early stages of treatment[25].

Services

The set of PSI services is determined by the program's goals and expected outcomes. One approach suggested in the literature divides services into:

- **Informational** (providing advice, training, sharing experience),
- **Emotional** (empathy, support, attention to needs),
- **Role modeling** (examples of successful adaptation, changing perceptions of disability).

Peer support specialists who consciously demonstrate trust, confidence, and self-sufficiency help clients rethink their situation. PSIs often incorporate the philosophy of independent living and the rights of people with disabilities, which helps clients better understand systemic barriers. It is important to clearly define the boundaries of peer support specialists' responsibilities: what falls within their competencies and when a client should be referred to a rehabilitation or mental health professional. This helps prevent burnout and adapt training.

PSIs can be delivered individually or in groups, in person or remotely – the chosen format should meet participants' needs. It is equally important to define the "dosage": the duration, frequency, and overall length of the intervention. For example, meetings may occur weekly or monthly, and their length may range from 30 minutes to several hours. The program should document these parameters with justifica-

25 — Wasilewski M. et al. Peer support for traumatic injury survivors: a scoping review. 2023. Disability and Rehabilitation, 14(33), pp. 2199–2232. doi: 10.1080/09638288.2022.2083702

tion to ensure consistency and quality of implementation.

Research shows that participants often prefer flexible approaches, with the option to adapt the schedule and communication format (e.g., using text messages for brief contacts). Most clients value one-to-one communication, during which peer support specialists provide information using more accessible language than healthcare professionals typically use[26].

Evaluation: Outcomes and Processes

The selection of outcomes for evaluating PSIs should be based on the theoretical foundation of the program, which defines both intervention goals and expected changes.

Short-term outcomes should directly align with PSI elements. For example, training programs can influence participant behavior regarding health, knowledge of symptoms, and skills to manage them. PSIs focused on self-management should enhance self-efficacy and patient activation (i.e., the patient's awareness of their role in the treatment process and possession of knowledge, skills, and confidence to manage their health). Various methods can be used to evaluate these outcomes: knowledge and skills tests, surveys, self-assessments, or feedback from program participants.

Long-term outcomes reflect a more comprehensive impact of PSI on participants' lives and rehabilitation services. These may include:

- Improvements in physical and mental health
- Improved quality of life
- Reduced hospital readmissions and associated costs
- Social integration
- Level of social activity
- Successful return to professional activity.

These outcomes can be tracked using electronic health record data, client surveys, or as part of independent effectiveness studies.

It is also important to evaluate the processes of PSI implementation. This helps monitor adherence to intervention protocols, identify needs for additional staff training, and improve overall service quality. Methods may include focus groups, interviews, document analysis, and observation. Additionally, it is advisable to assess the effectiveness of peer support specialist training programs on a regular basis. This helps to adapt content, update methods, and respond to new practical challenges in a timely manner.

Peer Support Specialist Qualifications

Successful fulfillment of the peer support specialist role is impossible without the clearly defined professional boundaries. This is a key factor for long-term effectiveness and emotional safety in the program. Boundaries are often outlined in internal organizational policies and procedures.

Selection criteria for peer support specialists vary greatly depending on the program. In some cases, candidates are chosen from among volunteers or former patients; in others, through competition or interview, focusing on:

- Previous experience supporting others (mentoring, advocacy)

26 — Wasilewski M. et al. Peer support for traumatic injury survivors: a scoping review. 2023. Disability and Rehabilitation, 14(33), pp. 2199–2232. doi: 10.1080/09638288.2022.2083702

• Knowledge of their community's needs

• Willingness to openly share their own lived experience with disability

• Personal progress in rehabilitation and adaptation to a new way of life

Some programs have specific requirements for the peer support specialists, such as having several years of experience post-injury or active community involvement. Overall, studies show that PSI participants value similarity with the peer support specialist in terms of age, gender, interests, and injury level[27].

Effective peer support specialists often demonstrate traits of transformational leadership: they inspire others through personal example, maintain belief in the possibility of change, adapt approaches to individual needs, and help rethink problems and find solutions. These qualities can be used as benchmarks in selecting and developing specialists.

Training

Training for peer support specialists is a critical stage in implementing PSIs. Its content and format depend on the program's specifics, but literature highlights key topics that should be covered. These include interpersonal communication skills, understanding role boundaries and responsibilities, fundamentals of confidentiality and ethical behavior, social and cultural context of the target audience, and safe self-disclosure. Depending on program specifics, training may include additional elements such as: clinical information related to the target group's medical condition; advocacy techniques; fundamentals of self-care and mental health support.

In rehabilitation PSIs, training duration varies significantly. For example, in one SCI support program, specialists completed 20 hours of preparation before starting work. Another program for wheelchair users included a two-day course with goal-setting based on the SMART model.

Training should be planned considering duration, format (in-person, online, hybrid), content (depending on PSI focus), instructional strategies (adult learning, transformational learning), trainer preparation, and continuing education system. Training programs should include regular feedback and be supplemented with new components as context changes, for example, support during social isolation or mental first aid skills.

PSI Setting (Location)

Skepticism on the part of healthcare professionals can reduce the PSI effectiveness. Some PM&R studies indicate distrust of PSIs on the part of healthcare professionals due to concerns about patient safety and well-being. For instance, in one study, staff expressed concerns that patients might feel pressured to share information they were not ready to disclose, be overwhelmed by emotionally sensitive topics, or receive advice that was inaccurate or even potentially harmful.

In another study, healthcare professionals expressed concern about group-based PSI. They noted that some participants might feel frustrated by comparing their progress with that of others or that one pessimistic partici-

27 — Wasilewski M. et al. Peer support for traumatic injury survivors: a scoping review. 2023. Disability and Rehabilitation, 14(33), pp. 2199–2232. doi: 10.1080/09638288.2022.2083702

pant could negatively affect group dynamics. One strategy to overcome such resistance is involving healthcare professionals in the PSI development, fostering shared responsibility and better understanding of the intervention.

Additionally, in resource-limited settings, PSI may not be prioritized at the facility or program level. The mere existence of PSI does not guarantee its quality implementation[28]. A favorable organizational environment is necessary for successful PSI. This should include openness to change, established interprofessional collaboration between healthcare professionals and peer support specialists, and a flexible support and training infrastructure which includes not only peer support specialists but all involved staff.

The PSI location is closely related to the stage of the patient's journey in which the intervention occurs. During inpatient rehabilitation, it may be appropriate to work within the healthcare facility, i.e. in patient rooms, gyms, or other available spaces that help create a trusting and confidential atmosphere. At the stage of adapting to independent living, meetings may take place in community spaces, local organization facilities, or even clients' homes. Each environment has its advantages and risks. For example, working at home reduces mobility barriers but requires attention to safety and interaction boundaries.

Integration of specialists into the rehabilitation team is also important. An autonomous model allows peer support specialists to maintain independence and focus on social aspects of health (transportation, housing, community participation), while an integrated model ensures access to specialists, team collaboration, and official recognition of the peer support specialist role.

Supervision

High-quality supervision is a key element in ensuring the professional resilience of peer support specialists and the effectiveness of the program itself. Peer support program supervisors typically have experience in social work, psychology, and/or rehabilitation. Their role is to regularly monitor specialists' activities, assist with completing documentation and reports, and analyze complex situations. In addition to individual supervision, group meetings are held, where specialists can exchange experiences, review cases, and support one another. These can be facilitated or conducted as peer circles.

Working in PSI, especially with people in crisis, can be emotionally and cognitively exhausting. Therefore, the supervision program should include clear definition of role boundaries, creation of a safe space to discuss challenges, access to self-help resources, and regular updates on stress management skills and professional development[29].

28 — Wasilewski M. et al. Peer support for traumatic injury survivors: a scoping review. 2023. Disability and Rehabilitation, 14(33), pp. 2199–2232. doi: 10.1080/09638288.2022.2083702

29 — Magasi S., Papadimitriou C. Peer Support Interventions in Physical Medicine and Rehabilitation: A Framework to Advance the Field. 2022. Archives of Physical Medicine and Rehabilitation. 2022 Jul;103(7S): S222–S229. doi: 10.1016/j.apmr.2020.09.400

1.2. Review of Country-Specific Experiences

The fragmented nature of peer support programs and the limited information about them make it impossible to provide a complete description of their scope in the target countries. Therefore, we will further focus on specific examples of programs that have a more systemic nature (for example, integrated into public services) and/or for which useful data are available on organizational models, effectiveness and performance.

1.2.1. USA

The United States is a country with a high level of PSI integration into the healthcare system and veteran services.

1.2.1.1. PEER SUPPORT IN THE MEDICAID PROGRAM

In 2007, peer support was recognized at the federal level as an evidence-based practice in the field of mental health and substance abuse recovery. The US were allowed to include these services in Medicaid – health insurance program for vulnerable populations. Currently, such services are available in 48 US states and territories.

At the federal level, it has been determined that peer support services must be provided by qualified specialists with lived experience of overcoming mental health disorders and/or substance use disorders. To include these services in Medicaid, states must meet the following conditions:

- Supervision: must be provided by a mental health professional. The scope and format of supervision are determined separately by each state.
- Care coordination: peer support must be part of an individualized care plan developed with the participation of the patient, taking into account their needs and goals.
- Training and certification: are mandatory, but the specific requirements (content, duration, format) are set at the state level. In addition to initial certification, ongoing professional development is required[30].

A comparative analysis of peer support specialist training programs across states[31] shows variability in their scope, duration, and requirements for candidates and trainers. In 2023, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed National Model Standards for Peer Support Certification[32]. Although they are not mandatory, states may use them as a guideline to standardize practices. The standards recommend training lasting 40–60 hours and work experience (paid and/or volunteer) of up to 120 hours.

30 — Peer Recovery Center of Excellence. Medicaid Reimbursement for Peer Support Services: A Detailed Analysis of Rates, Processes, and Procedures. 2024. Peer Recovery Center of Excellence, University of Missouri — Kansas City. https://policycentermmh.org/app/uploads/2024/07/May-2024-Peer-Excellence-Medicaid-Reimbursement-Report.pdf

31 — Peer Recovery Center of Excellence. The Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the United States. 2023.

32 — Substance Abuse and Mental Health Services Administration. National Model Standards for Peer Support Certification, Publication No. PEP23-10-01-001. 2023. https://library.samhsa.gov/sites/default/files/pep23-10-01-001.pdf

1.2.1.2. FEDERAL PEER SUPPORT SERVICES FOR VETERANS

In the field of veteran support, peer support has been established as a distinct profession – peer specialist or peer support technician – within the Veterans Health Administration (VHA). Peer specialists are staff members of the public system and are integrated into a range of programs, including: inpatient mental health treatment; outpatient mental health centers; psychosocial rehabilitation centers; substance abuse recovery programs; inpatient psychiatric rehabilitation programs; vocational rehabilitation services; integrated primary care teams; legal support programs; homeless veteran programs; and the veterans crisis line.

The VHA employs approximately 1,400 peer specialists. They are members of multidisciplinary teams providing services in the aforementioned areas[33]. This status helps address certain barriers to implementing peer support by ensuring: team-based work toward shared goals; access to medical records; reporting within a unified system; and formal employment rights (such as paid sick leave).

The VHA has numerous guidelines on peer specialists in mental health and psychosocial rehabilitation. At the same time, one of the key principles is flexibility: the peer specialist role is not fully standardized and is adapted to the specifics of the service and the needs of the team. Before including a peer specialist in a team, the following must be defined: purpose of involvement; profile and qualifications; job responsibilities; training and supervision needs; boundaries of the professional role; confidentiality policies; and approaches to disclosing lived experience[34].

Peer specialists must hold certification from a state training program (see previous subsection) or complete specialized VHA training. They are also required to complete at least 12 hours of continuing professional development annually[35].

In addition to mandatory training, further preparation within a multidisciplinary team is recommended. For example, teams may provide peer specialists with training on documentation requirements and completing medical records; responding to veteran crises; VHA policies; and emergency procedures. During team onboarding, peer specialists may also be offered shadowing opportunities to observe the work of other specialists[36].

The VHA primary care system has implemented the Patient-Aligned Care Team (PACT) model. The team is led by a primary care physician who coordinates the full range of medical services for the veteran, including collaboration with specialists. Since 2014, peer specialists have been included in PACT teams, marking a significant shift in the use of PSI – from narrow psychological assistance to broader mentoring in supporting veterans' health-related behavior change[37].

33 — U.S. Department of Veteran Affairs. Peer Support Services in VA. Accessed on 8 April 2025. Available from: https://www.veteranshealthlibrary.va.gov/142,41684_VA

34 — Peer Specialist Toolkit. Implementing Peer Support Services in VHA. 2013. https://www.mirecc.va.gov/visn4/docs/peer_specialist_toolkit_final.pdf

35 — VHA Directive 1163. Psychosocial Rehabilitation and Recovery Services. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=8438

36 — Peer Specialist Toolkit. Implementing Peer Support Services in VHA. 2013. https://www.mirecc.va.gov/visn4/docs/peer_specialist_toolkit_final.pdf

37 — Chinman M. et al. Provision of peer specialist services in VA patient-aligned care teams: protocol for testing a cluster-randomized implementation trial. 2017. Implementation Science 12, 57. https://doi.org/10.1186/s13012-017-0587-7.

1.2.1.3. PEER SUPPORT IN PM&R FOR VETERANS

PSIs in PM&R within the VHA are less standardized than in the field of mental health. The VHA directive on providing PM&R services to veterans[38] does not include peer specialists in the recommended multidisciplinary rehabilitation team (MRT), but it does encourage consultation with peer support groups. Specific rules for such groups have not been established.

At the same time, the joint clinical practice guideline of the U.S. Department of Veterans Affairs and the Department of Defense on rehabilitation after lower limb amputation[39] allows for the involvement of trained peer specialists in the Amputation Care Team. The guideline recommends the use of PSIs as a component of rehabilitation to improve the patient's psychosocial status. The strength of this recommendation is moderate due to a limited evidence base.

The recommendation is based on a single RCT that compared the effectiveness of the VETPALS program (Vet's Promoting Amputee Life Skills) – training in self-management skills involving both a clinician and a veteran with an amputation – with traditional training delivered solely by healthcare professionals without a peer component. After six months, participants in the VETPALS group showed better psychosocial outcomes and quality of life, although their physical functioning did not differ statistically.

The guideline developers note that other PSI studies for individuals with lower limb amputations are of low quality. Nevertheless, qualitative studies and veterans' feedback indicate the benefits of PSIs. Therefore, even with limited evidence, these interventions are considered to hold promise and to outweigh risks.

The guideline also endorses recommendations by the Commission on Accreditation of Rehabilitation Facilities (CARF International) which suggest that peer support specialist should be matched to the patient by age, gender, and type of amputation. The first introduction to the patient should preferably take place in person, with remote interaction possible thereafter. In small rehabilitation centers or rural areas, the implementation of PSIs should be carefully weighed due to limited resources. Although PSIs can be cost-effective, they still require organizational investment.

Integration of group peer support into behavioral interventions for veterans with amputations – alongside counseling, pharmacotherapy, etc. – is also endorsed. The strength of this recommendation is likewise moderate. Overall, the guideline emphasizes the need for further research into the optimal PSI model, training of peer specialists, and the impact of interventions on patients and their families.

A similar approach is reflected in the joint U.S. Department of Veterans Affairs and the Department of Defense clinical practice guideline on rehabilitation for individuals with upper limb amputation[40]. This document also recommends incorporating peer support into the rehabilitation process, despite the acknowledged limited evidence base. This again underscores the overall trend of supporting PSIs in PM&R, even in the absence of sufficient high-quali-

38 — VHA Directive 1170.03 Physical Medicine and Rehabilitation Service. 2024. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=12081

39 — VA/DoD Clinical Practice Guideline for Rehabilitation of Individuals with Lower Limb Amputation. Version 3.0 — 2024. https://www.healthquality.va.gov/guidelines/Rehab/amp/LLA-CPG_2024-Guideline_final_20250110.pdf

ty studies and detailed evidence-based recommendations on best practices.

1.2.2. CANADA: PUBLIC PEER SUPPORT SERVICES FOR VETERANS

Since 2001, Canada has operated the Operational Stress Injury Social Support (OSISS) program – a public peer support program for service members, veterans, and their families who experience service-related stress injuries. This term describes the psychological consequences of military service, including PTSD, anxiety and depressive disorders, sleep disturbances, substance use disorders, and other co-occurring mental health conditions.

The program is jointly implemented by the Department of National Defence and Veterans Affairs Canada. OSISS employs about 70 full-time coordinators who organize the work of a volunteer network – peers with lived experience of service-related stress injuries. As of 2020, the program included 127 such volunteers.

Coordinators and volunteers undergo specialized training. The training is delivered by clinical psychologists from the Operational Stress Injury National Network, which provides services to veterans and their families. In addition, psychologists provide consultation to peer support specialists during their work.

The main goals of the program are:

- Reducing the risk of self-harm and homelessness among veterans
- Improving mental health and overall well-being
- Encouraging medical help-seeking and treatment adherence
- Reducing the stigma of service-related mental health conditions
- Expanding access to services
- Facilitating the transition to civilian life[41]

Despite more than 20 years of implementation, evidence of OSISS's effectiveness remains limited. For example, a 2017 study found that about 20% of Canadian Armed Forces personnel sought professional psychological help during the year, but a mere 1.2% used OSISS services – mainly as a complement to specialized medical support. Most program users rated it as "at least somewhat helpful"[42].

