Interreg

EUROPESE UNIE

2 Seas Mers Zeeën

Ensure

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Evaluation Report ENSURE

by

HZ University of Applied Sciences

and

AP University of Applied Sciences

Lectoraat
HEALTHY REGION

AP HOGESCHOOL ANTWERPEN

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1 Introduction

Social exclusion is defined as: "a process through which individuals or groups are wholly or partially excluded from full participation in the society in which they live" (European Foundation, 1995). Within health and social care there is a growing number of socially excluded people whose needs are not recognized or met by current structures and services. In 2017, 112.8 million people in the European Union (EU) lived in households at risk of poverty or social exclusion (22.4% of the world population) and 16.9% of the population in the EU were at risk of poverty after social transfers (Eurostat, 2019). In specific the European coastal North Sea Channel areas Northern France, South-East England, West Belgium and South-West of the Netherlands (https://www.interreg2seas.eu/en) have the highest levels of limited access to employment and the development of social relations, increasing the isolation of certain population groups (Eurostat, 2019). Due to the inability to respond to these circumstances or lacking the capacity for resilience, people are or can become vulnerable (Briscoe, Lavender, & McGowan, 2016; Gathron, 2019). People can be invisible in society, because of fragmented services, inadequate continuity of care, negative experiences and/or poor communication between service providers and service users (Cline, 2016). Or simply because individuals have never accessed services or had sought help due to, for example, lack of knowledge of and information about social healthcare services, lack of confidence in the system, or to limited health literacy or language issues (Cline, 2016). Often these individuals or groups slip through the mazes of the net of current service provision and are unnoticed until a crisis arises, and harm has been done – affecting society as a whole as well as health and social care costs.

During times of need and distress, individuals tend to turn to social relationships for support in response to barriers or deficiencies encountered in the present health and social care system. In recognition of the importance of social relationships, **peer support** has been recognised as a solution to reach socially excluded and vulnerable people to prevent excesses, to improve equity, their connection to community, to facilitate psychosocial adjustment (emotional, healthy behaviour and disease management) as well as to support and to empower individuals (Cohen, Gottlieb, & Underwood, 2000; Dennis, 2003; Holt-Lundstad, Smith, & Layton, 2010; Perry, Zulliger, & Rogers, 2014).

1.1 General project information

All societies have their vulnerable people, some of whom risk falling through the cracks between health, welfare and social services. Many people, who do not fit pre-established labels within the system, are passed from one service to another without getting the support they need. Others are unable to access support despite meeting the criteria as they find it difficult to navigate health, social care and welfare structures. These are the kinds of people the ENSURE project is directed to with a goal to reduce and prevent vulnerability and the gap between people and public services and newly-developed training programmes.

1.1.1 Common challenge

Across the 2Seas region health/social care providers have become aware of a growing number of socially excluded vulnerable people whose needs are not recognized/met by current structures & services. At present services are accessed by allocating people a predetermined "label" eg autistic. ENSURE have reached both the significant number of people who do not fit these labels & are

passed from one service to another without attaining support as well as those who do not access support despite meeting the criteria. ENSURE provides a simple, effective solution to prevent their situation worsening & causing great cost to them & society. It recognizes that services are failing these people & provides a cost-effective system redesign to prevent vulnerability in our communities.

1.1.2 Overall objective

The focus of the ENSURE Interreg 2Seas project has been on breaking the cycle of disadvantage that prevents vulnerable people from being socially included. The ENSURE project group contained several social and healthcare partners and non-governmental organisations from the four European coastal North Sea Channel areas: Belgium, France, the Netherlands and the UK. The project group was diverse in composition, including parties that target a variety of groups, namely: young migrants, refugees and status holders, people with another ethnic background than the country of habituation, young adults with autism, care avoiders, people on welfare, non-accompanied minors, foster children and foster families, isolated individuals, pregnant women, unemployed/ unskilled/ untrained people. All project partners applied some shape or form of peer support within their services, based on expertise and progressive insight as a result of advanced experiences with their target groups, reporting varying effect and success.

1.2 Evaluation partners

The evaluation of the ENSURE project has been executed by the following two partners:

HZ University of Applied Sciences

The Research Group Healthy Region from the HZ University of Applied Sciences has thematic competences in applied research that could benefit the research for vulnerable people. The experience in participatory action research contributes to designing lifestyle interventions in co-creation with users to set up and evaluate the social and economic impact of social innovations.

AP University of Applied Sciences

The practice-based research on which AP University of Applied Sciences focuses contributes to society and education. The research group has experience with a bottom-up approach concerning vulnerability in general and specific subgroups, giving voice to the vulnerable groups themselves, their values, experiences and self-management abilities.

2 Central concepts

For the evaluation purposes valid measurements were carried out, taking into account the outputs in the application form. The application form was used as a basis, in which objectives and central outputs were converted into measurable units. The capacities of the target groups to be surveyed were taken into account to measure the impact of peer support programs, i.e. young migrants and unsupervised minors, young adults with autism, people with (mental) health problems, foster / shelter families, vulnerable pregnant women, people outside the labor force, elderly and homeless people. Table 1 shows the measured outcomes of the entire project, in which the central concepts are interwoven.