In 2021, an investigation by the Veterans Ombudsman of Canada revealed the absence of an adequate system for evaluating program effectiveness. Government authorities lacked sufficient data on OSISS activities, making it impossible to measure its performance[43].

1.2.3. LITHUANIA

We were unable to identify high-quality academic or government sources on the implementation of PSIs in rehabilitation in Lithuania. However, a representative of a Lithuanian NGO shared their experience with us in a written interview. The information presented below reflects the personal observations of our respondent.

In Lithuania, peer support is applied most effectively in the rehabilitation of

40 — VA/DoD Clinical Practice Guideline for the Management of Upper Limb Amputation Rehabilitation. Version 2.0 — 2022. https://www.healthquality.va.gov/guidelines/Rehab/ULA/VADoDULACPG_Final_508.pdf

41 — Canadian Forces Morale and Welfare Services. Operational Stress Injury Social Support (OSISS). Accessed on 10 April 2025. Available from: https://cfmws.ca/support-services/health-wellness/mental-health/operational-stress-injury-social-support-(osiss)

42 — Duranceau S., Angehrn A., Zamorski M. A. & Carleton R. N. Use of the Operational Stress Injury Social Support (OSISS) Program in a Nationally Representative Sample of Canadian Active Duty Military Personnel. 2022. Military Behavioral Health, 10(4), 397–407. https://doi.org/10.1080/21635781.2022.2057374

43 — Government of Canada — Veterans Ombudsman. Peer Support for Veterans who have Experienced Military Sexual Trauma. Investigative Report. 2021. https://ombudsman-veterans.gc.ca/sites/default/files/2023-01/Peer%20Support%20for%20Veterans%20who%20have%20Experienced%20Military%20Sexual%20Trauma.pdf

service members, veterans, and people with SCI (regardless of veteran status). Most such initiatives are implemented by NGOs, such as the charitable foundation Broliai Aitvarai and the Lithuanian Paraplegic Association.

The role of peer support specialists is not always formally defined, but often includes emotional support, mentorship, self-management skill development, and motivation to engage in rehabilitation. Selection of peer support specialists is based on similarity of life experience (type of injury, military background), which helps establish trust.

PSIs are usually introduced at the rehabilitation stage when physical stability has already been restored but psychosocial challenges remain. Interventions are conducted in person, individually or in small groups, most often in rehabilitation or recreational facilities with appropriate infrastructure. Sessions are typically held 1 to 3 times a week and may continue for a few weeks or months.

Lithuania has neither national standards for peer support specialist training or certification, nor government regulation of such initiatives. Training is organized by individual NGOs, varies in structure and scope, and often includes modules on psychological first aid, communication, ethics, and burnout prevention. Peer support specialists may be integrated into MRTs or work independently. Integration provides better coordination of the rehabilitation process but also requires more careful supervision.

PSI evaluation in Lithuania is mostly informal and often based on participant feedback. There is recognition of the need to introduce more structured, evidence-based evaluation tools (combining quantitative and qualitative methods) to better understand program effectiveness, strengthen trust, and support the development of new initiatives.

1.2.4. PEER SUPPORT IN THE REHABILITATION OF PEOPLE WITH SCI: EXAMPLES FROM DENMARK AND SWITZERLAND

1.2.4.1. DENMARK

In Denmark, there are only two specialized rehabilitation centers for people with SCI. Both have extensive experience in implementing peer support, however, in 2016 a standardized national pilot peer mentorship program was introduced at these centers as a supplement to professional rehabilitation[44].

The program was developed in cooperation between the rehabilitation centers and a patient organization. Participation was open to all adult inpatient SCI patients. Exceptions included cases where the patient's condition required specialized interaction, for example, if the patient had dementia, significant cognitive impairments, or mental disorders.

Each center had two program coordinators: one medical staff representative and one peer mentor – a person with lived experience after injury. They were responsible for selecting participants, forming mentor-patient pairs, organizing meetings, collecting feedback, and addressing ongoing organizational issues.

A total of 57 volunteer mentors were involved in the program. All had at least two years of experience living with injury, demonstrated high adaptability to

44 — Hoffmann D.D., Sundby J., Biering-Sørensen F., Kasch H. Implementing volunteer peer mentoring as a supplement to professional efforts in primary rehabilitation of persons with spinal cord injury. Spinal Cord. 2019. Oct;57(10):881–889. doi: 10.1038/s41393-019-0294-0

their own condition, openness, and tolerance. Compliance with these criteria was assessed by healthcare professionals who knew the candidates well due to long-term follow-up within the rehabilitation system.

Mentors underwent a group training seminar (3 hours), which covered ethical and legal aspects, confidentiality, and the mentor's role. Special attention was given to clearly distinguishing between personal experience and medical assistance. Training was conducted by mid-level medical staff, psychologists, and other specialists. During the program, group supervision meetings with experience sharing were held for mentors. They also had access to professional psychological support. Mentors worked on a voluntary basis but were reimbursed for travel expenses.

Mentor support was provided through in-person meetings at the center or at another convenient location. The point of intervention and meeting frequency were determined on a case-by-case basis with the involvement of the patient, mentor, coordinators, and medical staff. Typically, patients were offered three sessions with the possibility of extension if needed. Mentors were selected based on age, gender, level of injury, interests, and other characteristics important to the patients themselves. Most often, sessions focused on life after discharge and addressing everyday challenges related to the patient's condition.

Program evaluation was conducted through patient questionnaires before and after participation. Results showed a reduction in depression symptoms, improvement in quality of life, and a high level of satisfaction – 94% of participants recommended the program to others. At the same time, the study did not include a control group, which complicates the assessment of the impact of PSI on improvements. There was no observed change in pain levels or in effect relative to the number of sessions.

The authors concluded that implementing a national peer mentorship program within specialized rehabilitation is feasible and effective. They emphasized the need to establish a structured national system for mentor training and to conduct further randomized studies to evaluate the long-term impact of PSI.

1.2.4.2. SWITZERLAND

The Swiss Paraplegic Center (Nottwil) is a specialized institution that provides a full range of services to patients with SCI: from acute care after injury to lifelong rehabilitation. It offers a comprehensive peer support program as a standard component of services[45].

The center has a team of four peer support specialists. They are paid staff and are integrated into the rehabilitation team alongside doctors, nurses, physical therapists, etc. Additional mentors are engaged for patients who do not speak the center's main languages or have medical conditions other than SCI. The program covers more than 80% of patients with recent SCI, approximately 150 individuals per year. Peer support specialists also provide support to patients' relatives.

Mentors are mostly matched based on similarity in injury and gender. The first meeting with a mentor usually takes place one month after the patient's admission, once the acute phase

45 — Swiss Paraplegic Center. Peer Support and Work with Families. Accessed on 14 April 2025. Available from: https://www.paraplegie.ch/spz/en/patients-and-visitors/patient-information/peer-support-and-work-relatives/

of treatment has been completed. After that, the meeting schedule is determined on a case-by-case basis. Meetings are flexible – individual, at a time convenient for the patient, outside the main therapy schedule. Patients can ask mentors questions, share doubts, and receive practical advice.

The program also includes group seminars (Para Know-how) involving experienced patients sharing knowledge with newbies. Additionally, monthly community outings are organized (e.g., to stores or sports events), where patients, accompanied by mentors and medical staff, can practice skills in real-life environments. The center also hosts meetings (Rolli-Talks) where topics such as accessibility, sports, and rehabilitation technology are discussed.

Program evaluation showed a high level of satisfaction among both patients and peer support specialists. Patients described meetings with mentors as practical, motivating, and solution-oriented. They noted the openness of mentors, who served as examples of successful adaptation. An important aspect was the ability to discuss any issues with the mentor, especially those that patients did not always raise with medical staff, including personal hygiene, sexuality, relationships, travel, and daily living.

Patients reported that mentors' advice was often more practical and adapted to real life than recommendations from medical staff. They considered the common experience of using a wheelchair as central to identifying with the mentor, while also placing importance on similarities in age, gender, and interests. Intimate issues were more often discussed with mentors of the same gender. Informal, incidental contacts with mentors in the clinic, such as brief conversations during meals or walks, also played a significant role.

Mentors noted that the work was rewarding but required emotional resilience. The biggest challenge was determining the best time for the first meeting, especially with patients with high-level injuries who needed more time to be ready for interaction. Outings outside the hospital, group activities, and informal events were also considered important components of mutual support.

Mentors also emphasized that a deep personal connection with patients requires a clear understanding of personal boundaries to avoid secondary traumatization. Being paid staff at the facility made communication easier, helped patients feel safe in terms of confidentiality, and ensured support from other members of the rehabilitation team. At the same time, program evaluation called for additional mentor training in stress management and/or provision of professional supervision due to the emotional demands of their work[46].

1.2.5. PEER SUPPORT IN THE REHABILITATION OF PEOPLE WITH AMPUTATIONS: EXAMPLES FROM THE UNITED KINGDOM AND GERMANY

1.2.5.1. UNITED KINGDOM

In the United Kingdom, the Volunteer Visitor program of the Limbless Association has been operating for over 20 years. It connects people with a newly acquired limb amputa-

46 — Roth K., Mueller G., Wyss A. Experiences of peer counselling during inpatient rehabilitation of patients with spinal cord injuries. 2019. Spinal Cord Series and Cases. Jan 15;5:1. doi: 10.1038/s41394-018-0144-x

tion or those preparing for amputation with volunteer mentors who have themselves experienced limb loss. All mentors have at least two years of experience adapting to life after amputation and undergo criminal background checks[47].

In 2021, the organization introduced a structured six-month volunteer training program. After completing the training, volunteers gain access to supervision and professional development opportunities, which support the quality and safety of service delivery[48].

Support is provided through individual sessions lasting about one hour and conducted remotely, i.e. by phone or online. Typically, one to two sessions are offered per client, though the number can be increased if needed. All meetings are coordinated centrally through the Limbless Association and are recorded to ensure safety[49]. The topics of discussion are tailored individually according to the client's needs. These often include psychological adaptation, care of the stump, prosthetics, returning to work, leisure activities, disability status, and social rights[50].

In addition to individual sessions, the organization conducts a Training To Be An Amputee course (in-person, totaling 10 hours). It covers the rights of people with disabilities, access to rehabilitation resources, and the basics of independent living after amputation[51].

Patients can access the program via referral from healthcare professionals, at the initiative of relatives, or through self-referral. Information about the Volunteer Visitor program is included in the informational materials of the UK National Health Service (NHS)[52].

The clinical guideline of the UK National Institute for Health and Care Excellence (NICE)[53] recommends that NHS rehabilitation providers inform patients about peer support opportunities and provide contact information for relevant organizations. The guideline also encourages the establishment of peer support groups during inpatient rehabilitation.

Although formal evaluation data for the Volunteer Visitor program are not publicly available, participant testimony indicates a positive impact[54].

1.2.5.2. GERMANY

One of the most institutionalized examples of peer support in Europe is the German program Peers im Krankenhaus (PiK or Peers in Hospitals). The initiative was launched in 2010 at the Unfallkrankenhaus Berlin (UKB) and later scaled nationally[55]. It is coordinated by the Federal Amputee's Association (Bundesverband für Menschen mit Arm- oder Beinamputation, BMAB) in cooperation with rehabilitation

47 — Limbless Association. Amputees Supporting Amputees. Find out how our peer mentoring service can help you. Accessed on 15 April 2025. Available from: https://limbless-association.org/volunteer-visitors/

48 — Limbless Association. For Professionals Supporting Amputees. A Guide to the Volunteer Visitor service and volunteering programme. Accessed on 15 April 2025. Available from: https://limbless-association.org/vv-for-professionals/

49 — Limbless Association. Amputees Supporting Amputees. Find out how our peer mentoring service can help you. Accessed on 15 April 2025. Available from: https://limbless-association.org/volunteer-visitors/

50 — Limbless Association. Volunteer Visitor Leaflet. N/D. https://keepingmewell.com/wp-content/uploads/2021/09/LA-Volunteer-Visitor-Leaflet-Service-User-compressed.pdf#:~:text=The%20VV%20programme%20has%20been,clinical%20service.%20Who%20are%20%E2%80%98Volunteer%C2%A0Visitors%E2%80%99

51 — Limbless Association. Training To Be An Amputee. Accessed on 15 April 2025. Available from: https://limbless-association.org/amputee-learning-hub/ttbaa-ftf/

52 — Sherwood Forest Hospitals NHS Foundation Trust. Information for patients — Rehabilitation following lower limb amputation. N/D. https://www.sfh-tr.nhs.uk/media/jljh3fgk/pil202410-06-rflla-rehabilitation-following-lower-limb-amputation.pdf#:~:text=,association.org.%20Derby

53 — NICE Guideline. Rehabilitation after traumatic injury. 2022. https://www.nice.org.uk/guidance/ng211/chapter/Recommendations

54 — Batchelor A. No amputee should cope alone: the life-changing support of the Limbless Association. 2025. RWK Goodman. https://www.rwkgoodman.com/info-hub/tac-14-no-amputee-should-cope-alone-the-life-changing-support-of-the-limbless-association/#:~:text=At%20the%20Limbless%20Association%2C%20we,connect%20with%20others%20who%20understand

55 — Greitemann, B. Laudatio zur Verleihung der Kurt-Alphons-Jochheim-Medaille an Dagmar Marth. Deutsche Vereinigung für Rehabilitation e.V. (DVfR) [Laudation for the awarding of the Kurt-Alphons-Jochheim Medal to Dagmar Marth. German Association for Rehabilitation (DVfR)]. 2019. https://www.dvfr.de/fileadmin/user_upload/DVfR/Downloads/Jochheim_Medaille/KAJ-Medaille_2019_Laudatio_Greitemann_Ef_bf.pdf

centers and insurance funds, including DGUV (German Social Accident Insurance) and AOK Nordost[56].

In a clinical scenario, the invitation of a peer support specialist is initiated by a doctor or MRT. With the patient's consent, the first in-person meeting is arranged (usually within a week), with follow-ups held as needed[57]. Conversations are confidential and not recorded. Mentors do not give medical advice or impose solutions but may relay important information to the doctor if it serves the patient's interests[58]. As of 2020, 60–70% of amputation patients at UKB participated in the program. Consultations at UKB are provided by 12 mentors, who volunteer as part of official collaboration with the hospital[59].

Based on the UKB experience, BMAB developed a standardized system for mentor training and certification. Key requirements for peer support specialists: amputation that occurred at least three years ago, emotional stability, active BMAB membership. The training includes:

- 2-day basic course (medical, psychological, legal aspects, communication, practice): 2 points
- Annual national, regional, and local events (seminars, meetings): 12 points

A total of 14 points is required for initial certification. Certification is renewed annually through continuing education. BMAB covers participation costs (transport, accommodation, per diem). Individual training modules are also available to rehabilitation center staff implementing PSI at their respective facilities[60].

The PeerMap tool, maintained by BMAB and DGUV, allows hospitals to locate certified mentors in their region[61]. With the patient's written consent, a meeting is organized and recorded in a special form. Family participation is allowed at the patient's request[62]. Given the success of the PiK model, DGUV has begun expanding it to other medical conditions, such as cancer, multiple sclerosis, mental health, and SCI[63].

1.2.6. PEER SUPPORT IN THE REHABILITATION OF PEOPLE WITH VISUAL IMPAIRMENTS: EXAMPLE FROM THE NETHERLANDS

In the Netherlands, a structured mentorship program, Mentor Support, was implemented for young people with visual impairments, integrated into the rehabilitation service system. Mentor Support paired young people (15-22 years old) with visual impairments with volunteer mentors who had successfully adapted to life after vision loss (some mentors were sighted for

56 — BMAB. Peer Support for Amputees in the Hospital and in the Community. 2019. https://www.ic2a.eu/wp-content/uploads/2019/10/Peer-Support-for-Amputees-Dieter-Juptner-BMAB-Germany.pdf#:~:text=Peers%20have%20to%20be%20trained,staff%2C%20physiotherapists%20

57 — BMAB. PiK — Peers im Krankenhaus [Peers in hospitals]. Accessed on 15 April 2025. Available from: https://www.bmab.de/peersimkrankenhaus/?utm_source=chatgpt.com&v=5f02f0889301

58 — Greitemann, B. Laudatio zur Verleihung der Kurt-Alphons-Jochheim-Medaille an Dagmar Marth. Deutsche Vereinigung für Rehabilitation e.V. (DVfR) [Laudation for the awarding of the Kurt-Alphons-Jochheim Medal to Dagmar Marth. German Association for Rehabilitation (DVfR)]. 2019. https://www.dvfr.de/fileadmin/user_upload/DVfR/Downloads/Jochheim_Medaille/KAJ-Medaille_2019_Laudatio_Greitemann_Ef_bf.pdf

59 — REHACARE International. Peer Counseling in hospitals: Empowering amputees. 2020. https://www.rehacare.com/en/Media_News/Archive/Topics_of_the_Month/2020/February_2020_Empowerment_at_eye_level_%E2%80%93_Peer_Counseling/Peer_Counseling_in_hospitals_Empowering_amputees#:~:text=Whether%20it%E2%80%99s%20motivating%20patients%20throughout,a%20positive%20perspective%20on%20life

60 — BMAB. PiK — Peers im Krankenhaus [Peers in hospitals]. Accessed on 15 April 2025. Available from: https://www.bmab.de/peersimkrankenhaus/?utm_source=chatgpt.com&v=5f02f0889301

61 — REHACARE International. Peer Counseling in hospitals: Empowering amputees. 2020. https://www.rehacare.com/en/Media_News/Archive/Topics_of_the_Month/2020/February_2020_Empowerment_at_eye_level_%E2%80%93_Peer_Counseling/Peer_Counseling_in_hospitals_Empowering_amputees#:~:text=Whether%20it%E2%80%99s%20motivating%20patients%20throughout,a%20positive%20perspective%20on%20life

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comparison). The program aimed to help adolescents improve social participation, in particular in education, leisure, and peer relationships.

Each participant was assigned a mentor, with whom approximately 12 in-person meetings were held per year. Sessions took place in environments familiar to the mentees, i.e. public spaces or not far from their homes. The topics of the meetings covered three areas: education and work, leisure, and social interaction. The content of the sessions was tailored on a case-by-case basis: from learning the route to a new sports club to practicing social skills or visiting the mentor's workplace.

The program was coordinated by two national organizations in the field of rehabilitation for people with visual impairments—Bartiméus and Royal Dutch Visio. They were responsible for selecting participants and mentors, developing training materials, and supporting the process. A manual was developed that described the structure of the meetings and offered practical tasks for participants, as well as a website accessible to users with visual impairments. Mentors completed standardized forms after each meeting, allowing the process to be monitored and supervisory support to be provided[64].

The program was evaluated in a RCT with 76 young people with visual impairments. The study did not show significant differences in social participation levels (engagement in education or work, leisure activity, social contacts) compared with a control group that received only standard rehabilitation services without any mentoring. At the same time, participants who had mentors with their own experience of vision loss reported higher satisfaction with support than those whose mentors were sighted or who did not have a mentor at all. This indicated the added value of a "peer" experience in building trusting relationships[65].

The implementation of Mentor Support also revealed several challenges. A significant number of mentor-mentee pairs ended contact prematurely, mostly at the initiative of the young participants. The main reason cited by respondents was insufficient communication skills of the mentors, which complicated the development of trusting relationships. This was particularly noticeable among mentors who themselves had visual impairments and were not always able to effectively help in areas beyond their own experience.

Based on the results, the researchers concluded that more thorough mentor training was necessary: they need not only their own stories of successful adaptation but also communication skills, youth support skills, and an understanding of realistic goals. At the same time, mentees should also be prepared for interaction with a mentor to avoid unrealistic expectations[66].

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Section 2

Overview of the Ukrainian Experience

2.1.1. REGULATORY FRAMEWORK

In Ukraine, peer support in mental health is recognized at the legislative level. The Law On the Mental Health Care System in Ukraine[67] (to come into force in 2026) establishes the concept of informal support in this area, based on personal experience, community initiatives, and the peer support principle. It complements professional support from respective specialists and, if necessary, should be accompanied by supervision. Such services are defined as a form of psychosocial assistance.

The law defines the main objectives of peer support programs and groups, including:

- Creating a safe and educational environment for developing social connections and a sense of belonging to a community of people with similar experiences
- Providing positive role models and support
- Preventing the development or worsening of mental disorders
- Enhancing psychological resilience, motivation to seek help, confidence, communication, and social skills

In addition, various organizations have developed materials to promote the application of peer support in psychosocial support. For example, the Ministry for Veterans Affairs of Ukraine (MinVeterans) in cooperation with the Mental Health for Ukraine (MH4U) project and the National Psychological Association developed guidelines for creating veteran psychosocial support groups[68]. The document is aimed at developing local initiatives and describes mechanisms for establishing self-help groups in communities. In addition to these recommendations, there are other manuals, for example, Self-Help Groups: Theory and Practice from the GURT Resource Center, developed with the support of the UN Recovery and Peacebuilding Program[69].

The peer support model is also included in some state standards for social services. In particular:

- In the field of social rehabilitation for people with mental and intellectual disabilities[70], as well as those with substance use disorders[71], a «peer social worker» has been introduced (a person aged 25-65 years old who has successfully undergone substance use treatment at least two years ago, and who has completed training and internship).

In the standard for social service of counseling, there is a provision for in-

67 — Law of Ukraine On the Mental Health Care System in Ukraine No. 4223-IX of January 15, 2025. https://zakon.rada.gov.ua/laws/show/4223-20#Text

68 — Ministry for Veterans Affairs of Ukraine, National Psychological Association, MH4U. Organizing Veteran Peer Support Self-Help Groups to Provide Better Psychosocial Support: Recommendations for Local Authorities and Community Leaders. N.D. https://mva.gov.ua/storage/app/sites/1/uploaded-files/_%D0%9F%D0%94_%D0%A0%D1%96%D0%B2%D0%BD%D0%B8%D0%B9_%D1%80%D1%96%D0%B2%D0%BD%D0%BE%D0%BC%D1%83.pdf

69 — GURT Resource Center. Self-Help Groups: Theory and Practice. A manual for managers, organizers, and facilitators of self-help groups. 2021. https://www.undp.org/uk/ukraine/publications/hrupy-samodopomohy-teoriya-i-praktyka

70 — Order of the Ministry of Social Policy of Ukraine No. 1901 of December 17, 2018 On Approval of the State Standard for Social Rehabilitation of Persons with Intellectual and Mental Disorders. https://zakon.rada.gov.ua/laws/show/z0066-19#Text

71 — Order of the Ministry of Social Policy of Ukraine No. 677 of October 1, 2020 On Approval of the State Standard for the Social Service of Social and Psychological Rehabilitation for Individuals with Substance Use Disorders. https://zakon.rada.gov.ua/laws/show/z1218-20#Text

volving consultants with experience in overcoming similar life circumstances. Their role includes providing psychological support, developing social skills, and organizing self-help groups[72].

2.1.2. PRACTICAL APPLICATION

Practical application of peer support in the field of psychosocial rehabilitation proved to be the most controversial part of our study. Respondents described both advantages and significant risks associated with this approach. They emphasized the difference between the Ukrainian context and the conditions under which PSIs are implemented in most other countries. While international programs generally assume that peer support specialists have undergone several years of integrating their own traumatic experiences, in Ukraine, veterans are living in a state of ongoing war. This creates risks of retraumatization both for peer support specialists and for their clients.

One of our respondents described the involvement of a veteran as a peer support consultant in a mental health and rehabilitation center. His task was to build trust between patients and psychologists, conduct psychoeducational sessions, and reduce the stigma around psychological support. At first, this practice showed positive effects: the veteran consultant helped remove communication barriers and motivated patients to engage in treatment. However, over time, difficulties in the work began to emerge. According to our respondent, the consultant refused supervision and therapy, began competing with psychologists, and exhibited signs of decompensation of his own symptoms. Patients began to doubt the correctness of his approaches. Center representatives linked this experience to the premature use of peer support in 2023, when most veterans were still in a depleted state.

Similar observations were shared by representatives of an NGO working with veterans:

> "We saw that very often a person's traumatic experience manifested itself in their counseling. It... became just too much, and they provided too many personal judgments, personal context instead of professional support." **(NGO representatives working with veterans)**

They emphasized that international PSI models, which they had used as references, do not work directly in Ukraine:

> "What we saw in the U.S., Canada, Denmark, does not always work in Ukraine... Veterans who were returning home were mostly just beginning their counseling journey and had not yet accumulated this experience." **(NGO representatives working with veterans)**

Respondents identified the greatest challenges as finding veterans in Ukraine who have fully integrated their own traumatic experiences:

> "It is currently difficult for us to find a veteran who has fully integrated their traumas because our war has not ended... They may have integrated past experiences, but something new happens every day." **(Representative of a mental health and rehabilitation center)**

72 — Order of the Ministry of Social Policy of Ukraine No. 678 of July 02,2015 On Approval of the State Standard for Social Counseling Services. https://zakon.rada.gov.ua/laws/show/z0866-15#Text

In response to these challenges, the practice underwent an evolution. Instead of applying the peer support approach as a standalone therapeutic intervention in mental health, some respondents began to position it as an "entry point" to services, i.e., a way to build trust and prepare the client for contact with a qualified professional. A mixed format of peer support specialist working alongside a psychologist is also being introduced. For example, in support groups, a psychologist acts as a moderator, while a veteran with related experience can serve as a co-moderator.

> "This carries a major risk of retraumatization and of the person bringing in their experience as if it has been processed and integrated, but it turns out it is not processed or integrated. At that moment, the trauma and emotional injury will impact both the person and the participants... What can be done here? Having a psychologist colleague who can step in." **(NGO representatives working with veterans)**

Respondents emphasized that critical factors for the safety and effectiveness of PSI in mental health are the careful selection and clear definition of peer support specialist roles, as well as providing them with conditions (supervision, intervision, personal therapy) comparable to those available to psychologists:

> "I am working with a large team of psychologists... They all have mandatory supervision... and access to personal therapy. ...This is important because we are working with trauma while living in a traumatizing situation. I think this is also important for the veterans. They just don't always realize that they need it." **(Representative of a mental health and rehabilitation center)**

Special attention was also given to risks in small communities. There, participants and consultants often know each other personally, which increases the likelihood of breaches of confidentiality or the relationship turning into a friendship. This underscores the importance of internal rules and ethical codes for PSI.

Overall, the interviews revealed concern that positioning peer support as a standalone profession for veterans may be premature for Ukraine, at least in the mental health field. Respondents believe that mixed models or formats are the most promising (peer support specialists working alongside professional psychologists), where peer support occurs in the context of communication, leisure, or shared hobbies:

> "Promoting and advocating peer support as a career path for veterans is harmful... And we are critical of labeling everything that happens for veterans as a therapeutic intervention. People often just need normal social interaction, leisure, and shared experiences that are not therapeutic." **(NGO representatives working with veterans)**

Thus, under current conditions, PSI is safer and more beneficial when integrated as a complement to professional mental health services or when implemented in leisure and community formats rather than formalized therapy.

2.2. Peer Support in PM&R

2.2.1. ROLE OF PEER SUPPORT SPECIALISTS

Our interviews showed that within PM&R, the role and added value of peer support are the most clear and tangible. Although the functions of such specialists are not always clearly defined at the organizational level, respondents' descriptions largely coincided. They reflect the types of support systematized in international literature: role modeling, development of self-sufficiency and self-management skills, information sharing, and psycho-emotional support.

One of the most influential functions was role modeling between people with similar trauma. Seeing an example of someone who has adapted to life after trauma and is socially integrated can have a strong motivational and therapeutic impact. This was noted by all respondent groups, starting with peer support specialists themselves:

> «She writes to me in tears: '...I saw that your toenails were painted... I realized I am a woman, so why wasn't I taking care of my feet?' Just because they can't walk doesn't mean it's all over. You know, it's about reading each other, catching the small details – how I make the bed, how I dress...» **(Representative of an NGO supporting people with SCI)**

> «He sees that the boy... doesn't have both legs above the knee, and he walks... without a cane.... And the best thing – he is smiling. He didn't give up. He has achieved what psychologists describe as post-traumatic growth. He became a better version of himself. And, of course, after seeing this, not to mention hearing it, a spark of hope begins to flicker in that boy's mind.» **(Director of a department in a non-governmental rehabilitation center)**

This was also highlighted by program beneficiaries:

> «A boy... lives his life freely even though he's missing three limbs. And when you arrive at the center ... and look at this boy, you realize nothing is impossible. If he can, you can.» **(Peer support program beneficiary in a non-governmental rehabilitation center)**

Healthcare professionals also noted this function as extremely useful in daily practice. By example, peer support specialists help motivate patients to take a more active role in their own recovery:

> «It's very hard... for me, a professional without mobility impairments, to motivate someone... because this person has to trust me... But when a person in a wheelchair comes to your ward and says, 'I drove here, let's go for a ride...' And

the person who just got injured thinks: wow, if that's possible, ... then I can do it too. And then it's easier for us to teach these young people.» **(Physical therapist at a veterans' hospital)**

At the same time, respondents with many years of experience in PSI emphasized that role modeling must be balanced and should not turn into showcasing one's own achievements at the client's expense:

«One of our principles is that the instructor should not show off. We should demonstrate skills through our behavior, lifestyle, and everything else, but not... boast, like... 'I won medals...' So the person could feel humiliated... There is a very fine line here.» **(Representative of an NGO supporting people with SCI)**

Another in-demand function is teaching self-management skills (wheelchair use, prosthetic care, driving for people with SCI, spatial orientation for people with visual impairments, etc.) and providing information about living with trauma. This is especially valuable in areas sensitive to discussion with healthcare professionals, for example, bladder and bowel management, sexual and reproductive health for people with SCI.

Equally important is psycho-emotional support. It creates a sense of safety for the patient and helps build a bridge between the patient and medical staff:

«When you arrive at the hospital, you don't know who to turn to. Your doctor says something, but you can't take it seriously... But when a fellow serviceman comes up to you and says: 'Brother, calm down. Everything's okay. Now you need to rebuild your social life, go through rehabilitation...' This is very important.» **(Peer support specialist at a non-governmental rehabilitation center)**

«Some people are crying, some are embarrassed, I come over, pat their head... If the person has no arms... I wipe away their tears, their face... And start saying that yes, everything's okay, ...life goes on...». **(Peer support specialist at a regional hospital)**

«It's necessary to understand how... you can be a bridge between the doctor or other professional and the patient. Because sometimes there is... a disconnect, where the patient does not always understand the doctor or the doctor cannot explain things in the patient's language.» **(Director of a department in a non-governmental rehabilitation center)**

2.2.2. SHARED EXPERIENCE

International studies show that the PSI effectiveness in PM&R largely depends on the degree of shared experience between the peer support specialist and the beneficiary. Age, gender, and type of injury can affect trust between participants and the perceived value of support. For service members and veterans, an additional dimension is shared military experience. At the same time, these dimensions do not always overlap: a peer support specialist may be a

veteran without a similar injury, or, conversely, a civilian with the same injury but without a military background.

Our interviews showed that respondents evaluated the degree of shared experience in different ways. For support beneficiaries, the status of being a service member or veteran often came first:

> "The simplest rule applies here: a soldier to a soldier, a veteran to a veteran... The type of injury doesn't matter." **(Peer support program beneficiary in a non-governmental rehabilitation center)**

> "There is distrust toward civilians... However, there was more positive feeling toward military personnel. They will understand you, they will hear you. And even if they say 'I feel you', those won't be empty words." **(Participant in a rehabilitation camp for veterans)**

Paid peer support specialists in rehabilitation facilities, as a rule, had military service experience themselves and worked with all current and former service members in need of support, regardless of age or gender, and often regardless of type of injury. However, they acknowledged that matching by type of injury increases support effectiveness when it comes to learning practical skills or preparing for amputation or prosthetics:

> "In the rehabilitation room, if it's just a conversation or support, [matching by injury] isn't effective... But if it's initial prosthetics, then it's very effective to connect that patient with a young man who has the same experience. If it's preparation for amputation, the same rule applies." **(Director of a department in a non-governmental rehabilitation center)**

> "It doesn't matter what the injury is. I work with everyone. However, of course, when someone shows up with the same injury as mine, I spend more time with them." **(Peer support specialist in a non-governmental rehabilitation center)**

Some specialists noted that a difference in injury can create obstacles to trust. One respondent said that patients sometimes devalued his work because his "injury was not severe enough", and he had to overcome this barrier each time he met new beneficiaries. Others emphasized that these differences were not critical for them, but agreed that the gap between the experiences of people with SCI and those with amputations was noticeable, and encouraged pairing that took this into account.

> "I am a person in a wheelchair. I survived captivity... So they can't just tell me: 'You won't understand us'... However, some people still say that... That's why I believe that it would be a good idea to hire two specialists at once. One with a spinal cord injury, in a wheelchair. And the other with an amputation... Because the experiences are completely different." **(Peer support specialist at a non-governmental rehabilitation center)**

Specialized NGOs working with specific types of injuries took a completely different approach. In our interviews, their representatives focused precisely

on the specificity of the medical condition (rather than on shared military background) and stressed that the experience of similar conditions is not interchangeable.

> "And I notice that even among the military, they've started to view a wheelchair user as an authority on everything." Of course, that's not true, because the conditions are different..." **(Representative of an NGO supporting people with SCI)**

> "Even if I provide you with the methodology, I cannot explain these subtle nuances of what needs to be said to a person who was at war and lost a limb. I know the theory, but I haven't lived through that experience... And that's a different thing." **(Representative of an NGO supporting people with SCI)**

Peer specialists from NGOs were more often civilians, and they often viewed this as an advantage in working with veterans. First, civilian specialists could work against the biases of the military community, which sometimes complicated the rehabilitation process. Second, it was easier to find civilians who had already integrated the experience of living with an injury and had the resources and skills to help others.

> "The general principle in the organization is that we do not single out [veterans] as a separate group. On the contrary, we try to integrate their experience with that of civilians." **(Representative of an NGO supporting people with SCI)**

> "We tried to involve mentors in our rehabilitation activities from among veterans who had gone through several stages of rehabilitation with us. But they lacked the experience and knowledge to be mentors. It was a little difficult." **(Representative of an NGO supporting people with visual impairments)**

At the same time, some NGO respondents emphasized that the best combination is military experience plus personal injury experience, since this ensures identification with beneficiaries across all key dimensions:

> "Considering that he is a service member, he has his own approaches... [A]lthough I also understand this, because I used to be a police officer before my injury..., but combining the two is better." **(Peer support specialist at an NGO supporting people with SCI)**

Finally, some of our respondents also pointed out the advantages of pairing peer support specialist and patient by gender, and the shortage of female specialists with whom female patients could communicate more openly.