Looking at specific outputs, the following enumeration can be made:

- reduce & prevent vulnerability – empower/ optimise or strengthen help-seeking
- increase non-professional support (support volunteers)
- increase access and use of health & social/welfare services
- increase social inclusion/ decrease social isolation
- increase wellbeing
- increase empathy solidarism among (health/social/welfare) professionals
- decrease stigmatism among (health/social/welfare) professionals
- increase sense of competence
- improve community health and resilience target group
- increase knowledge and transferable skills peer-to-peer community workers
- increase involvement in employment market/ paid job peer-to-peer community workers
- increase self-efficacy peer-to-peer community workers in supporting vulnerable individuals
- increase reciprocity between peer-to-peer community workers and target group
- number of peer-to-peer community workers trained
- number of vulnerable individuals reached
- increase knowledge healthcare professionals
- increase social prescription of healthcare professionals
- increase self-efficacy healthcare professionals in involving peer-to-peer community workers
- increase reciprocity between peer-to-peer community workers and healthcare professionals
- number of healthcare professionals trained

Table 1 links the central concepts derived from the outputs above to a selected (validated) measuring instrument. Different target groups within ENSURE (VP, peer supporters, professionals) were taken into account. The **first column** indicates how the method of measuring the variables, namely questionnaires (quantitative method) or interviews / focus groups (qualitative method). The **second column** lists the concepts derived from the project outputs. In the first row, for example, is the concept of wellbeing, which is a central concept in the current study. The **third column** describes the name of the measurement instrument chosen to measure the concept. For the majority of concepts (such as well-being, social inclusion) it was possible to use a list of validated questions to measure it. Where "keeping track of numbers" is mentioned, this means that pilot partners were responsible for monitoring and collecting information with that regard. The **fourth column** describes when the measurement took place, for example before (pre) and after (post) the implementation of the pilot / intervention. The **last three columns** on the right-hand

side describe for which target group (vulnerable people, peers or professionals) the measurement applied and how many items it amounted to. Ultimately, a questionnaire of 57 items (Appendix 1) was developed to measure change in VP's attitudes / states / behaviors. Please notice that peer supporters had to answer 20 questions, while professionals only 10 (see Table 1 for detailed overview). The pluses (+) indicate which group was interviewed (number of items does not apply here). For the convenience of different target groups, the questionnaire was available in different languages, namely: English, Dutch, Arabic, Spanish, French, Turkish and Tigrinya. An example questionnaire in English can be found in appendix 2.

Table 1: Concepts and measurements

how	what	measure	when	# items		
				VP	peer supporters	professionals
QUANTITATIVE	wellbeing of VP	Warwick-Edinburgh Mental Wellbeing Scale	pre and post	14	14	-
	quality of life VP	Brief Resilience Scale	pre and post	6	6	-
	empowerment (strenghening) VP	Self-Esteem	pre and post	10	-	-
	(perceived) social inclusion	Lubben Social Network Scale	pre and post	6	-	-
	(perceived) social isolation / loneliness	CEL tool	pre and post	3	-	-
	(perceived) professional and non-professional support	Functional Social Support Questionnaire	pre ad post	8	-	-
	self-efficacy peer-to-peer community workers in supporting vulnerable individuals	General Self-Efficacy	pre and post	10	-	10
	involvement in employment market VP	keeping track of numbers	post	+	-	-
	paid job peer-to-peer community workers	keeping track of numbers	post	-	+	-
	number of peer-to-peer community workers trained	keeping track of numbers	post	-	+	-
	number of vulnerable individuals reached	keeping track of numbers	post	+	-	-
	breaking of intergenerational transmission of problems	interviews / focus groups	post	+	-	-
	bridging the gap between VPs unmet needs and professional organisations	interviews / focus groups	post	+	-	+
QUALTITATIVE	increased collaboration between stake-holders & peer supporters giving better access to VP & giving VP the support they need	interviews / focus groups	post	-	+	+
	personal development for peer support volunteers leading to engagement with the labour market.	interviews / focus groups	post	-	+	+
	increase access and use of health & social/ welfare services	interviews / focus groups	post	-	-	+
	increase professional and non-professional support (support volunteers)	interviews / focus groups	post	-	+	+
	Increase knowledge and transferable skills peer-to-peer community workers	interviews / focus groups	post	-	+	+
	increase reciprocity between peer-to-peer community workers and target groups	interviews / focus groups	post	-	+	+
	increase empathy solidarity healthcare professionals	interviews / focus groups	post	-	-	+
	decrease stigmatisation among (health/ social/welfare) professionals	interviews / focus groups	post	-	-	+

*VP: Vulnerable people

3 Procedure

The evaluation of outputs was conducted by two research methods 1) a quantitative pre- and post-tests (see chapter 2. Central Concepts for more information about the measurement) and 2) qualitative follow-up with VPs and/or peer supporters. The goal of the quantitative pre-test was to determine baseline of concepts under investigation (e.g. feelings of anxiety or loneliness prior to start of the pilot). In the post-test the same concepts were measured again, accounting for some control variables such as Covid-19 influences and the duration of the intervention. The ultimate goal was to compare the results of both pre- and post-test to determine the change in attitudes/ feelings/ states of VPs, peer supporters and professionals due to engaging in the pilots.

Each pilot partner has been paired with a member of the evaluation 'team'. The contact person:

- explained the procedure,
- provided pilot partners with survey links and codes,
- monitored the data collection,
- answered all pilot partners questions with regard to evaluation.