Thus, our study confirms international findings: in PSIs in PM&R, it is important to consider the level of shared experience between the peer support specialist and the patient. At the same time, the Ukrainian context does not always allow for "perfect matches" across all parameters. This requires seeking a balance: combining universal veteran programs with the narrow expertise of NGOs for specific types of injuries, as well as engaging both military and civilian specialists depending on program goals and beneficiary needs.

2.2.3. PROGRAM STRUCTURE AND QUALITY

Our study showed that the level of structuring and professionalism of programs, as well as the status of peer support specialists in PM&R, varies considerably.

2.2.3.1. FRAGMENTED INITIATIVES

In some HCFs, peer support is implemented through one or more staff members who work with quite a bit of flexibility, without being clearly assigned a systemic function. The formal job titles of such specialists vary widely and often do not correspond to their actual job. For example, one of our respondents was officially employed as a physical education instructor but in fact also counseled patients on accessing social services and using a wheelchair. Another worked in a large municipal hospital as a data entry operator, but his main job was to do ward rounds, provide emotional support, and even advise on prosthetics:

> "...In the morning ... together with the general director, we go to the polytrauma ward and talk with the wounded... And then he leaves, and I start walking around on my own... I come to the nurses' station and ask: '...who do we have today?' and they say: 'In room X, such-and-such person is crying; in room Y, so-and-so is very sad.'" **(Peer support specialist at a regional hospital)**

Such practice points to the problem of the absence of a formalized job title of peer support specialist. As a result, people are hired into random, often irrelevant positions, which limits their capabilities, makes their real contribution to the rehabilitation process invisible, and complicates the evaluation of their performance. A partial solution may be certification of peer counselors and the official inclusion of this profession in the Classifier of Professions (see section 2.4.2).

2.2.3.2. SYSTEMIC PRACTICES

In our study, there were only a few examples of peer support programs in PM&R that stood out for their more systemic approach, high integration into the rehabilitation process, and carefully planned preparation of specialists.

2.2.3.2.1. NON-GOVERNMENTAL REHABILITATION CENTER

In one non-governmental rehabilitation center, peer support has been implemented through a dedicated department of five paid specialists – former patients of the center. This team provides systematic support to patients from the very first days of hospitalization. The peer support specialists introduce themselves and present all the opportunities of the rehabilitation center and their department, explaining how they can help and in which matters patients can turn to them. Subsequently, support is provided both individually and in group settings. The department organizes a variety of rehabilitation and recreational activities (sports sessions, museum visits, music therapy, etc.), adapted to the physical

condition of the patients. Daily personal interaction creates an atmosphere of trust that is difficult to achieve through the efforts of medical staff alone.

Peer support specialists become navigators of the rehabilitation process in the center. They explain what to expect during the stay, advise on the use of prostheses or wheelchairs, and share their own adaptation experiences. If necessary, peer support specialists help refer patients to other professionals:

> "Either they take you by the hand and go to the prosthetists or the PM&R doctor, and you find out the reason for the sensations you're experiencing, and accordingly, your prosthesis or condition is brought to the ideal format." **(Peer support program beneficiary in a non-governmental rehabilitation center)**

The team also pays close attention to patients' psychological well-being. When needed, they gently guide them to a psychologist, sometimes even without the patient realizing it (for example, suggesting a coffee together with the specialist). This facilitates the integration of psychological support into the rehabilitation process.

> "...There were moments... when... it was breaking me down, mentally, psychologically... At that moment, the guys noticed my waning motivation for rehabilitation and referred me to a psychologist, with whom I had several very pleasant sessions, and everything fell back into place..." **(Peer support program beneficiary in a non-governmental rehabilitation center)**

The department specialists also provide initial legal consultations (regarding disability certification, MMC, etc.) and, if necessary, refer patients to lawyers.

Thus, the structured program covers all aspects of adaptation: from emotional support and motivation to practical advice and help with paperwork, serving as a bridge between the patient and the medical team.

At the same time, the program relies on systematic staff training and institutional support from the rehabilitation center. Each specialist has clearly defined functional responsibilities, and the team adheres to the principle of "do no harm". To this end, regular intervisions and supervisions are conducted. Department specialists constantly engage in professional development: they undergo additional training in related fields (psychology, physical rehabilitation), attend workshops, learn from advanced global and Ukrainian experience, and share their own practices with specialists in other institutions.

2.2.3.2.2. REHABILITATION PROGRAM FOR VETERANS WITH VISUAL IMPAIRMENTS

A second example is the rehabilitation program of a non-governmental organization that works with veterans who have vision loss or impairment and their families. Its distinctive feature is the involvement of instructors with personal experience of vision loss. They pass on practical knowledge on orientation, mobility, and independent living while serving as role models.

> "Sometimes, when veterans and their spouses arrive, they don't immediately understand the extent of vision loss of our trainers. But then they are amazed, they learn, and realize that they can do it too. This is an educational and motivational supportive therapy with peer support." **(Representative of an NGO supporting people with visual impairments)**

The program combines psychological and informational support with training components and is based on a multidisciplinary approach. Psychologists, typhlopedagogy experts, physical therapists, IT specialists, and lawyers are involved in working with veterans. Some specialists are paid staff of the organization, while others work as volunteers or contractors providing rehabilitation services. All rehabilitation activities are conducted according to an approved program and methodological materials published on the organization's website. Training the specialists themselves is a key component of the model. All trainers have specialized education, but additionally undergo regular training and experience exchanges, in particular with international specialists.

The program covers several support stages:

- **Initial stage:** informational and emotional support and first steps of training in military hospitals
- **Main stage:** offsite rehabilitation camps where veterans acquire social and daily living skills, learn Braille, IT tools, and participate in group and individual sessions with a psychologist
- **Mobile team visits** home, as needed
- **Continued communication** through regular meetings, phone calls, and messaging groups.

The organization strives to begin interaction with veterans as early as possible, ideally while they are still in a healthcare facility. However, participation in the rehabilitation program requires the patient's readiness to take active steps:

> "We start working in the hospital if we are invited… this is informational and emotional support at the first stage. Once the person is ready… they ask for a cane and to be taught orientation… And only after that do I invite the veteran… to our rehabilitation program." **(Representative of an NGO supporting people with visual impairments)**

The organization also maintains contact with veterans after the rehabilitation program completion, although this element remains limited in coverage:

> "We have a certain number of people who constantly call our guys, asking how they are doing, what they are up to, if they need support… So there is a support process. I can't say it's as dynamic as I would probably like it to be." **(Representative of an NGO supporting people with visual impairments)**

Despite significant achievements, the program cannot fully meet the existing need of veterans with vision loss, especially in smaller communities. Specialized services are lacking there, and such veterans rarely participate in veteran hubs:

> "As for regions, communities, towns, programs specifically targeting the blind are practically nonexistent. People with total loss of vision or hearing are a very separate community. First, they often feel uncomfortable in general groups. Second, they are very little involved. While veterans with amputations come to veteran hubs for training, the blind usually do not come on their own..." **(Representative of an NGO supporting people with visual impairments)**

Thus, the program demonstrates the advantages of a systemic and multidisciplinary approach to peer support in PM&R. At the same time, it emphasizes that the needs of veterans with different types of injuries vary significantly. This makes the standardization of PSI in PM&R challenging and requires flexibility and specialized expertise.

2.2.3.2.3. PEER SUPPORT PROGRAM FOR PEOPLE WITH SCI

The most systematic and large-scale program among those covered in our study was the peer support initiative implemented for many years by an NGO supporting people with SCI. From the very beginning, the organization's approach has been based on a clear methodological foundation, borrowed from international experience and adapted to the Ukrainian context. Over time, the program has evolved into a comprehensive model that combines several complementary components.

First, there are **"first contact instructors"**, i.e. peer support specialists who work directly in healthcare facilities. By agreements (memoranda of cooperation) between the NGO and HCFs, instructors visit wards, meet new patients with SCI, and join their rehabilitation during inpatient care. The instructors' work is integrated into the rehabilitation plan, coordinated with the medical team, and aimed at achieving the patient's individual goals.

> "If a patient does not achieve the goals in which the first contact instructor and the entire rehabilitation team are involved, it means we are working ineffectively." **(Physical therapist at a veterans' hospital)**

Second, the organization provides **remote consultations.** People with SCI and their close ones can receive guidance on a wide range of topics, such as pressure sore prevention and proper positioning, bladder and bowel management, hygiene products selection and use, mobility and self-management, disability certification and verification. Remote consultation serves several functions simultaneously. First, it addresses issues that first contact instructors do not have time to resolve during the patient's inpatient stay. Second, it ensures **continuity of support after discharge**, allowing contact with patients at home or in the community. Additionally, remote support serves as a **navigator**: consultants help connect the person with other necessary services.

Third, the organization holds intensive **active rehabilitation camps**, which people with SCI can join after inpatient treatment. They are based on daily training, practical tasks, and group sessions. Instructors teach participants independent living skills through practice and sports activities. Alongside this, the program offers lectures and

discussions on legal, intimate, and other matters, covering a broad range of post-injury life needs.

> "Ten days of camp, three training sessions, lectures, and informational content. But most importantly, the instructors are all... the goal of training is not to teach tennis, but to get together, learn to dress and wash up quickly, and not be late for the next training session..." **(Representative of an NGO supporting people with SCI)**

Finally, the NGO also runs **smaller workshops for those who have already achieved basic self-sufficiency.** The focus here is on social activities and practicing daily living skills in real-life conditions. Participants take maximum responsibility, for example, they organize outdoor trips, meal preparation, and leisure activities themselves. This approach enhances the sense of control over one's life and develops self-organization.

Thus, **this model covers all phases of recovery – from the first days after injury to returning to the community** – offering a continuous peer support cycle for people with SCI.

A key feature of the program is investment in the training and development of instructors. The organization has **21 first contact instructors** across Ukraine. New candidates are usually selected from among participants of active rehabilitation camps who demonstrate leadership qualities, communication skills, and motivation to help others; they then undergo **advanced training and internships** (see section 2.4.3).

The NGO operates **a supervision system.** Two supervisors and a general coordinator oversee the program. Challenging or new cases are brought to supervision meetings; if necessary, specialized professionals are involved to resolve disputed issues and update knowledge on rehabilitation approaches for people with SCI:

> "We also had good practice... where we engaged a physical therapist, occupational therapist, and PM&R doctor to address aspects we had not yet covered regarding new treatment approaches. And there were cases with controversial issues... so with the help of these specialists, we figured out which approaches to apply." **(Representative of an NGO supporting people with SCI)**

This selection, training, and supervision system is intended to ensure uniform standards in instructors' work and maintain the quality and safety of services at all stages.

2.2.4. COMPLEXITY OF INTEGRATION INTO HCFS

All of our respondents emphasized the critical importance of peer support specialists' interaction with medical staff and the regular exchange of information regarding a patient's condition, needs, and progress. This is necessary for a wide range of reasons, starting with adherence to the "do no harm" principle. The medical condition of each person, especially during active rehabilitation, is unique, and a peer support specialist's experience is not always directly relevant. Any activities with a

patient must be coordinated with the treatment plan, which our physician interviewees particularly emphasized:

> "Every specialist involved in the rehabilitation process must know the patient's examinations, goals, plans... We cannot tell a patient: '...I can't walk, ...so you won't walk either,' when the patient actually has a prognosis for regaining mobility... If, for example, a first contact instructor shares their experience of learning a certain skill, and the patient cannot acquire it due to secondary complications that the instructor is unaware of... we can only cause harm." **(Physical therapist at a veterans' hospital)**

A similar view was expressed by the peer support specialists themselves:

> "Yes, because without [interaction] it is impossible to provide quality services, and sometimes, perhaps, we could even do harm. For example, if I ... want to involve a patient in sports activities or other engagements, I always first consult with specialists... If I see a patient in a depressed state and I cannot build rapport with them, I turn to psychologists..." **(Peer support specialist at a non-governmental rehabilitation center)**

At the same time, our interviews showed that detailed coordination practices are far from universal. Some specialists rely more on their own vision of support:

> "I'm 61 years old, and you, kid, will be able to run in three months, well, basically, I start talking about positive things..." **(Peer support specialist at a regional hospital)**

Such assurances, if not aligned with an objective medical prognosis, can create unrealistic expectations for the patient and lead to disappointment. As other respondents explained, the challenge for a peer support specialist is to find a delicate balance between support and honesty:

> "It's really tough when you're talking to a patient who insists they will walk. But we know that will not happen... And you have to handle this carefully – not denying their hope, but also making sure they stay committed to ongoing rehabilitation..." **(Representative of an NGO supporting people with SCI)**

Beyond clinical aspects, the administrative dimension of interaction is also important. To maximize the benefit of PSI, the medical team must understand the knowledge and competencies of the peer support specialist, assign tasks to them, and evaluate their performance. Meanwhile, as mentioned above, in some facilities, specialists effectively work in a 'free' mode, without any clear goals or oversight mechanisms. This complicates effectiveness assessment and poses the risk of reducing the work to 'informal chats' instead of structured support:

> "To receive a quality service, you need to understand how to make a request... Because, most likely, it will turn into chats over coffee, smoking breaks, etc. The instructor also needs a supervisor to under-

stand what to do, rather than figuring it out for themselves…" **(Representative of an NGO supporting people with SCI)**

Among the respondents, there was no consensus on the best depth of integration of peer support specialists into HCFs. For example, in the NGO supporting people with SCI, in addition to first contact instructors interacting with medical staff, there is also a category of mentor-trainers who are full members of the MRT. The first model is more common.

In general, according to some interviewees, the need for deeper integration of peer support specialists with rehabilitation teams is due to the fact that the rehabilitation system in Ukraine is still developing and operates under a heavy workload. Under these conditions, healthcare professionals require additional support and sometimes training from organizations with years of experience in highly specialized work with certain types of physical impairments.

> "When it comes to the blind, this is a huge problem right now. We are not involved in multidisciplinary teams, but we work in hospitals as volunteers… Everyone says that without the volunteers, the hospital would have lacked essential stuff. The blind don't have any training opportunities." **(Representative of an NGO supporting people with visual impairments)**

When peer support specialists are engaged through NGOs, questions arise regarding their status and rights within HCFs. These are often governed through informal agreements, and in some cases through framework cooperation memorandums. However, this format has a number of limitations. For instance, it can complicate protecting patients' rights and responding to quality-of-care issues due to fears of losing access to the facility. Another issue is granting specialists access to patient medical records.

> "No, of course, they have no access to patients' medical records. That's not even up for discussion. They have totally different tasks; they can only receive information that the patient chooses to share with them. If something is unclear medically, they can clarify it with other specialists." **(PM&R physician at a regional hospital)**

In this case, the issue was partially resolved by employing the peer support specialist at the hospital halftime as a social worker, which allowed participation in MRT meetings. At the same time, such an approach cannot serve as a systemic solution.

Overall, integrating peer support specialists into rehabilitation services within HCFs requires clearer regulatory frameworks. As the example of veteran support specialists shows (see section 2.3.2 below), creating a regulatory framework for better integration of such specialists is entirely feasible.

2.2.5. OTHER CHALLENGES

Our respondents emphasized that peer support specialists must receive fair compensation for their work and should not operate solely on a volunteer basis. All peer support specialists in our sample were paid; however, respond-

ents noted that **volunteer-based engagement** still exists and warned about its risks to delivering quality support.

Donor or charitable contributions remain the main source of funding for rehabilitation PSI. This creates **risks for program sustainability** as well as employment and income unpredictability for specialists. For instance, one of the organizations in our study had to temporarily suspend peer support specialists' work in some HCFs after the U.S. government aid to Ukraine was cut.

When specialists were officially employed by the state-owned or municipal HCFs, they mostly received **minimum wage.** Such compensation limits the quality and motivation of specialists, affecting program effectiveness.

Donor funding also has another side effect. If a program is implemented by an external NGO using donor funds (without financial involvement of the HCF), **HCF management may not fully recognize its value.** As a result, these programs can be perceived as temporary or secondary measures, questioning their long-term implementation.

A possible future solution could be a model in which HCFs purchase peer support services from specialized NGOs. This would allow clearer requirements and standards for service quality, while also increasing the facilities' interest in program development.

Another significant challenge is **insufficient attention to preventing burnout and secondary trauma** among peer support specialists. Only a few programs in our study provided systematic supervision, intervision, or individual therapy for specialists. In most cases, such support is limited or absent, and specialists themselves do not always realize its necessity.

For example, one respondent, a peer support specialist in a municipal HCF, said he could consult psychologists in his department but considered it unethical, as patients trusted him with information they would not want disclosed to other staff. This created risks of breaching confidentiality and role overlap. Another respondent acknowledged the problem of burnout but noted a lack of resources to address it:

> "This is a problem. There are no methods. Burnout happens. The only mechanism that actually works right now is our friendliness... We can't afford anything else yet... We have a psychologist who sometimes works on this, but in many cases trainers don't even realize they are in the process of burning out." **(Representative of an NGO supporting people with visual impairments)**

An additional challenge is the blurring of professional and personal boundaries between peer support specialists and patients. Often, communication extends beyond working hours and turns into friendships or informal services. Some organizations establish internal rules to limit these relationships, while others view them almost as an integral part of work in the Ukrainian context.