3.1 Quantitative part

The goal for each participant was to complete the pre- and post-test. The planning of the quantitative evaluation part (see Appendix 6 for more detail) was based on 9 activities, explained in the following paragraphs:

1 Engaging participants
2 Coding
3 Pre-test (peer supporters/professionals)
4 Completing data collection (peer supporter/professionals)
5 Training peer supporters/professionals
6 Pre-test VPs
7 Completing data collection (VPs)
8 Intervention
9 Post-test (peer supporters/professionals/VPs)

3.1.1 Engaging participants

Participants were engaged by the local partners. Each participant has been informed about the project based on the information given by the **information sheet** (see appendix 4). **Consent** (see appendix 3) was asked at the start of the survey. Links to the survey were provided by the evaluation partner.

In case pilot partners were working with minors (16y-18y) the guardians/parents needed to be informed as well (see appendix 5).

3.1.2 Coding

Each respondent has received a code. This code was needed to link person's pre- and post-tests. In this way precise effect of the pilot was measured with statistical analyses.

Respondents were asked to fill in this code in the pre-testing (pre-survey, before the intervention) as well as in the post-testing (post-survey, in the end of the project).

Data protection

No personal data has been gathered in the survey. Instead each person used an individual code. While the pilot partner could link the codes with names of the respondents, the evaluation partner was only able to link the codes with answers to the survey questions. In this way the **individual names have never been directly linked to the gathered from the survey data, assuring the privacy of the respondents**. Moreover, the informed consent has been asked in the beginning of the survey, and the participation in the survey was on a voluntary basis. The respondent could stop filling out the survey anytime.

After the final data collection (post-tests), the pilot partners were asked to destroy the codes and names of the participants.

3.1.3 Pre-test

The evaluation partners provided pilot partners with the link to the surveys in different languages (English, Arabic, French, Dutch, Spanish, Turkish). The pilot partners were responsible for:

- providing the code to the respondents under consideration,
- distributing the link to the survey among the concerned participants.

3.1.4 Post-test

After the intervention (=pilot), post-tests were conducted. Again, the evaluation partner provided pilot partners with link to the surveys in different languages (English, Arabic, French, Dutch, Spanish, Turkish). The local partners distributed the link among the concerned group. Participants used the **same code** as in the pre-test, which allowed a correct evaluation of the data.

3.2 Qualitative part

Since not all of the outputs could be measured with quantitative survey (e.g. personal development for peer support volunteers leading to engagement with the labor market, increase knowledge and transferable skills peer-to-peer community workers) more in-depth investigation was needed after the pilots were finalized. The target groups of this investigation were vulnerable people, peer-supporters, professionals and community workers.

The qualitative evaluation consisted of two parts:

- interviews with professionals/ community workers
- round tables with VPs and peer supporters

3.2.1 Interviews with professionals

The interviews with professionals were conducted by the evaluation partners. Before the professional could be included in the study, the professional had to meet the following three requirements:

- the professional played a role within the ENSURE project,
- the professional was proficient in the English, Dutch and/or French language,
- the professional has worked with the target group for at least half a year.

Duration of the interview: approximately 60 minutes.

The interview questions can be found in the attachment 7.

3.2.2 Round table discussions with VP's and peer supporters

Next to interviews with professionals, round table discussion with VP's and peer supporters were organized by pilot partners.

Roles

In the round table discussions there were different roles:

- **Mediator** – Lead the focus group from a neutral position by:
  - asking questions
  - ensuring explanation and rephrasing where needed
  - keeping track of time
- **Scribe** – Observed the interaction within the focus group, took notes and supported the mediator with time keeping.
- **Peer supporters** – Participated in the focus group from their own perspective.
- **VP's** – Participated in the focus group from their own perspective.

Design of the workshop

First, the mediator welcomed the group and explained the aim of the round table discussion: to understand the effects of the project ENSURE from the perspectives of the participants. The round table discussion were held under a couple of conditions:

- small groups from 6 to 8 participants (combination of VP's and peer supporters or 2 separate groups depending on the trust/interaction/bias).
- post-its with color code were given to all the participants. Only the mediator and scribe were informed about the meaning of the color code (e.g. yellow for VP's, pink for peer supporters).

Instructions for the mind maps: The group received mind maps on the different topics printed/drawn on A3 (or bigger) (appendix 8). In text balloons statements were made, the participants could agree or disagree. The members of the group had to attach their post-it to the mind maps based on whether they agreed or disagreed. If their answer were more nuanced they could attach their post-it more towards the central line.

The mind maps and post-its were a starting point for discussion. The text balloons had different colors to give a direction to the conversation:

- Green: question that the peers need to answer and evaluate with peer supporters,
- Orange: question the peer supporter needs to answer and evaluate with the peers,
- However, everybody could add post-its with their thoughts, no matter the color of the text balloon.

After each topic, the mediator have summarized what was noted. Each time the mediator asked feedback on the summary. The group concluded whether all perspectives were incorporated. The scribe wrote down the conclusions.

Data storage

The mediator and scribe recorded the session to help them write the summaries. Recordings and other identifiable content were deleted after analyzing the data.