> "This is our humanity and friendly approach. Everyone who visits us says: 'You're the best team.' That's a plus, because we support and motivate them. But it's also a disadvantage. Because... an informal dependency develops... This

boundary between official rehabilitation and friendship has somewhat blurred." **(Representative of an NGO supporting people with visual impairments)**

"When training people, you also have to understand our mentality and context. We gladly give strangers a ride and can even feed them borscht. I mean, we are different, and we don't have legal regulations that prevent us from doing this. There's no real ethics, because there's no formal profession as such." **(Representative of an NGO supporting people with SCI)**

Another challenge is ensuring continuity of support after the completion of inpatient rehabilitation. Some programs maintain informal contact with patients after discharge or implement more structured initiatives to continue support (for example, remote counseling at an NGO that supports people with SCI). However, these practices are not systematic. Our respondents emphasized that PSI should be integrated into the system of rehabilitation services at the community level, which is being introduced in Ukraine:

"Rehabilitation is just a very short period of time. And then the person leaves. Where to? Who will guide them further? Right now, everything is being done to establish rehabilitation services in the community: a physical therapist, an occupational therapist, a rehabilitation nurse. But it would also be a good idea to have a first contact instructor there. And not only for spinal cord injury patients, but also for people with amputations, after a stroke, with a traumatic brain injury, or with other conditions..." **(Physical therapist at a veterans' hospital)**

Further PSI development in PM&R will require systemic changes: the shift to stable financing mechanisms, implementation of standards for supervision and burnout prevention, clear delineation of professional and personal boundaries in interactions with patients, as well as PSI integration into communities to ensure continuity of support. Without these steps, programs will remain significantly variable in quality, and their potential to improve the effectiveness of rehabilitation services will remain underutilized.

2.3. Veteran Support Specialists

2.3.1. PROGRAM INTRODUCTION

In 2023, a pilot project was launched in Ukraine to introduce the institution of the «veteran assistant». Its idea was to create an «entry point» for veterans into the support system, i.e. a person who knows the specifics of life after war and can serve as a guide to governmental and community services. This was the first attempt to institutionalize case management based on the peer support model within the state system.

The program was coordinated by the MinVeterans and covered 10 regions. Assistants worked as paid employees of municipal institutions and were to support up to 100 veterans or their family members. Their tasks included helping with paperwork, providing information about programs and benefits, assisting with employment, and facilitating access to medical and social services[73].

Assistant candidates had to be veterans or family members of veterans (or of fallen service members) having completed, at minimum, an associate-level (i.e. junior bachelor) program. Selection included testing and an interview, followed by training[74].

We were unable to identify a report on the results of the pilot project in open sources. At the same time, representatives of veteran organizations expressed concerns about the quality of its implementation[75]. MinVeterans itself also acknowledged that the results of the pilot revealed a number of shortcomings and the need for further improvement[76].

2.3.2. IMPROVEMENT AND INTEGRATION INTO HEALTHCARE

In 2024, the model was significantly updated[77]. The officially recognized profession of “specialist in supporting veterans and demobilized members” was introduced[78]. A professional standard and a model educational program were developed for it, which included not only knowledge of legislation but also skills in crisis counseling, working with psychological trauma, communication, and interagency cooperation. Specialists may begin work before training but are required to take continuing education course – at least 150 hours over three years. At the time of our study,

73 — Resolution of the Cabinet of Ministers of Ukraine On the Implementation of an Experimental Project to Introduce the Institution of the Veteran Assistant in the System of Transition From Military Service to Civilian Life No. 652 of June 19, 2023 (as amended). https://zakon.rada.gov.ua/laws/show/652-2023-%D0%BF#Text

74 — Media Solutions Rubryka. Training for veteran assistants begins in Ukraine: why this decision matters. 2023. Accessed on April 18, 2025 at: https://rubryka.com/2023/08/17/navchannya-pomichnykiv-veretaniv/

75 — Committee on Social Policy and Protection of Veterans’ Rights. The Committee states: MinVeterans failed to take a leadership or coordinating role in the Cabinet of Ministers of Ukraine regarding the implementation of the state’s veteran policy. 2023. Accessed on April 18, 2025 at: https://komspip.rada.gov.ua/news/main_news/76585.html

76 — Ukrinform. Launch of the training program for veteran and demobilized member support specialists. Press conference organized by MinVeterans. YouTube video. 2024. Accessed on April 18, 2025 at: https://www.youtube.com/watch?v=GQJ1yPLUr98

77 — Resolution of the Cabinet of Ministers of Ukraine Certain Issues of Ensuring the Institution of the Veteran Assistant in the System of Transition From Military Service to Civilian Life No. 881 of August 2, 2024 (as amended). https://zakon.rada.gov.ua/laws/show/881-2024-%D0%BF#Text

78 — Professional Standard «Specialist in Supporting Veterans of War and Demobilized Members» approved by the Order of the Ministry for Veterans Affairs No. 508 of December 31, 2024. https://register.nqa.gov.ua/uploads/0/706-ilovepdf_merged_13.pdf

more than 1,300 support specialists were already working in Ukraine. In the future, their number may grow to 13,000[79].

In 2025, a new stage of program development took place – the integration of support specialists into the healthcare. In particular, the Government determined that specialists may be paid employees of municipal HCFs[80]. The procedure for their interaction with healthcare facilities was also approved[81]. According to it, patients who are service members, veterans, or their family members have the right to receive support from a specialist during inpatient treatment and/or rehabilitation. Doctors bear the responsibility for informing patients about this possibility; and in the case of rehabilitation services this is done by social workers or other MRT members. At the same time, the specialist is not required to be present in the facility permanently – it is possible to assign one from another organization that provides the relevant services.

Support specialists may also participate in providing outpatient medical and/or rehabilitation care, in particular during the military medical commission process, functional status assessments, or disability certification. If necessary, the specialist may be involved in MRT work at the request of a PM&R physician. All information about the patient's health status is provided to the support specialist only with the patient's consent, and the specialist is obliged to maintain confidentiality.

According to the government procedure, HCFs may cooperate not only with municipal but also with private providers of support services for veterans and their families. At the same time, the practical implementation of this provision raises doubts, since current legislation stipulates that a support specialist must be a paid employee of a municipal budgetary institution or a municipal non-commercial enterprise[82].

2.3.3. POSITIVE ASPECTS

Our respondents emphasized that support specialists are often motivated, caring people. The program goes beyond the classic peer support approach and allows family members of service members and veterans to fulfill their potential.

> "These are people with very good intentions who want to help. Often they are families of fallen soldiers, those held in captivity, or missing in action. This really reflects a strong need for support." **(NGO representatives working with veterans)**

According to MinVeterans, support specialists have already processed more than 60,000 requests. Respondents from the Ministry stressed that the emergence of specialists has become an important resource for veterans during the most difficult period after injury, especially in dealing with

79 — Opportunities. Oksana Koliada: The story behind the creation of the veteran and demobilized member support specialist role was anything but simple (blog). 2024. Accessed April 22, 2025 at: https://pm.in.ua/news/oksana-kolyada-istoriya-poyavy-fahivtsya-suprovodu-veteraniv-ta-demobilizovanyh-osib-bula-ne-legkoyu-blog

80 — Resolution of the Cabinet of Ministers of Ukraine On Amendments to the Procedure for Ensuring the Activities of Specialists in Supporting Veterans of War and Demobilized Members No. 115 of February 4, 2025. https://zakon.rada.gov.ua/laws/show/115-2025-%D0%BF#n9

81 — Resolution of the Cabinet of Ministers of Ukraine On the Provision of Services by Certain Categories of Specialists to Certain Categories of Persons Who Defended the Independence, Sovereignty, and Territorial Integrity of Ukraine, and Members of Such Persons' Families in Healthcare Facilities No. 448 of April 15, 2025. https://www.kmu.gov.ua/npas/pytannia-nadannia-posluh-deiakymy-katehoriiamy-fakhivtsiv-okremym-katehoriiam-s448150425

82 — Resolution of the Cabinet of Ministers of Ukraine Certain Issues of Ensuring the Institution of the Veteran Assistant in the System of Transition From Military Service to Civilian Life No. 881 of August 2, 2024 (as amended). https://zakon.rada.gov.ua/laws/show/881-2024-%D0%BF#Text

bureaucratic issues and accessing benefits:

> "When a person is going through rehabilitation, valuable time is not wasted. Just as there is a golden hour in evacuation, there are also the first 3 months after an injury that are crucial for recovery and for securing one's rights... That is why it is so important to have a specialist there to help with the paperwork..." **(Representative of the Ministry for Veterans Affairs)**

Although the integration of support specialists into healthcare facilities is still at an early stage (about 100 employed specialists and 400 open vacancies), MinVeterans also assesses its first practical results positively:

> "For example, in the Lviv Region, at a [rehabilitation] center, there is a support specialist... He helps a person at all stages: preparation for the MMC, MSEC, and compiling a full package of documents. As a result, the person leaves already with veteran status, discharged from military service, with all documents in hand..." **(Representative of the Ministry for Veterans Affairs)**

Some practitioners also shared favorable impressions of the program:

> "[Support specialists] are a must. Why so? Because they... simplify complex situations, speed up and improve the course of treatment, and the rehabilitation and habilitation process... I see their work, I cooperate with such specialists — and this cooperation is quite productive." **(Director of a department in a non-governmental rehabilitation center)**

2.3.4. CHALLENGES

Alongside the positive aspects, respondents also pointed out a number of problems. The most frequently mentioned was the lack of clarity in defining the role of the support specialist.

> "It is very important to clearly define the person's goals and functions. When... there is a lot of room to interpret the functions in different ways, that is a bad sign." **(NGO representatives working with veterans)**

> "Support specialists are often seen simply as employees who come to work every day and do some stuff. Very often, people don't even know what they actually do. And that is a big problem." **(Representative of the Ministry for Veterans Affairs)**

> "It feels like... a large, bearded social worker, presented with a nice-looking role, only to be swamped with paperwork. And at some point, he himself no longer understands what he is doing, what he wants, or how he is being useful." **(Director of a department in a non-governmental rehabilitation center)**

In practice, support specialists work in very different municipal institutions: from veteran hubs to social protection services and hospitals. Each of these areas has its own specifics, which complicates the standardization

of their work. Moreover, although the main task of specialists is to act as navigators in the system, unclear functions sometimes lead to expectations that they themselves will provide services. At the same time, according to some respondents, the program lacks a training system capable of preparing specialists for such a wide scope of tasks:

> "It's often a matter of searching for resources on your own, because you're dealing with a huge, often unmanageable number of requests, with very different expectations placed on you. It's kind of a black hole." **(NGO representatives working with veterans)**

> "They need more training... They are hungry for information." **(Representative of an NGO supporting people with visual impairments)**

Representatives of the Ministry for Veterans Affairs acknowledged that the lack of competencies is a challenge at this early stage of the program:

> "Yes, sometimes people do lack competencies. We are trying to teach them. But this profession was created last year. There is no worldwide model for the profession like ours. These almost one and a half thousand people... are creating this profession and writing its opening chapter." **(Representative of the Ministry for Veterans Affairs)**

Our study illustrated these challenges in the work of support specialists in HCFs. Representatives of Min-Veterans emphasized their key role in helping patients with paperwork, the MMC, and assessing daily functioning. However, at the data collection stage, it remained unclear to us whether their work covers systematic navigation of healthcare pathways and full-fledged interaction with the MRT at all stages of the patient's rehabilitation. An additional limitation is that the existing system of continuing education for support specialists is not adapted to the specifics of healthcare.

> "It is important to understand that a support specialist, even if they work in the healthcare system... that is not his only function... Our training program covers all aspects and areas in which such a specialist can work." **(Representative of the Ministry for Veterans Affairs)**

Another challenge is the risk of hiring people as support specialists who have unprocessed trauma and the possibility of their further burnout due to heavy workloads:

> "There are many veterans in each group, but they are very different. Some are excellent, I am glad and place great hopes on them... But there are also people with such vivid, acute PTSD symptoms that will have to face big problems. So the issue is not whether it will work. The issue is how and who selects them and by what criteria." **(Representative of a mental health and rehabilitation center)**

At the same time, systemic supervision and psychological support for the specialists themselves remain underdeveloped. Some elements are included in continuing education programs,

but for the most part it depends on the initiative of the leadership of a specific facility:

> "The mechanism works very well when support specialists are employed at veteran hubs. It is possible to ensure supervision there... But again, it all depends on the management of the facility... and on the willingness or readiness... of the district or regional authorities to implement veteran policy." **(Representative of the Ministry for Veterans Affairs)**

Finally, some respondents warned against viewing the institution of support specialists as an all-in-one solution or a substitute for the state's ability to provide the services veterans need:

> "This is not an approach that will solve all problems... Perhaps [if] we funded some social services in the communities, we would achieve more than from the navigation role of a single person, who... took on this number of requests, could not resolve them effectively, and became discouraged. Because it is hard. There is a lot of helplessness here." **(NGO representatives working with veterans)**

Thus, the institution of veteran support specialists has become an ambitious state project in the field of supporting service members and demobilized members. It created a new entry point into the service system, opportunities to reduce barriers to benefits and paperwork, and gave communities an additional resource. At the same time, the program still faces major challenges: unclear functions of specialists, the gap between the generic design of the role and the specific demands of practice (particularly in healthcare), lack of competencies, risk of burnout and retraumatization of specialists, as well as the absence of systemic supervision. Whether the state will be able to combine the motivation of support specialists with clear standards, quality training, and adequate support will determine whether this institution becomes a sustainable and effective element of the system of veteran rehabilitation and social integration.

2.4. Training for Peer Support Specialists

2.4.1. FRAGMENTATION OF TRAINING INITIATIVES

The interviews conducted as part of our study showed that the training for peer support specialists in Ukraine is highly fragmented. Respondents described a wide range of their training experiences: from systemic academic education (for example, in psychology or physical rehabilitation) to various short-term programs.

Short courses lasting from one to several days remain a common form of training initiatives. They can provide useful basic tools for applying the peer support approach but, according to respondents, do not create systematic preparation for work with veterans in complex rehabilitation processes. One of our respondents described the problem as follows:

> «Three to five days of peer support training? Forget it... Just imagine getting an IV from a nurse who studied for five days. That's about how it would go if a veteran got only three days of training.» **(Representative of a mental health and rehabilitation center)**

Short-term courses create space for sharing experiences and can be important for motivated and active participants who are constantly developing. At the same time, the competence level of those who have completed only one such program remains very limited. Respondents highlighted the lack of supervision and therapeutic support for participants as a particular problem:

> «And it's not enough to only teach veterans. They need... help to integrate their trauma. That is, each such course should still include intensive psychoeducation and some therapeutic interventions or a course in psychotherapy...» **(Representative of a mental health and rehabilitation center)**

Therefore, a more systemic step in the professionalization of the peer support approach was the launch of a certificate program at Taras Shevchenko National University of Kyiv (KNU).

2.4.2. MOVE TOWARD PROFESSIONALIZATION

In 2025, the Institute of Postgraduate Education at Taras Shevchenko National University of Kyiv launched the first state certificate program in Ukraine for training pee support counselors as part of the Nationwide Mental Health Program «How Are You?». Its launch was the result of collaboration among the Coordination Center for Mental Health under the Cabinet of Ministers of Ukraine, the KNU Psychiatry Institute, the University of California San Diego, Charles University, and a group of veterans. The program was created «from scratch» and took into

account both the best international standards and the Ukrainian context.

> «The certificate program – as of today, it is the only one in Ukraine... Very often, people assume that if they have similar experience (be it combat, use of prosthetics, amputation, disability) that alone gives them the right to be called a peer. But we need to understand that this is a specialist, a counselor who must be trained and certified in order not to cause harm. Not to retraumatize oneself or the person they are supporting.» **(Expert at the Coordination Center for Mental Health)**

The program has specific admission requirements: tertiary level education, combat experience, and personal positive experience of recovery from mental disorders or substance use disorders[83]. According to respondents, the training aims to provide future counselors with key knowledge and skills that will allow them to carry out peer support activities safely and effectively.

> «When a referral to a specialist is needed, when there may be mental disorders, work with... substance use disorders, emotions, aggression. A person who just has this experience but lacks practical skills, evidence-based knowledge, cannot identify 'red flags' and does not work in a multidisciplinary team with medical staff – we cannot... call [such a person] a peer support counselor.» **(Expert at the Coordination Center for Mental Health)**

The first enrollment of the program included 27 participants: military personnel, veterans, psychologists, educators, representatives of government agencies, NGOs, and the private sector. Training lasts four months and covers 300 hours (142 classroom hours and 158 hours of self-directed learning). The thematic modules include:

- Basic skills of psychological support
- Assessment and screening of psychological state
- Practice of motivational interviewing
- Development of psychological resilience: theory and practice
- Mental disorders and substance use
- Psychological self-help
- Strategies for managing impulsive reactions
- Integration of veterans into society

It is expected that graduates will receive supervisory support for at least six months after completing the program.

In the future, this model is planned to be scaled. The Coordination Center representative said that a new certification program is already being prepared at the Ukrainian Catholic University, focused on coping with grief for women who have experienced loss. At the same time, the inclusion of the peer support counselor profession in the Classifier of Professions and the development of a professional standard is being considered, which will open the way to official employment.

> «Yes, certification must be mandatory. This is non-negotiable, 100%... Because we need to approach everything responsibly and we should not turn it into a testing

83 — Ministry of Education and Science of Ukraine, Taras Shevchenko KNU. Certificate Program — Training of Peer Support Counselors as Part of the Second Level of Tertiary Education. 2024. https://ipsycho.knu.ua/wp-content/uploads/2025/01/op_rivnyi_rivnomu.pdf

ground.» **(Expert at the Coordination Center for Mental Health)**

Thus, the KNU certificate program is not only an educational but also an institutional step that has begun laying the foundation for professionalizing peer support in Ukraine.

2.4.3. CHALLENGES IN DEVELOPING TRAINING SYSTEM

Some of our interviewees shared positive feedback about the KNU certificate program and saw it as an opportunity to raise standards in the sector:

> "I am looking forward to when this training at KNU and 'How Are You?' ends because they have a top-notch program. They put a lot of meaning into it..." **(Director of a department in a non-governmental rehabilitation center)**

At the same time, many practitioners who have long worked with peer support have not yet heard about the launch of this program. Respondents emphasized the significant shortage of opportunities for professional training:

> "It's hard to find the right courses – I wish there were more courses and that they were more extensive and specialized." (**Peer support specialist in a non-governmental rehabilitation center)**

> "I very rarely see specialists who could act as mentors in a peer support specialist capacity. I mean not only people who are blind – but veterans in general. So: train, involve, work with those who are already there." **(Representative of an NGO supporting people with visual impairments)**

An important challenge is the issue of universality: how well a single standardized certificate program can cover the full range of contexts in which peer support specialists work. Representatives of the Coordination Center emphasized that universal basic knowledge is a necessary foundation, and then additional specialized education (e.g., for physical therapists) can be obtained. At the same time, practitioners working in rehabilitation programs noted that the type of injury often determines the specifics of the work and cannot be fully addressed by a universal course.

Doctors and physical therapists also noted the need for basic medical knowledge. A peer support specialist must understand the anatomy and pathophysiology of their own condition in order to provide patients with accurate information:

> "It would be very good if first contact instructors at least had a basic understanding of medical issues, anatomy, and their own illness. Because this affects their further communication – which information can be given to a patient, and which cannot." **(Physical therapist at a veterans' hospital)**

For example, an NGO supporting people with SCI has developed its own multi-level program for first contact instructors, which includes an online course (40 hours) and practical mentorship with an experienced instructor in healthcare facilities. The program also covers topics specific to SCI, from

prevention of complications and bladder and bowel management to sexual and reproductive health. The training emphasizes the limits of the instructor's competencies: peer support specialists do not interfere with treatment or prescribe medications; they focus specifically on social, psychological, and physical rehabilitation. This understanding of roles protects both patients and instructors.

Another challenge lies not only in the certification of peer support counselors themselves but also in the readiness of organizations to integrate them into their work:

> "They probably have to find employment in a facility themselves, and the facility should monitor their work. But I am almost certain that most facilities don't really understand how to work with them. You can hardly rely on someone to come in on their own and explain what they will do. Instead, they end up walking around, knocking on doors when the team doesn't know what to do with them..." **(Representative of an NGO supporting people with SCI)**

To overcome this barrier, the NGO supporting people with SCI trains key healthcare facility staff at the beginning of collaboration:

> "If we have a new facility, we offer them training. We take the key staff... and explain the main benefits of the work. This way, we set up the facility and establish the framework for communication." **(Representative of an NGO supporting people with SCI)**

Such trainings are also held for physical therapists, occupational therapists, and rehabilitation nurses.

> "The biggest advantage is that our instructors serve as role models, so others can practice on them without exhausting patients." **(Representative of an NGO supporting people with SCI)**

Thus, the peer support specialist training system in Ukraine is characterized by fragmentation and a predominance of short-term courses, which do not ensure adequate quality. The launch of the KNU certificate program is a landmark step toward institutionalizing the profession and establishing standards. At the same time, training unification has limitations when it comes to specific injuries or work contexts of peer support specialists. A possible direction for further development in the PM&R field could be combining standardized courses at leading universities with highly specialized programs developed and implemented by organizations with practical expertise in specific types of injuries. Equally important is investing in the competencies of healthcare facility staff, enabling them to effectively integrate peer support specialists into their work.

2.5. Evaluating the Effectiveness of Peer Support Initiatives

2.5.1. BACKGROUND INFORMATION

A shared challenge across the peer support program landscape is evaluating their effectiveness. According to the international experience (see Section 1), this problem is not unique to Ukraine. Organizations in various countries often lack systems for tracking PSI outcomes, as well as a clear understanding of which results should be measured.

Our interviews confirm that this also applies to the most systematic Ukrainian organizations. None of them currently has a comprehensive set of indicators for assessing the effectiveness of their peer support initiatives, although some respondents are already aware of this need. The reasons vary: difficulties in data collection, the sensitivity of the topic, and the fact that PSIs are often only part of a more comprehensive service and are not measured separately:

> "We would like to have assessments at an entry... and at an exit point. But the problem with psychological support in the Armed Forces of Ukraine is that people are tired of tests and don't want to fill out questionnaires..." **(NGO representatives working with veterans)**

> "To be honest, we didnt think about it because... we have a large, complex service..." **(Representative of a mental health and rehabilitation center)**

2.5.2. ATTEMPTS TO CREATE INDICATORS

Some organizations are already trying to develop internal key performance indicators (KPIs) for peer support programs. Most often, these are process indicators, such as the number of consultations, patients, visits, etc. One of our respondents described a possible approach to forming KPIs at the level of specific areas of activity. He emphasized that the current system allows seeing the scope of work, but clear quality indicators are still lacking:

> "Of course, we're not working at a factory where you have to show maximum output. In this area, there's no point in going on without ensuring the quality." **(Director of a department in a non-governmental rehabilitation center)**

This reflects the general situation: organizations would like to monitor quality but do not always know how to do it or lack the necessary resources. Even those institutions that have implemented electronic record-keeping systems remain mostly at the level of tracking processes and activities. This

creates the risk that the actual results for clients, i.e. changes in their health status, social integration, or quality of life, fall out of view.

2.5.3. MOST SYSTEMATIC PRACTICES

The most structured approach to tracking outcomes of peer support interventions has been implemented by an NGO supporting people with SCI. It combines several approaches: from subjective assessments of client progress to an automated record-keeping system.

> "...this is more of a subjective assessment – getting a person out of medical rehabilitation... We had a full funnel: the person... returned home, set up their living space, started living their own life." **(Representative of an NGO supporting people with SCI)**

The organization has a CRM system with a SOAP (Subjective, Objective, Assessment, Plan) module. It allows recording every meeting between a first contact instructor and a client, describing the topic of work, additional requests, and assessing progress. Data are checked by supervisors, and if necessary, the client's case is sent for additional review.

> "We have a CRM system, there's a process – funnels, two levels, three levels... The instructor records every meeting with the patient: what was done, what actions... Each SOAP is reviewed by a supervisor." **(Representative of an NGO supporting people with SCI)**

The NGO supporting people with SCI also collects client feedback via online surveys after remote consultations.

Thus, the evaluation of PSIs in Ukraine is at an early stage of development. Organizations primarily focus on process indicators (number of meetings, number of clients, consultations provided), while qualitative changes for clients are rarely measured. This is expected, as establishing monitoring systems requires expertise and significant financial resources, which is a serious challenge for Ukrainian organizations.

At the same time, as peer support becomes more professionalized and more deeply integrated into the healthcare and social support system, measuring effectiveness becomes far more important. International literature offers approaches to evaluating peer support programs in PM&R. For example, studies recommend assessing not only processes but also outcomes, which may include: recognition of symptoms and disease management skills; reduction of anxiety levels and depression; development of self-sufficiency and self-management skills; social integration, overcoming barriers and stigma. Gradual implementation of such approaches in Ukraine could improve the quality of peer support programs and make them measurable and scalable at a systemic level.

Section 3

Ethnographic Study of Peer Support Service During Rehabilitation

Example of a Hospital in a Rear Region of Ukraine

Currently, there is a professional discussion regarding the advantages and disadvantages of the peer support service in rehabilitation wards serving military personnel. To triangulate the desk-based (analysis of open sources) and qualitative (interviews with stakeholders, beneficiaries, and service providers) parts of this study, we decided it was necessary to conduct an ethnographic study of the peer support service at one hospital in a rear region of the country.

The main task of this part of the study was to observe the daily realities of mentors' work in the peer support program with injured military personnel in the context of interaction among four agents: mentor[84] – patient – patient's relatives – hospital staff. The ethnography lasted four full days at the beginning of August 2025 and involved immersion in daily hospital life while accompanying mentors, staff, and patients through their daily routines.

As part of the ethnographic study, the shadowing of mentors was conducted[85], along with informal conversations were held with mentors and patients in public spaces of the hospital. Informal conversations also took place with physical and occupational therapists and hospital management. Special attention was paid to communication with patients both in the presence of mentors (for example, during sports activities, art therapy sessions, leisure time, and random encounters) and in their absence (in hospital corridors, smoking areas, cafés, stores around the hospital, workshops, etc.).

Communications with patients covered people with military experience (men only) who were undergoing rehabilitation after limb loss, neurological injuries, spinal injuries, psychiatric complications, or complete loss of vision as a result of combat injuries, and who had experience interacting with mentors. Significant attention was given to analyzing everyday communication between mentors, medical staff, and patients in order to identify the specifics of peer support within the hospital's internal culture. No audio or video recordings of conversations were made; only written notes were kept in a field journal. All communication was conducted on the basis of anonymity, and any further quotes or narratives in this text are deliberately generalized to prevent the identification of specific individuals.

84 — Hereinafter, the reference is made to mentors in the peer support program. Throughout the text, the word 'mentor' is used exclusively in the masculine form to ensure the anonymity of study participants.

85 — This refers to one of the ethnographic methods, which involves observing a person or a group of people during their everyday activities at the study site.

3.1 Mentorship: Between Work and Calling

According to healthcare facility management, mentors were involved at the initiative of the hospital itself to work with both civilian and military patients. All mentors are recruited after an interview, with an assessment of their prior experience and soft skills, such as the ability to inspire trust, communicate effectively, demonstrate a proactive stance, and show leadership qualities. Currently, according to the hospital management, Ukraine offers training solely for mentors who work with patients with spinal injuries. However, rehabilitation departments practice a probationary period during which newcomers are paired with more experienced mentors and learn from them. At the time of the study, some of the mentors working at the hospital had military experience and disabilities, while others were civilians with disabilities.

The hospital actively engages former patients into mentorship when it sees they have the necessary skills: sensitivity, proactivity, sociability, the desire to help others, etc. According to hospital management and mentors, «We engage charismatic patients in mentorship», «We encourage people to become mentors, to feel needed».

For some mentors, their interactions with patients are, above all, hard work: «The work of a mentor means no days off; it's about interacting with service members in different emotional states, about the need to be a source of support.» At the same time, a key quality for this work is flexibility, since it allows mentors to build trust effectively and find ways to connect with different people: «Mentorship is situational by nature, unfolding spontaneously in response to the patient's shifting moods».

At the same time, some mentors refused to call their work with patients a job, instead framing it as a calling and a need to help people: «It's not a job, because you have to love the patient.» Often, mentors described their activity as a «way of life», since it involves irregular hours, full engagement, and the need to prioritize patients over personal matters. Moreover, mentors' overtime work is unpaid and may include various additional activities – off-hours communication, advocacy for veterans and people with disabilities, post-rehabilitation support, organizing activities for patient groups, or individual sessions for specific patients (such as supporting creative expression, teaching how to drive a car with hand controls), etc.

It is important to add that after discharge, communication between mentors and former patients does not stop. Mentors may call patients, ask how they are doing, request feedback on rehabilitation, while patients may continue to turn to mentors for advice or help.

WHAT IS PEER SUPPORT?

To better understand the specifics of peer support service, it is important to outline how it is understood by pa-

tients, mentors, hospital management, and medical staff, that is, how this concept is seen from within the hospital's culture. During informal conversations, all the mentioned actors seemed to share a fairly common understanding of this term. However, it should be noted that patients generally did not understand the term "peer support" itself, but instead confidently used the term "mentor" and readily shared their observations of mentors in the hospital, usually referring to the specific person with whom they had interacted.

In the course of the study, we found that the most important principle of the peer support approach in the study hospital is engaging a person with similar experience to motivate the patient toward the maximum possible independence, given his injury, and consequently, a better understanding of his own future in a new body.

Mentors describe this principle of independence as follows: "All he needs is a nudge; after that, he'll manage by himself," "Don't do the work for him; let him do what he can himself," "Your rehabilitation depends only on you," "You need to learn to take responsibility for yourself," "Disability is in the head and heart, not in a wheelchair or prosthesis. A wheelchair is just a means of transportation." Patients and medical staff interviewed also shared this understanding of the principle. During informal communication, one patient stressed that he specifically asked his family to go home and not stay with him at the clinic, so that he could learn everything by himself: "My family was next to me all the time, and then I sent them home, because otherwise it was hard to learn on my own." After that he emphasized that he has strong motivation for such independence: "I have someone to live for, my loved ones are proud of me."

According to mentors, the key to independence is motivation, so they use different approaches to help the patient find what will enable him personally to move forward. Approaches to a person often depend on the mentor's personality and beliefs and are selected on a case-by-case basis: sometimes the communication is gentler, sometimes more straightforward, and sometimes even rough. These can be questions the person is invited to answer: "Why was it you who survived?", "What can you, as a veteran, later do for your brothers-in-arms?", "What do you need to do for your family?", "How can you avoid becoming a burden for your family?", "Do you really want your 40-kilogram (90-pound) wife to carry you, a 100-kilogram (220-pound) man, in her arms for the rest of your life?" etc.

During informal conversations, patients often emphasized that they found motivation in everyday situations, and mentors supported them in this process. For example, achieving independence in personal hygiene is often a priority for patients, as it is closely tied to their sense of dignity and masculinity. Patients stressed that they tried to work hard on their rehabilitation because "I can't imagine myself walking around in a diaper", "I didn't want anyone to wipe my butt", or because they didn't want "to be a burden on my wife", and so on.

However, mentors note that this approach to stimulating independence works only in hospitals with proper infrastructure, professional staff, and an appropriate internal culture, since it requires time, effort, motivation, and a supportive atmosphere.

WHAT SHOULD A MENTOR BE LIKE?

Based on ethnographic data, we tried to reconstruct the emic (i.e., culturally specific to the study hospital) understandings of the ideal mentor.

1. Shared experience

The ideal mentor (according to both mentors and patients) should have life experience and a physiological state as close as possible to that of the patient: **"A mentor has to be a mentor, meaning they have to have gone through this path", "A mentor has to be a one-hundred-percent comrade-in-arms."**

It is believed that mentors with military experience find it easier to establish contact with patients. After all, communication automatically becomes more relaxed because the individuals already share an important background. According to one patient, with such mentors, one can talk **"freely,"** that is, in **"military style"**, i.e. directly, to the point, without extra explanations about one's emotional state. This is especially important for people who still find it difficult to communicate with the civilian world after service and injury. Communication with a mentor usually starts on a first-name basis and allows the patient to express emotions freely, without having to conform to civilian communication styles, which come with their own limitations and rules of etiquette. A significant role in such communication is played by **"comrade language,"** that is, the specific jargon of the military, the particular sense of humor, the use of profane language to express emotions, etc.: **"With a comrade, you're on the same wavelength, so you can use dark humor, profanity."** Indeed, during interactions, mentors and military patients often use dark humor. This technique promotes effective emotional release and, as mentors say, replaces "whining" (complaining about one's physical condition and negative emotions). However, it is important to understand that such dark jokes can only be made by a mentor, not a doctor.

Through "military" communication, mentors bypass many barriers that patients may have regarding civilians. This allows them to get closer to the patient effectively, even if the patient shuts themselves off from family or medical staff. Sometimes, a mentor's higher military rank or position can become an advantage in such interactions. Until fully reintegrated into civilian life after injury and discharge, a patient often remains well-adapted to military hierarchy, so a mentor with a higher rank may have more authority in the patient's eyes. Overall, thanks to communication with mentors who have military experience and similar injuries, patients can no longer say "you don't understand me", which is very important for building trust and ensuring effective future cooperation.

However, the study hospital also employs civilian mentors with relevant injuries. According to them, there are occasional situations where military patients reproach them for lack of combat experience or behave condescendingly, demand special treatment, or speak aggressively, etc. One civilian mentor noted that patients sometimes exhibit behavior he calls manipulative: **"Manipulation with veteran status: 'everyone owes me, I'm a hero', therefore, he believes that "this must be nipped in the bud because everyone is responsible for their own decisions."** However, these episodes of bias against civilian

mentors do not apply to all patients. Without a doubt, a civilian mentor can also find an approach to a military patient: **"The soldiers connected with me and shared their traumatic moments."**

It should be noted that a mentor's appearance matters to patients, particularly the visibility of the injury. For example, if a veteran mentor enters a military ward for the first time but has an invisible neurological injury, attitudes toward him may be biased. That is why it is important for a mentor to have a visible similar injury. A mentor's mood also plays an important role. A good mentor looks on the bright side and knows how to boost the morale of others: **"The ideal mentor is positive, cheerful, he cannot be depressed," "a mentor should not be dull, he must control his emotions".**

2. Set an example

A mentor must "set an example" because they lead others, confirming their authority through their own achievements. A mentor must demonstrate, by personal example, how a person can live a full life even with a physical injury. For instance, by doing sports, being socially active, and being professionally and personally fulfilled. Mentors articulate their mission as follows: **"I know what it's like – I tell them about my own personal experience."** According to patients, in moments of confusion after injury and complete lack of understanding of themselves and their bodies, a mentor shows by their example **"what can come next", "that life doesn't end here"**, and **"teaches how to live with it."**

This approach also works effectively for mentors without military experience. For example, when a civilian with a prosthetic shows the path they followed after amputation and how they managed to fulfill themselves professionally and personally, or when a mentor in a wheelchair shares his sports achievements, this becomes a powerful motivation for patients. If a mentor's injury is even more severe than the patient's, an additional motivational effect arises, but this is not a requirement for successful mentorship.