4 Analyses and Results

In this section analyses and results will be discussed. Firstly sample description per target group and method applied will be discussed. Next, analyses and results will be described per concept measured. The analyses are organized as follows:

- firstly the concept measured is shortly described (for the full operationalization of the quantitative measurements - see appendix 1; for the full operationalization of the qualitative part – see appendixes 7 and 8),
- the results per concept are described,
- the reference to tables with results is mentioned for more detailed overview.

4.1 Sample description

The sample description will be divided into five segments:

- sample description of the pre and post-test of the peer supporters,
- sample description of the pre and post-test of the vulnerable people,
- sample description of the professionals
- sample description interviews
- sample description round tables

4.1.1 Sample description peer supporters

The **pre-test for peer supporters** was completed by 54 individuals. Of these individuals 68,5% (37) were female. In total 25 respondents were 30 years old or younger (46,3%). About 26,3% of the respondents were between 31 and 50 years old. The minority of the respondents were older than 51 years old (24,1%). The oldest respondent was 71 years old and the youngest respondent was 20 years old. Half (27) of the respondents had completed a bachelor degree or higher. In total 46,3% of the respondents (25) had completed secondary education and every respondent had completed primary education (2). About a fifth of the respondents did not answer the question in which country they were born. The majority of respondents were in The Netherlands (29,6%). An equal number of persons were born in Belgium and France (6). In total 16 respondents were from other countries. Most of the respondents spoke Dutch as their mother language (40,7%) followed by English (29,6%), French (11,1%), Arabic (3,7%) and five other languages. Respondents had suffered a little bit from the COVID-19 epidemic (mean 2,4/4) however, more than half of the respondents had not been in quarantine (64,8%).

The **post-test for peer supporters** was completed by 29 individuals. Of these individuals 75,9% (22) were female. Ten individuals (34,5%) were between 31 years and 50 years old or 51 years and older (34,5%). In total 9 of the respondents were 30 years old or younger (31,0%). The oldest respondent was 71 years old and the youngest respondent was 21 years old. Each respondent had completed secondary education. In total about a third of the respondents had completed a bachelor degree or higher (37,9%). Most respondents were born in Belgium (27,6%) followed by France (17,2%), The Netherlands (13,8%), The United Kingdom (13,8%) and 8 other countries. For most of the respondents their mother tongue was Dutch (41,4%). The majority (69,0%) of the respondents did support someone as a peer or buddy for less than a year. Seven of the respondents supported someone as a peer or buddy for between 1 or 2 years and 1 person supported someone for more

than 4 years. Respondents had suffered a little bit from the COVID-19 epidemic (mean 2,3/4). About half of the respondents had been in quarantine (51,7%).

4.1.2 Sample description vulnerable people

The **pre-test for VP** was completed by 46 individuals. Of these individuals 73,9% (34) were female. About 20 of the respondents were between 31 and 50 years old (43,5%). In total 18 of the respondents were older than 51 years old (41,3%). Three respondents were 30 years old or younger (6,5%). The oldest respondent was 74 years old while the youngest respondent was 17 years old. Almost half of the respondents had completed secondary school (43,5%) while 26,1% had also completed a bachelor degree or higher. In total 10,9% had not completed primary school and 8,7% had completed primary school. Most of the respondents were born in Belgium (19,6%) followed by Morocco (15,2%), The Netherlands (8,7%) and 13 other countries. Most of the respondents spoke either Arabic (26,1%) or Dutch (21,7%) as their mother tongue. Eight other different languages were spoken as a mother tongue. The respondents indicated that they suffered a lot from the COVID-19 epidemic (mean 2,8/4) however, a majority of the respondents indicated that they had not been in quarantine (65,5%).

The **post-test for VP** was completed by 40 individuals. Of these individuals 80,0% (32) were female. More than half of the respondents were older than 51 years old (55,0%). In total 15 respondents were between 31 and 50 years old (37,5%) and the minority of the respondents were 30 years or younger (6,5%). The oldest respondent was 77 years old and the youngest respondent was 27 years old. Almost half of the respondents had completed secondary education (42,5%) while 22,5% had completed a bachelor degree or higher. About 17,5% of the respondents completed primary school and 10% had not completed primary school. Most of the respondents were born in Morocco (22,5%) followed by Belgium (20,0%), Somalia (10,0%) and 12 other countries. Most of the respondents spoke either Arabic (22,5%) or Dutch (22,5%) as their mother tongue. Eleven other different languages were spoken as a mother tongue. The respondents indicated that they had suffered a little bit from the COVID-19 epidemic (mean= 2,23/4) however a majority of the respondents indicated that they had not been in quarantine.

4.1.3 Sample description professionals

There was only one survey for professionals, after completion of the pilot. The survey was filled in by 93 professionals. Of these professionals 86% (80) were female. All of the professionals were born after 1989 and were mostly between 20 and 25 years old (80,1%). Six respondents (7,2%) were older than 25 years old and only one person was younger than 20 years old. Most participants had completed secondary education (73,1%) while the others had completed a bachelor degree or higher (16,1%). In total 10 participants (10,8%) did not complete this question. The majority of the respondents were born in The Netherlands (43,7%) and a third of the respondents were born in Belgium (33,3%). Six other countries were reported. A majority of the respondents indicated that they had Dutch as a mother tongue (71,0%). Fourteen other languages were reported. Respondents indicated that they had suffered a little bit from the COVID-19 epidemic (mean=2,17/4) however, the majority had not been in quarantine (50,6%).

4.1.4 Sample description interviews

There were 12 professionals interviewed in 8 interviews. The number of interviewees per interview ranked from 1 to 3. The professionals were engaged in the project as social workers, lecturer and project managers. Their ages ranged between 34 and 70. They all benefited from a higher education.

Description participants - Google Sheets

4.1.5 Sample description round tables

The round tables included 45 participants spread over 7 round table discussion. The men/women ratio was 8/37. Age ranked between 20 and 58. The language used during the round tables was for 18 participants not their mother tongue.

4.2 Empowering Persons Reached (VP)

In this section analyses and results with regard to vulnerable persons will be discussed. Content is organized by concept measured, namely: mental well-being, quality of life, self-efficacy, social support, and self-esteem.

4.2.1 Mental well-being

Mental well-being is more than just the absence of a disease or condition and focuses on the personal perception of mental health (Magyar & Keyes, 2019). It refers to people's coping mechanisms with daily activities in the field of psychological functioning, life satisfaction and the ability to develop and maintain mutually beneficial relationships (Tennant et al., 2007). In this study, mental wellbeing was measured with the Warwick-Edinburgh Mental Well-Being Scale (WMWBS) (Stewart-Brown & Janmohamed, 2008). This scale describes 14 positively worded items relating to different aspects of positive mental health, such as:

"I've been feeling optimistic about the future"
"I've been close to other people"

The questionnaire used a five-point Likert scale with the categories none of the time, rarely, some of the time, often and all of the time. Table 2 presents the mean scores of both the pre- and post-test including significance testing (*p*-values) conducted with independent sample t-tests. Mental wellbeing had a pre-test mean score of 48,4 (*SD* 10,3); indicating an average score. In the post-test the mean score increased to 50,6 (*SD* 8,7), however not significantly (*p*=,294).

Table 2: Mean comparison between pre- and post-tests among people reached

	Scale	Mean pre-test	Mean post-test	Mean difference	*p*
Mental wellbeing	14-70	48,4	50,6	2,2	,294
Resilience	1-5	3,0	3,2	0,2	,153
Self-esteem	10-40	21,4	19,2	2,2*	**<,05***
Self-efficacy	10-40	27,3	28,7	1,4	,261
Social support	1-5	2,2	4,0	1,8*	**<,05***

***p < ,05 = significant mean difference**

4.2.2 Quality of life

Quality of life is a broad concept and has various definitions. Many instruments are offered to measure this concept, such as the SF-12 with its strong emphasis on the physical and mental concept of health (Jenkinson & Layte, 1997). Mental wellbeing (mentioned in the previous section) also measures the quality of life in a broad sense (Salvador-Carulla, Lucas, Ayuso-Mateos, & Miret, 2014). Providing resilience is a crucial part of overall well-being and consists of: successfully adapting to difficult or challenging life experiences through mental, emotional, and behavioral flexibility as well as adjustments to external and internal demands in order to arrive at certain outcomes or solutions (Aburn, Gott, & Hoare, 2016). It was therefore decided to take a closer look at the concept of resilience, which was measured in this project with the Brief Resilience Scale (Smith et al., 2008). This scale uses six items for assessing resilience, for example:

"I tend to bounce back quickly after hard times"
"I usually come through difficult times with little trouble"

The questionnaire used a five-point Likert scale with the categories of strongly agree to strongly disagree. Table 2 presents the mean scores of both the pre- and post-tests, including p-values referring to independent sample t-tests. Resilience had a pre-test mean score of 3,0 (*SD* 0,7). This indicates an average resilience score. In the post-test the mean score increased to 3,2 (*SD* 0,7), however not significantly (*p*=,153).

4.2.3 Self-efficacy

Self-efficacy is an important concept in the ENSURE study. It refers to the confidence in one's own abilities to achieve a goal or get into a certain state (Bandura & Wessels, 1994). Self-resilience refers also to being able to successfully influence an environment, performing a behavior or solving a problem (Maddux & Gosselin, 2012). Self-efficacy is important for our target group which is expected to learn many new skills while still being unsure about their own capabilities. A sufficient degree of self-efficacy for a specific behavior appears to be decisive in whether or not to perform certain behavior (Olivier, Archambault, De Clercq, & Galand, 2019). In this project, self-efficacy was measured with the General Self-Efficacy scale (Chen, Gully, & Eden, 2001). This scale consists of ten items and measures the general self-efficacy of the target group, for example:

"I can always manage to solve difficult problems if I try hard enough"
"If I am in trouble, I can usually think of a solution"

The questionnaire used a four-point scale with the categories of *not at all true to exactly true*. Table 2 presents the mean scores of both, the pre- and post-tests including p-values referring to independent sample t-tests. Self-efficacy had a pre-test mean score of 27,3 (SD 0,7), indicating an average to good self-efficacy score. In the post-test the mean score increased to 28,7 (SD 0,4), however not significantly (*p*=,261).