It should be added that by demonstrating what life can be like after injury, a mentor emphasizes **"opportunities rather than limitations"**. Experienced mentors believe that **"rehabilitation takes time and work"**, so its success depends directly on the patient's efforts to change their condition. At the same time, beyond rational arguments about future possibilities, a mentor's example provides a positive emotional stimulus and inspiration to the patient: **"If I see that mentor can do it, then I can too!"**

3. Being a leader and being equal

A mentor combines two functions: being a leader and being equal. At the study hospital, it is believed that mentors must have leadership qualities because a significant part of the mentor's work involves motivating people and organizing activities for patients. These activities include sports, fishing, gardening, attending concerts, plays, exhibitions, professional conferences, workshops, etc. Interestingly, the tradition of organizing activities for patients at this hospital was initiated by a physical therapist, and mentors joined later.

Mentors guide patients, showing that even after injury, the world offers many opportunities to take advantage of: **"It all comes down to charisma, then it works."** Such activities become

an important tool for mentors, serving as icebreakers and sometimes as the main point of entry into communication with closed-off patients. If a person agrees to participate, it means they have taken the first step, and the mentor can cautiously try to build rapport with them. Moreover, participation in activities is always motivating. Patients gain entirely new experiences or, conversely, realize that hobbies and entertainment are still accessible to them despite injuries. Mentors describe how during activities, patients' eyes **"light up"**, and how this inspires them.

However, although a mentor is a leader, they do not set themselves apart: They go to the gym with everyone, emphasize similarities in experience during conversations with patients, and remind patients how difficult it was for them too. Nevertheless, mentors, patients, and medical staff complain that the same people tend to take part in most activities. Certainly, they gain very important experience this way, but it is uncommon to engage more withdrawn or challenging patients on a large scale. This leaves room for improvement in procedures to engage mentors with a wider range of wounded patients.

It is also important to note that peer support principle implies that mentors treat all patients equally, i.e. without bias, preference, or changes in attitudes due to a patient's status. Mentors say that this means **"seeing people for who they are"**. However, this rule is not universal for all mentors, as everything largely depends on the personal qualities of the mentor.

Mentorship is also a special friendly bond, so interactions between mentors and some patients may be closer than with others. Mentors may feel greater responsibility toward certain patients, for example, due to their service experience or family situation. In such cases, they try to be more actively involved than usual to stabilize the patient and reduce the likelihood of undesired antisocial behavior after hospital discharge.

4. Being supportive

Mentors believe that a mentor should provide unconditional support to a patient in critical situations at any time. A patient can text or call such a mentor whenever an urgent important issue arises or they are in a difficult psychological or emotional state. Mentors also define themselves as people willing to share the patient's emotional experiences: **"A person who is by your side through good and bad times."**

Additionally, a mentor can engage their own social circle to help patients pursue important motivating activities outside the hospital (sports, music, driving, etc.): **"A mentor provides social contacts to help others."**

Sometimes a mentor becomes an emergency contact who can assist in a difficult situation even after the patient has been discharged and, for example, harmed others. Mentors accept patients with their mistakes and fears, helping them recognize undesirable behavior and get proper help.

5. Reading people

A mentor must be empathetic and able to **"read people"**, know whom to approach and whom not to disturb, understand who they can joke with, how to talk to different patients, and where the boundaries lie. Shared experience helps mentors "read" a person better.

Mentors sometimes describe this as follows: **"I see the person", "A comrade understands a comrade, it's like being in the trenches".**

According to mentors, "reading people" is not something one can learn; you either have it or you don't. It is grounded in sensitivity, empathy, care, and common experience. In reality, during informal communication, mentors often reflect that they chose this field because they **"had to do something for others", "wanted to help", "knew what it's like [for patients – T.P.] and wanted to show that life goes on"**, etc.

MENTORS' EVERYDAY LIFE

At the study hospital, mentors are not assigned to specific patients. Therefore, one or several mentors may interact with a person (patients usually meet other mentors during different activities). A patient can also completely refuse mentorship.

Mentors have no uniform opinion on communicating with someone who refuses to cooperate. It depends on the mentor's personal stance and beliefs. Most often, mentors regularly work with patients who express interest. At the same time, they try to reach withdrawn patients, have brief conversations with them, and invite them to participate in activities: **"You have to bring the closed-off people out into the world."** However, if a person flatly refuses to communicate with a mentor, their choice is respected. Sometimes mentors recall their own period of withdrawal and emphasize that it would have "pissed them off" if someone had forced themselves on them.

Some mentors follow the principle of "don't knock on closed doors". That is, if a patient refuses to cooperate, the mentor sees no sense in **"investing time in them; it's a better idea to spend that time with those who already need it".** This, in particular, **"helps mentors avoid burnout".** At the same time, this approach can coexist with the belief that **"there's a key to everyone; it's only a matter of willingness and timing".** This approach involves weighing the benefits of investing efforts in a particular patient against the likelihood that their rehabilitation will take enough time for them to be ready to open up: **"Closed-off people need time; you can't push them too hard."**

During the day, mentors have informal, mostly unplanned, individual and group conversations with patients, communicate with patients' families and medical staff, and also (or with other mentors or hospital staff) organize activities for patients under their responsibility (both at the hospital and offsite). If the patient's family happens to be at the hospital when the offsite activity takes place and the patient is willing to participate, his family is also invited to participate with him.

Mentor-patient conversations often occur during random encounters in hallways or at the designated smoking places. This format allows maintaining a friendly and informal tone, where patients are not obliged to over-share. Mentors repeatedly emphasized that **"a person will never tell more than they are ready to share at the moment".**

During the ethnographic study, a series of observations were made of mentor-patient interactions. Typically, a mentor first asks how the patient is doing, may joke, for example, they may ask why a patient hasn't moved from a wheelchair to crutches, or about their mood. If a patient raises an urgent

problem, a mentor may provide, for example, contact details of a specialist doctor at the hospital dealing with that issue, share their own rehabilitation experience, or help find someone in their social circle who can help solve the problem.

Sometimes mentor visits are planned, for example, during a weekly interdisciplinary ward round when the mentor joins. Sometimes the mentor may have a prior arrangement with the patient, or the medical staff may request the mentor to speak with a patient. Patients may also initiate meetings with mentors if they feel the need to talk.

Offsite activities take place almost weekly. However, each outing is preceded by consultation with the attending physicians and obtaining their approval for patient participation. It is important to note that most activities are conducted under the full responsibility of the mentor, who signs the relevant documents. All patients in the rehabilitation department are added to a group in a messaging app, where announcements about upcoming activities are usually posted. Those interested may express their willingness to participate. Sometimes mentors may additionally visit wards or call patients to remind them of an upcoming activity. However, if a patient refuses to participate, the mentor does not insist. In fact, this approach forms the basis for mentor-patient contact, and during activities, mentors have the opportunity for more informal communication and closer connection with the patient.

Beyond discussing the patient's physical and psychological condition, the mentor's role can cover a wide range of post-injury and/or post-discharge practical situations. For example, a mentor can share personal experience or knowledge regarding legal matters, such as post-injury benefits, war disability allowances, and so on. These can be targeted tactical consultations, for example, on how a veteran can apply for housing, properly complete disability documents, and receive all benefits the veteran is entitled to. Such consultations are consistently in demand among patients. Mentors working with spinal injuries may have expertise in selecting and adjusting wheelchairs, choosing anti-decubitus cushions, and adapting housing.

Previous studies by Pryncyp[86] confirm significant biases among service members, especially males, regarding psychological support. Many of those who actually need psychological or psychiatric help refuse services, claiming they are not "crazy", and that they "definitely don't need it", and can handle it themselves, or saying that a civilian psychologist "could never understand or help them".

During interdisciplinary rounds, routine sessions with medical staff, and communication with mentors and other hospital staff, considerable effort is made to convince military patients who need it to seek psychological and psychiatric help. However, these attempts currently yield insufficient results.

In this context, mentors effectively provide basic psychological support to patients. Without professional knowledge in psychology or psychiatry, they gain an advantage due to similar experiences, which makes patients more open to communicating with them. Thus, mentors often try to use this trust to help people find new meaning in life and take responsibility for their

86 — Transition from military service to civilian life: contexts, experiences, solutions. Study — Kyiv, March 2025. — pp.179–180. From injury to recovery. Ethnographic study of veterans and their families / [Tina Polek, Yevhen Lysenko, Oleksii Moskalenko, Denys Sultanhaliiev, Liubov Halan]; Ed. by L. Halan, D. Sultanhaliieva. — Kyiv, 2023. — pp.47–54

rehabilitation outcomes. It is important to emphasize once again that mentors communicate with patients informally, in a comradely manner. As a result, patients do not feel that someone is deliberately prying into their personal life; they feel that a person with similar experience will understand, will not judge, and will not ask "stupid" questions. That alone lays much of the groundwork for a successful exchange. According to medical staff: **"Mentors take on half of the psychological work."** It is clear that such support without proper training carries potential risks – both ethical issues and the possibility of unintentionally causing psychological harm to the patient or the mentor. Additionally, some mentors note that working with patients can trigger a "rescuer syndrome" where **"you want to help the entire patient's family".** And this is not always beneficial. However, patients respond positively to mentors' support for their moral and psychological state, and medical staff often ask mentors to speak with specific patients **"who clearly seem to have lost spirit".** According to healthcare professionals, these conversations generally have a noticeable positive effect.

It is clear that working with negative human emotions, as well as regularly returning to one's own traumatic experiences, is a significant challenge for the psychological and emotional state of the mentors themselves. Mentors reflect a great deal on burnout, sharing their own methods of preventing it, for example, **"not getting overly immersed in the patient's personal issues",** engaging in sports, spending time with family, taking vacation, switching to other activities, etc. Regarding supervision, mentors hold different views: some believe they do not need supervision; others say they would prefer more informal help rather than professional treatment or therapy; others still feel that turning to a psychologist for help is something they might be ashamed of. Some mentors emphasize that being in therapy is necessary, but it is important to have a psychotherapist who does not work in the same hospital as the mentor, in order to avoid a conflict of interest.

Summarizing the subsection on mentors' everyday life, we once again stress that there is no single prescribed standard of mentorship in the hospital under study. This system is based on experience, trust, specific personalities, and the general informal culture of this hospital, that is, on what is customary and what is not. Therefore, in real life, the actions of mentors largely depend on how they "read" their patients and on who they are as individuals. Some are more straightforward, others more careful with their words, and some think patients should be allowed to learn from their own mistakes – there is no single approach.

Finally, we want to add that the culture of mentorship in the hospital under study is characterized by flexibility and informality, which makes it possible to build patient trust and establish close contact with them. At the same time, the entire mentorship system is aimed primarily at helping the patient find motivation that will guide them toward independence and help them discover new meaning in a new body.

Such a flexible approach excludes measurability and KPIs in the mentorship process, but it does not mean that it yields no results. Mentors themselves say that they feel the greatest satisfaction when they realize that **"the patient is succeeding, and you contributed to**

that". There can be an endless number of such successes: managing to find a new type of employment or return to a previous one, standing on prosthesis, repairing broken family relationships, starting to help other veterans in one's community, etc.

3.2. Patient: A New Body and a New Meaning

One of the important goals of the ethnographic study was immersion into the daily lives of patients in the context of their cooperation with mentors. In order not to bother those patients who were more reserved and did not seek any communication, we focused exclusively on those who had experience working with mentors and expressed willingness to communicate. Therefore, this aspect of our study has some limitations – its conclusions are based mostly on conversations with open, active people who had a positive attitude toward mentorship. It became clear in the course of the study that, when describing the results of working with mentors, patients often mirrored the ways their mentors communicated, for example: **«a lot depends on you, you have to keep your chin up and keep working».** At the same time, patients were no less eager to recall mentor initiatives that proved to be most effective for them and their psycho-emotional well-being: **«There are so many activities here that you have no time to think about your trauma», «The main thing is to take part in the events and not shut yourself off».**

It should be emphasized that mentorship combines two equally important components: group and individual communication. Group communication (for example, during activities) also involves interaction with other patients, which provides an additional effect. Individual communication allows one **«to speak out in front of someone who will not judge you»**, to ask for advice, to

complain. Some patients, for instance, shared with mentors personal stories about inadequate treatment in previous healthcare facilities they were admitted to after being wounded. These stories mostly concerned the incompetence of hospital staff and uncertainty about the next steps to improve patients' physical condition in the future. After such experiences, specific advice from mentors served as important markers that they were competent, and therefore the patient in this hospital was cared for and would definitely be helped: **«In just 20 minutes of consultation, I learned more from the mentor than I had in the four hospitals before that.»** Often, thanks to the knowledge gained from their own experience, as well as awareness of other patients' stories and the hospital's resources and state support, mentors have basic competencies to inform patients about their physical condition and social opportunities. In addition, mentors, as carriers of experience, may be informally approached by patients and their partners with highly delicate questions they are too embarrassed to ask doctors, for example, about intimate life after injury, aspects of communication between partners, etc.

Overall, for patients, the mentor's work is not always about the body and not always even about motivation, but rather about meaning. In recounting their rehabilitation after injury, patients pointed out that they faced fundamental questions of identity and their place in the world after being wounded, such as **«Who am I?», «Who will I be able to become?»**. It was mentors who helped patients find answers, becoming something like spiritual mentors. By their example and support, mentors gave patients an understanding that they had a reason to keep living and that they had many opportunities for self-fulfillment at all levels: **«The mentor helped me understand how to live on», «The mentor helped me find meaning», «Mentorship is about spiritual search»,** etc. Such a combination of physical rehabilitation counseling and support in the search for meaning is so valuable that some say: **«Without the mentor I wouldn't have achieved even half the progress in rehabilitation».**

However, it is only fair to add that mentors are not the only ones supporting patients in the hospital – the medical staff also contributes to this as much as possible. In addition, there is camaraderie and solidarity among patients themselves, either among roommates or, for example, among those who take part in certain activities. In this way, patients support each other, empathize, and encourage one another, since they essentially share the same experience, being at similar stages of treatment and rehabilitation. For example, according to one patient, he **«supported single guys a lot, because they had no one».**

Attention should also be paid to the problems patients face during the rehabilitation process. Unfortunately, these issues are common in all hospitals, and their systemic resolution remains an extremely difficult task. The three categories of patients who are most problematic to involve in mentorship are: those who abuse the opportunity to receive social benefits and deliberately prolong their hospital stay[87]; those who lead an openly hedonistic lifestyle in the hospital, wasting their benefits and

87 — According to current legal regulations, if a person has not had a break in treatment after being wounded, throughout this entire period they receive the same financial support as during frontline service. Therefore, some patients abuse this, trying to stay in treatment as long as possible and progress as slowly as possible.

not working on improving their physical condition[88]; and those who have substance use disorders[89]. These are the categories of patients that mentors find the hardest to work with, because they may shut down and be unwilling to change anything in their condition.

For patients, mentorship turns out to be not only support in physical rehabilitation but also an important source of meaning and guidance in the search for a new identity after injury. Patients view mentors as competent advisors whose attention and experience build trust in treatment and help them not feel alone. At the same time, mutual support among the patients themselves also plays a big role, creating an atmosphere of brotherhood. However, there are serious challenges associated with the abuse of legal and financial opportunities, lack of financial literacy, and problems with substance use disorders. Despite these difficulties, mentorship can be regarded as an important element of the rehabilitation environment, one that combines physical recovery with the creation of new life meanings for patients.

3.3. Medical Staff: The Experience Divide

Interaction with medical staff provided a clear understanding of how much the «military-civilian» divide affects patients' rehabilitation process. The basic stance of medical staff is usually that **«military patients must be understood first and foremost».** For this purpose, any opportunity for informal interaction may be used, for example: **«The first question from the occupational therapist: Do you smoke? Because then we can get the patient outside.»** By the way, mentors also make use of this, because the smoking area is the main place for communication in the hospital. For example, during the study, one patient shared his experience of quitting smoking in the smok-

88 — Among patients, there is a lack of financial literacy – not all of them know how to handle such relatively large amounts of money, so they spend money on instant gratifications (for example, restaurant food deliveries, dating and meeting women). Because of these hedonistic expenses, patients neglect the needs of their families and later are unable to save money as a financial cushion, which they will need if their injuries mean eventual discharge.

89 — Another serious problem hindering patients' rehabilitation is substance use disorder. Most often it is alcohol abuse. As for narcotics, according to mentors and medical staff, only isolated cases of substance use disorders were reported in the hospital under study. Of course, alcohol use is prohibited by hospital rules, and when a patient is «caught red-handed», they receive a warning. After the third warning, a patient may be discharged early from the hospital. However, alcohol abuse is not always noticeable. For example, one hospital patient in a wheelchair took daily walks with a bottle of sweet soda, and only later did it become clear that he was adding alcohol to it every day. In cases of alcohol abuse, a patient in an acute state may be referred for psychiatric treatment. If the condition is not acute, the patient will be encouraged to work with psychologists competent in treating substance use disorder and trauma, since alcohol abuse is often a consequence of aggravated PTSD. In addition, the hospital's medical staff and mentors try to involve the patient's family as much as possible for systemic work with such substance use disorders.

ing area. According to him, his attempts to quit ended after a few months because **«when you don't smoke, you feel lonely, there's no reason to leave the ward».**

However, even empathy and informal communication do not guarantee successful cooperation during rehabilitation. It is absolutely typical for a patient to refuse to attend sessions or perform certain exercises because of pain or discomfort, a bad mood, or disappointment at slow progress. In such cases, the patient's response to rational arguments from a doctor or medical staff is often, **«You don't understand me».** Most medical staff encounter this reaction, and this barrier significantly complicates the work of rehabilitation departments. One medical staff member emotionally described such a situation with a patient by saying, **«So, am I supposed to chop my leg off to understand?».** This response is a vivid illustration of the emotional pressure faced by civilian staff when working with severely injured military patients. During interviews, medical staff also emphasized that psychological support would be helpful, as their work also involves difficult emotional experiences.

The main problem for medical staff is the inability to build rapport with military patients in order to establish an effective rehabilitation process. According to staff, a typical situation is when people expect instant results and become disappointed if they don't see them: «**2-5 minutes of negative experience – and they go 'why do I even need this?'»** In such cases, or in cases of aggressive behavior or withdrawal, medical staff suggests patients see a psychologist, because **«it all starts in the head».** However, they encounter strong resistance (**«seeing a psychologist means I am weak», «this won't help me»**). Even if a patient agrees to one session with a psychologist, it is unlikely that they will continue working with them afterward.

In cases of misunderstandings with patients, medical staff turn to mentors as mediators in the rehabilitation process: **«A mentor is a bridge; a mentor can work with those who don't want to cooperate with medical staff», «A mentor is a translator between doctor and patient»** (because the patient may be afraid of or distrust the doctor), **«Mentors help establish a connection between the patient and the occupational therapist»**, etc. In addition, a mentor has their own trauma experience, so they can provide the patient with a concrete example of someone who did the necessary exercises and achieved results: **«Patients have to spend a lot of time here – they are in pain; the mentor can show an example.»** According to one healthcare professional, **«mentors relieve tension».**

Furthermore, for physical and occupational therapists, a mentor becomes a translator who helps better understand the patient's physical sensations during exercises, for example, what kind of pain the patient feels in the stump, how a particular prosthetic feels, or what sensations occur in the back.

For medical staff, a mentor can also act as a «protector» from patients, if they behave aggressively, make tactless remarks about hospital staff, or sabotage the rehabilitation process. Mentor's reaction depends on their personality and character. For example, if a patient treats a doctor with disrespect or aggression, a mentor may directly state that the conditions in this particular hospital are incomparably

better than elsewhere, and that the patient fails to appreciate the infrastructure or exceptional care, which they wouldn't get in other facilities. Or a mentor may bluntly tell a patient that these sessions are **«not for the doctor, but for you»**, thus encouraging them to continue. After such interactions with mentors, the likelihood that a patient returns to sessions increases significantly, and sometimes patients even apologize to doctors for being rude.

Medical staff generally speak positively about the work of mentors, express regret that there are currently too few in the hospital, and insist that working with them is much easier and more effective than without them. For example, one hospital department had a group of mentors funded by the USA working there for an extended period. After this funding ended, medical staff could compare working with and without mentors from their own experience: **«When there were mentors funded by the US, it was very convenient for occupational therapists because they had experience with rehabilitation, knew everything firsthand, patients accepted them much better, and they couldn't say 'you don't understand me'. We can compare before and after, and now it's much more difficult.»**

Medical staff experience shows that finding common ground with military patients is challenging. Attempts at empathy and informal contact often do not yield the expected results, and feelings of misunderstanding lead to conflicts and emotional exhaustion. In this context, mentors become key intermediaries: they reduce tension, help restore trust, and motivate patients to rehabilitate through their own experience. For doctors and physicians, the involvement of mentors makes the process significantly more effective, whereas without them, working with patients becomes much more difficult.

3.4. Family: Support, Overprotection, and Other Challenges

The stay of patients in rehabilitation departments (except for those who do not have family) usually involves regular visits from relatives and close ones. Therefore, in reality, patients' interactions and attitudes toward rehabilitation largely depend on the quality of their relationships with close people and how those close ones view the injury or disability of their loved ones.

Given this, mentors and medical staff regularly communicate not only with patients but also with their families.

Undoubtedly, relatives and close ones are extremely important actors in effective rehabilitation. Family provides emotional support, helping the person find meaning and strength. This is why the hospital is open to interaction with families: family members can freely enter the hospital, are invited to participate in activities, and couples can have dates, etc. At the same time, mentors often become the people who explain to family members, in simple terms, the nuances and specifics of the patient's physical and emotional state and help form realistic expectations, in particular about returning to civilian life. Additionally, mentors define their role in interacting with families as providing maximum information about the trauma the loved one has suffered and their subsequent life with that trauma, **«so the family doesn't panic»** and don't undermine the patient's motivation.

One of the most common issues with patient families that hinders achieving set goals, according to medical staff and mentors, is overprotection. While a person is surrounded by those ready to respond to any request, they will not develop motivation to act on their own. Moreover, sometimes patients get used to this care and demand complete self-sacrifice from their relatives, even when their physical condition does not require it, believing that now, after a severe injury and military service, the family owes them.

Occasionally, due to their own hyper-control, relatives may complicate the patient's rehabilitation process. For example, mentors and medical staff cited the behavior of one patient's mother as an illustration of this pattern in the hospital. She interfered with all processes, cut her son off from communication, pressured him, demanded quick results rudely, and humiliated him for his failures. During sessions, staff tried to distract and remove this woman from the rooms, communicating with her through mentors and medical staff. However, this had little success. The situation was later resolved: the patient was added to a messaging group, allowing him to communicate with others directly, without any additional interference.

The role of family in patient's rehabilitation is dual. On one hand, they provide emotional support and a sense of meaning; on the other, their overprotection, hyper-control, or lack of understanding due to absence of military experience can slow the progress down. Thus, to avoid negative impact on patients, families often need simple, clear explanations of their loved one's physical and emotional condition and the formation of realistic expectations. Mentors serve as intermediaries between the patient's relatives, hospital staff, and the patient. They not only help avoid inflated or destructive expectations regarding the patient's physical condition but also explain emotional state, behavior, and communication style. In addition, mentors sometimes take care of the patient's relatives, reminding them to conserve their own resources, rest, and switch focus, so as not to become exhausted in caregiving and to be more effective. Thus, mentors' interaction with families becomes an important component of patient rehabilitation.

The ethnographic study in the rear hospital reported that the peer support

service relies on the everyday interaction of four actors – mentors, patients, medical staff, and patients' relatives – and works through trust, shared experience, and flexible informal practices. Mentorship in this culture is perceived both as work and a calling. It combines leadership and equality, organization of activities, and constant emotional presence, with its effect grounded in the ability to «read people», demonstrate possible life trajectories after trauma through personal example, and translate professional medical language into understandable meanings. Moreover, mentors with military experience have a higher trust factor and shorter distance to patients, making communication more informal, direct, and conducive to greater openness.

For patients, mentor support helps shift focus from the «new body» to exploring new identities and motivations. Both group formats, which help create community, and individual conversations with a mentor about personal topics, remain important. At the same time, patients' rehabilitation is complicated by practices of intentionally prolonging treatment, demonstrative hedonism, and alcohol abuse – factors requiring systemic solutions at all levels.

For medical staff, mentors become «bridges», «translators», and «mediators». They reduce tension, restore trust, and facilitate communication where there is a gap between military and civilian experiences or between the experiences of persons with and without disabilities. Mentors also «protect» healthcare professionals from patient aggression, help find approaches to more closed-off patients, and support more effective rehabilitation.

The role of family in rehabilitation is ambiguous. On one hand, families provide emotional support, motivation, and a sense of purpose. On the other, excessive care and control hinder patient autonomy and become a barrier to progress. Here, mentors also play an intermediary role: they explain patient's condition in simple terms, form realistic expectations, and remind relatives to conserve their own resources to avoid exhaustion in caregiving.

In summary, peer support emerges as a flexible practice embedded in the culture of a specific hospital. It combines physical recovery, the search for motivation, meaning, and new identities, the establishment of relationships with medical staff and families, and the creation of community among patients.

However, the rehabilitation departments of the study hospital resemble a bubble of like-minded individuals, where each patient is surrounded by attention and care. Upon discharge, a person returns from this bubble to their place of residence, and the civilians' attitude toward them may not be as positive. In particular, systemic neglect by the state of the transition from service to civilian life has fostered a persistent belief that, as one doctor said, **«military don't understand civilians, and civilians don't understand military».** In this context, mentoring serves another hidden but critically important function – it superficially prepares patients to leave the hospital community, face misunderstanding and «indifference» in the civilian world. This is facilitated by the emphasis on fostering independence and preparing for future self-fulfillment. Mentors, having personal experience of such reintegration,

can not only provide examples of adaptation but also explain to patients that the difficulties of this transition are surmountable. At the same time, their support gives patients the sense that even after discharge, they will not face their problems alone. Thus, the peer support service extends beyond the hospital walls and becomes a bridge between the protected rehabilitation «bubble» and the ambiguous reality of civilian life.

Conclusions

Our study confirmed that peer support can become an important reinforcing element of the rehabilitation system for service members and veterans in Ukraine. It builds trust where traditional medical services encounter barriers, translates medical language into categories understandable to patients, and helps in the search for identity and new life meanings after trauma and injury. Peer support specialists act as «bridges» between patients, their loved ones, and medical staff, reducing tension and increasing engagement in rehabilitation. They assist with acquiring practical independent living skills after trauma and support the resolution of legal and social issues.

Several «flagship» organizations in Ukraine already demonstrate relatively mature models for integrating peer support into PM&R. They gradually build a life-cycle of support – from inpatient treatment to community living. In PM&R, not only veterans but also civilians with personal experience of living with trauma can be peer support specialists, which expands the workforce potential.

In the field of mental health, peer support is less mature. This is due both to the sector itself being in an early stage of development and to the specific Ukrainian context, where veterans live in an ongoing war environment and are constantly at risk of retraumatization and acquiring new psychological injuries. Further development will require finding effective forms of cooperation, for example, hybrid models in which peer support specialists work in tandem with mental health professionals.

A positive development for the entire sector is the growth of educational initiatives. These include a certificate program for training peer support counselors within the nationwide mental health program «How Are You?» as well as training courses by specific NGOs that focus on particular types of trauma. This creates a foundation for the qualitative development of the practice.

At the same time, our study identified several serious challenges for peer support programs in rehabilitation (both in PM&R and in the mental health). The absence of standards and a full-fledged training system leads to significant differences in specialist competency levels. Where organizations invest in training and supervision, program quality is noticeably higher, but systemic initiatives remain the ex-

ception rather than the rule. In most organizations, the approach remains fragmented: peer support specialists are often employed in ad hoc positions without clear functions or official recognition of the profession. This makes their work invisible to the system and sometimes potentially risky for patients.

Protection and support mechanisms for peer support specialists are almost nonexistent. Burnout and secondary trauma risks are acknowledged, but resources for prevention are limited. Stable funding mechanisms for peer support services in rehabilitation are also nearly absent. These services rely on charitable aid, grants, and volunteer work, which does not allow for long-term sustainability or the formation of an ecosystem of effective programs.

Our study showed that the peer support approach is characterized by informality and flexibility. These traits allow peer support specialists to build trust, find common ground with clients, and adapt support to individual needs. At the same time, they create risks: blurred professional and personal boundaries, lack of established ethical norms, and differences in service quality provided by different organizations and individual specialists.

The evaluation of the effectiveness of peer support programs is at an early stage. In Ukraine, public data on the design and outcomes of such programs is virtually nonexistent, which makes comparisons both within the country and internationally difficult. Qualitative methods in our study identified examples of good practices, but scaling them requires greater transparency and promotion of successful models.

Thus, the peer support approach in the rehabilitation of service members and veterans in Ukraine has proven its value but requires a gradual transition from ad hoc solutions to systemic implementation. Its future will depend on the ability to overcome challenges in workforce training, funding, and protection of both patients and peer support specialists. At the same time, it is important to preserve the unique feature of the approach – flexibility and responsiveness to individual patient needs. Standardization and regulation can improve service quality but may also create barriers to access. The state's task will be to find a balance between institutionalization and preserving space for a living, responsive peer support practice.

Recommendations

1. Training and Knowledge Sharing

• Develop and scale systemic, long-term training programs for peer support specialists, including the certificate program as part of the nationwide mental health program «How Are You?» as well as specialized NGO courses that work with particular types of trauma (SCI, visual impairments, etc.).

• In the future, implement mandatory certification for peer support specialists, at least when services are funded by the state or communities.

• Foster synergy between universal educational programs at higher education institutions and specialized NGO initiatives targeting specific types of trauma or disorders.

• Include basic knowledge (anatomy, pathophysiology) about the medical conditions of the target community in the training of peer support specialists in PM&R to prevent the risk of incorrect counseling.

• Emphasize awareness among peer support specialists of common mental disorders, psychological support skills, and clear referral procedures to get professional help.

• Invest not only in training the peer support specialists themselves but also in strengthening the competencies of MRT members to effectively integrate the peer support approach into the rehabilitation process.

• Develop multidisciplinary training models where peer support specialists learn alongside mental health and PM&R specialists to foster mutual understanding of roles and competence boundaries.

• Create opportunities for networking and experience exchange among peer support specialists through professional communities, intervision, and open platforms with methodological resources.

• Disseminate knowledge about strong institutional examples of peer support programs as guidance for other initiatives, but not as models for direct replication. Implementation must aim to integrate best practices based on adaptation to local contexts and target group needs while maintaining flexibility.

2. Defining Professional Function

• At the state level, develop a professional standard for peer support consultants and include this profession in the Classifier of Professions.

• Organizations implementing the peer support approach should clearly define specialist functions depending on context (PM&R, mental health, veteran programs, etc.) and specific organizational needs.

• In PM&R, peer support specialists should collaborate with MRT members. MRT members the specialist will work with should be involved in defining their functional duties.

• In mental health, prioritize a multidisciplinary approach: a peer support specialist works in tandem with a mental health professional, and the support is not positioned as a separate therapeutic intervention.

• Develop model recommendations for ethics and professional boundaries of peer support specialists: confidentiality, rules of interaction with patients and their families, and referral mechanisms for cases beyond the specialist's competence.

3. Funding and Sustainability

• Integrate peer support services into state rehabilitation funding: consider coverage through the National Health Service of Ukraine (as part of rehabilitation packages) or programs of the Ministry of Social Policy, Family, and Unity of Ukraine.

• Establish mechanisms for service procurement: pilot the procurement of peer support services by healthcare facilities from specialized NGOs or certified independent practitioners.

• Set transparent requirements and standards for services and providers as part of financial mechanisms, including defined functions and competencies, minimum training and supervision requirements, alignment with individual rehabilitation plans, and reporting on outcomes.

• Ensure program sustainability by diversifying funding sources (state programs, local budgets, donor support, and private sector participation) to reduce reliance on short-term grants.

4. Integration into Rehabilitation Care

• Regulate rights and mechanisms of cooperation between peer support specialists and HCFs, especially when they are not staff members (similar to regulations for veteran support specialists).

• Allow peer support specialists to participate in MRTs and access patient data with written consent.

5. Continuity of Support

• Design peer support programs to ensure continuity from inpatient treatment to community and home life.

• Develop partnerships between HCFs and the public sector to support this continuous cycle.

• Systematically inform patients and families about available community peer support resources during inpatient care.

• As the network of community rehabilitation services develops, ensure the involvement of peer support specialists in the relevant rehabilitation teams.

6. Supervision and Burnout Prevention

• Ensure systemic support for peer support specialists through regular supervision, intervision, and access to psychological support.

• Include supervision requirements in service specifications for procurement by HCFs, state agencies, or communities.

• Develop model guidelines for organizations to support peer support specialists using flexible formats available under limited resources (e.g., group meetings, experience sharing).

• Foster a culture of care for peer support specialists: train them to recognize signs of burnout and encourage use of available support mechanisms.

7. Monitoring and Evaluation

• Develop monitoring and evaluation systems for peer- support programs using both quantitative (coverage, number of contacts) and qualitative indicators: return to social roles, reduction of secondary complications, acquisition of independent living skills, etc.

• Increase awareness among peer support providers of possible monitoring and evaluation models, as well as qualitative and quantitative indicators of PSI effectiveness in PM&R. At the same time, the findings from international literature and the experience of foreign organizations can be used, adapting them to the Ukrainian context.

• When implementing monitoring and evaluation tools, it is important to maintain a balance between standardization and flexibility. Indicators should improve programs rather than become a formality. Avoid excessive standardization, which could undermine a key feature of peer support – sensitivity to context and individual patient needs.