4.2.4 Social support

Having a meaningful social network is crucial to overall well-being. This can be differentiated in terms of the number of people in the network, but also in how the social support from that network is experienced by someone. Social support can help to achieve certain health goals, to increase resilience and to experience happiness (Berkman & Glass, 2000). The perception of social support is measured in ENSURE with the Functional Social Support Questionnaire (Martins et al., 2022). The questionnaire consists of eight items, for example:

"Chances to talk to someone I trust about personal and family problems"
"Love and affection"

The questionnaire used a five-point scale with the categories of *as much as I would like to much less than I would like*. Table 2 presents the mean scores of both the pre- and post-tests including p-values referring to independent sample t-tests. Social support had a pre-test mean score of 2,2 (SD 0,9). This indicates an average social support score. In the post-test the mean score increased significantly to 4,0 (SD 0,6), with p<,05. Perception of social support among VP's increased significantly by the end of the project. .

4.2.5 Self-esteem

Self-esteem appears to be decisive for successful integration into society (Porter & Washington, 1993) and participants worked on self-esteem and self-image during the course of the study. The concept was measured with the Enablement Self-Esteem Questionnaire (Rosenberg, 1965). This scale consists of ten items assessing people's self-esteem, for example:

"On the whole, I am satisfied with myself"
"I take a positive attitude toward myself"

The questionnaire used a four-point scale with the categories of strongly agree to strongly disagree. Table 2 presents the mean scores of both the pre- and post-tests including p-values referring to independent sample t-tests. Self-esteem had a pre-test mean score of 21,4 (SD 5,8). This indicates an average to low self-esteem score among VP's. In the post-test the mean score significantly decreased to 19,2(SD 3,8), p<,05). The self-esteem of the people reached is significantly reduced between the pre- and post-test.

4.2.6 Social inclusion

The Lubben social network scale (LSNS-6) is a tool used to measure an individual's social inclusion (Lubben, et al., 2006). Social inclusion refers to the process of ensuring that individuals and communities, regardless of their background, have equal access to opportunities and resources, and are able to participate fully in the social, economic, and political life of their society. The LSNS-6 assesses an individual's social inclusion by measuring the size and composition of their social network, and the level of support and companionship provided by that network. The scale can be used to identify individuals who may be at risk of social isolation and exclusion, and to evaluate the effectiveness of interventions aimed at promoting social inclusion. The LSNS-6 was only used for the VP's. Although there cannot be a part of person, the table describes the number of persons that can be called upon (Lubben et al., 2006).

Table 3: Comparison mean scores pre- and post-tests social inclusion

	Scale	Mean pre-test	Mean post- test	Mean difference
How many relatives do you see or hear from at least once a month?	≥0	7,72	9,97	2,25
How many relatives do you feel close to such an extent that you could call on them for help?	≥0	4,22	12,97	8,75
How many relatives do you feel at ease with that you can talk to about private matters?	≥0	3,96	4,82	0,86
How many friends do you see or hear from at least once a month?	≥0	5,26	5,74	0,48
How many friends do you feel close to such an extent that you could call on them for help?	≥0	3,54	5,82	2,28
How many friends do you feel at ease with that you can talk about private matters?	≥0	2,54	2,87	0,33

On average the mean scores of the post-test were higher in comparison with the pre-test. Several substantial differences can be seen between the pre and post-test, for instance in the amount of relatives that can be called upon for help (on average +8 relatives), the amount of friends that can be called upon for help (on average +2 friends) and the amount of relatives that they hear from at least once a month (on average +2 relatives) (table 3).

4.2.7 Social isolation

Social isolation refers to the lack of social connections and interactions with others, which can lead to feelings of loneliness and disconnection from one's community. It can negatively impact an individual's physical, mental, and emotional well-being, and increase the risk of health problems such as depression, cognitive decline, and cardiovascular disease. Campaign to End Loneliness scale (CEL) is used to measure this phenomenon and to evaluate the level of social isolation an individual is experiencing (Campaign to End Loneliness, 2015).

The CEL scale is a self-report questionnaire that can be used to identify individuals who may be at risk of social isolation and loneliness, and to evaluate the effectiveness of interventions aimed at reducing loneliness and promoting social inclusion. In ENSURE project 4-point (*strongly disagree, disagree, agree and strongly agree*) CEL scale has been used in order to measure social isolation. The lower the score the more likely to have feelings of loneliness (Campaign to End Loneliness, 2015).

Table 4: Comparison pre- and post-tests social isolation

	Scale	Mean pre-test	Mean post-test	Mean difference
I am pleased with my friendships and relationships.	1-4	2,89	2,97	0,08
I have enough people I feel comfortable asking for help at any time.	1-4	2,93	3,23	0,3
My relationships are as satisfying as I would want them to be.	1-4	3,23	3,18	-0,05

None or insignificant differences in mean scores between the pre and post-test were measured (table 4). The average mean score of the pre-test was 3,01 while the average score of the post-test was 3,00.

4.2.8 Professional and non-professional support

VP's indicated an increase in non-professional support. They got to know peer-supporters better by participating in this project. The difference in professional support depended on the pilot. With regard to professional support, one of the participants stated:

> *"... I can only say that [peer] supporters have good awareness of services people can use and have access to these to follow up if needed."*

The peer support method improved accessibility to the services, at the same time participants discussed a duality in this accessibility as they did not feel an improved contact or collaboration with professionals. One of the peer supporters emphasized there are still conditions for the professional help:

> *"Professionals are available .... , if people are available to do their steps towards them".*

4.2.9 Number of vulnerable individuals reached

"Persons reached" refers to the number of individuals who have been directly or indirectly impacted by a program or intervention. This can include individuals who have received services or support directly from the program, as well as those who have been influenced by the program through changes in their community or environment. In the context of a program or intervention, measuring the number of persons reached is important for understanding the program's reach and impact, and for making decisions about resource allocation and future planning. In total the ENSURE project has reached 1824 VP's that can be accounted for. Four of the project partners did not report the amount of VP therefore, the amount of vulnerable individuals reached was higher.

4.2.10 Breaking intergenerational transmission of problems

In case of vulnerability we often speak of 'intergenerational transmission of problems'. This means that the problems such as for instance being in care, poor parenting, violence, substance abuse, low aspirations, aggression, non-attendance in school and few or no qualifications are transferred from one generation to another. Often the roots of this kind of behavior are to be found in the (early) childhood. In addition, people are often not aware of their presence. This concept has been measured in this study.

In general, the results of the interviews with the professionals found subconscious intergenerational transmission of problems strongly present among the VP's. Through the ENSURE training, some of the peer supporters and professionals have become aware of this and were (are) trying to deal with it. ENSURE has helped them in their journey to break that cycle and to tackle the problems in a sustainable way by working in an accessible way. From this experience, they try to approach their lives differently and are more likely to seek help. Especially the low-threshold approach of addressing the people without immediately wanting to be the care provider makes that there is more trust among the participants.

4.2.11 Bridging the gap between VP's unmet needs and professional organisations

The VP's gained more access to different professional organizations based on their needs. "Accessing social welfare and health care was not an obstacle" as one participant said. "The problem was trust in both, one's own skills and professionals".

It can be therefore concluded that peer-supporters had an important role in bridging the gap between VP's and professional organisations as it was thanks to peer-supporters that VP's gained more trust in themselves and in other people who are there to help them.

4.3 Empowering Peer Supporters

Empowering peer supporters involves providing them with the necessary tools and resources to effectively support their peers. By empowering peer supporters, we enable them to build meaningful relationships with their peers and foster a sense of community and belonging. Empowered peer supporters are better equipped to promote positive change and help their peers overcome challenges and achieve their goals, thereby building a stronger and more supportive community.

4.3.1 Mental well-being

Just as with the persons reached, mental well-being was measured among the peer supporters. The same concept and questionnaire was used (see paragraph 4.2.1 for further details). The questionnaire used a five-point scale with the categories none of the time, rarely, some of the time, often and all of the time. Table 5 presents the mean scores of both the pre- and post-tests, including p-values referring to independent sample t-tests. Peer supporters scored 51,8 (SD 9,2) on the mental wellbeing pre-test. This indicates an average to good score. In the post-test the mean score increased to 55,1 (SD 7,6), however not significantly (p=,086).

Table 5: Mean comparison between pre- and post-tests among peer supporters

	Scale	Mean pre-test	Mean post-test	Mean difference	*p*
Mental wellbeing	14-70	51,8	55,1	3,3	,086
Resilience	1-5	3,3	3,4	0,1	,455

4.3.2 Quality of life

Similarly to quality of life of VP's, quality of life among peer supporters has been measured by Brief Resilience Scale (see paragraph 4.2.2 for detailed more explanation). The questionnaire used a five-point Likert scale with the categories of *strongly agree to strongly disagree*. Table 5 presents the mean scores of both the pre- and post-tests, including p-values referring to independent sample t-tests. Peer supporters scored in pre-test on average 3,3 (SD 0,9) on resilience. This indicates an

average to good resilience score. In the post-test, the mean score increased to 3,4 (SD 0,9), however not significantly (p=,455). These analyzes show that the level of resilience among peer supporters has remained consistent throughout the project.

4.3.3 Paid job peer-to-peer community workers

The number of paid job peer-to-peer community workers after the program is an important metric to evaluate the success and impact of the program. It indicates the number of individuals who have been engaged in the program and have been able to benefit financially from it. A relative high number of paid job peer-to-peer community workers after the program suggests that the program has been effective in creating employment opportunities for individuals within the community. It also shows the program's sustainability and long-term impact on the community, as these workers can continue to provide services and support after the program has ended. The ENSURE project resulted into at least 59 paid jobs as community workers. Four of the project partners did not report paid job peer-to-peer community workers. Therefore, the impact of the ENSURE project could be bigger than 59 paid jobs.

4.3.4 Number of peer-to-peer community workers trained

The number of peer-to-peer community workers trained is an important metric to evaluate the success and impact of a program or initiative. It indicates the number of individuals who have received training and have the skills and knowledge to provide services and support to their community members in a peer-to-peer capacity. A high number of peer-to-peer community workers trained suggests that the program has been effective in building the capacity of individuals within the community. It also shows the program's ability to create a pool of trained and skilled community workers who can continue to provide services and support to their community even after the program has ended. In total the ENSURE project resulted into 115 community workers trained. The impact of the ENSURE project could be even bigger because four of the pilot partners did not report number of peer-to-peer community workers trained.

4.3.5 Increased collaboration between stakeholders & peer supporters giving better access to VP & giving VP the support they need

The collaboration gave better access to VP in different ways, such as the peer supporters i) enjoyed an extensive network ii) played a key role in the communication, e.g. translating, calling and iii) were asked to advice the professionals due to their expertise and trust. The peer supporters and peers did experience an improved accessibility due to the collaboration between stakeholder and peer supporters.

4.3.6 Personal development for peer support volunteers leading to engagement with the labour market

The peer support volunteers are unanimous that they have grown as a person through the training program, mainly in terms of self-confidence. As a result, they think they have a better chance on the job market, as one of the participants said :

> *"I feel that the training and experience gained is extremely helpful to any job working with others".*

The project has contributed to the confidence in themselves and their abilities and gave a permanent improvement of skills in various areas. In addition, the project also increased the network of peer supporters. Increased professional and non-professional support.

4.3.7 Increase knowledge and transferable skills peer-to-peer community workers

A quote of one of the peer supporters sums it up:

> *"Yes, there is much opportunity to learn from the project".*

The training offered multiple opportunities, one of the opportunities identified was the skill of listening without judgment and carefully understanding the needs. Also how to say 'no' and distance themselves if necessary. Peer supporters emphasize how they learned about their own coping mechanisms during the training. Throughout the project the peer supporters were faced with different frames of references and these experiences led to more knowledge about language, culture and independence.

4.3.8 Increase reciprocity between peer-to-peer community workers and target groups

As the participants and peer supporters interacted more, they began to understand each other. There already was reciprocity between the peer-to-peer community workers and the target groups in the projects where the peer supporters were member of the targeted community. In this project it was mentioned

> *"You will have to face the situation yourself to be able to recognize it and help others face it as well".*

In this project it has been challenging for the participants to understand what training and which tasks the peer supporters take on. In other projects the peer supporters felt they had an improved understanding due to the training. However, they were well aware of the unconscious bias. Some peer supporters noted that it helped spending time together.

4.4 Empowering Professionals

Empowering professionals is crucial for improving self-efficacy and performance, particularly for peer-to-peer community workers who play a critical role in providing support and services.

4.4.1 Self-efficacy peer-to-peer community workers in supporting vulnerable individuals

Self-efficacy is an important concept in the ENSURE study. The concept has also been measured among the people reached (see paragraph 4.2.3) and it refers to the confidence in one's own abilities to achieve a goal, solve a problem or successfully influence an environment (Bandura & Wessels, 1994; Maddux & Gosselin, 2012). Self-efficacy is also relevant for professionals in guiding vulnerable target groups or peer supporters and applying the necessary coaching skills. Self-efficacy was measured with the General Self-Efficacy scale (Chen et al., 2001), at the end of the project. This scale consists of ten items and measures the general self-efficacy of the target group. Example items are:

> *"I can always manage to solve difficult problems if I try hard enough"*
> *"If I am in trouble, I can usually think of a solution"*

The questionnaire used a four-point scale with the categories of not at all true to exactly true. Table 6 presents the mean score with standard deviation, minimum- and maximum score. The higher the score, the better the self-efficacy. Professionals scored on average 29,1 (SD 2,6) on self-efficacy

scale. At the end of the project, professionals indicated that they have confidence in their own abilities to work with the target group and to apply the required skills.

Table 6: Self-efficacy among professionals

	Scale	Mean	SD	Minimum	Maximum
Self-efficacy	10-40	29,1	2,6	20	38

4.4.2 Bridging the gap between VP's unmet needs and professional organisations

It was very clear to the professionals that the participants gained more access to different professional organizations. One professional expressed that the project clearly helped because

> *"She is in the middle of that gap between the environment [from the participant] and the system-world".*

We translate the system world as professional organisations in this case. Additionally, a professional stressed the importance of working step by step as long-term thinking is often not present among the clients.

4.4.3 Increased collaboration between stakeholders & peer supporters giving better access to VP & giving VP the support they need

There was an obvious increased understanding and collaboration among professionals and stakeholders due to peer supporters who have been able to explain the professionals and stakeholders the world their clients live in and the problems they face. Nevertheless, a professional stated still more efforts are needed to succeed in collaborating. The structure is very important here. One of the professionals observed how one point of contact for concerns and problems works smoother and more natural than fragmented care and different contacts. There are also clearly fewer thresholds visible when there is a point of contact instead of a professional behind a physical barrier.

4.4.4 Personal development for peer support volunteers leading to engagement with the labour market

The professionals experienced that the network of the peer supporters grew as well as their self-confidence. One professional stated how the peer supporter learned skills that can help them in the labour market, such as agenda management and communication skills. In the cases where the lack of work was a primary aspect to the vulnerability of the participants, the network build during the project helped them look for and find jobs. The experiences that the professionals had matched with those of the peers.

4.4.5 Increase access and use of health & social/welfare services & Increase professional and non-professional support

The professionals agreed that the project contributed to getting the help that was needed. In the projects where the peer supporters were part of the targeted community a professional explained how they encouraged each other (non-professional) in getting the suitable help (professional). For example, in one of the projects the peer supporters became a group of people (non-professional) that had certain specializations (e.g. experience in health care). Through this non-professional support, the right and effective professional support was addressed.

4.4.6 Increase knowledge and transferable skills peer-to-peer community workers

The ENSURE project contributed enormously in providing the right help for the participants with a healthy balance between professional and non-professional help. The low-threshold approach and especially the first informal contact ensures that the barriers fade away for the participants. This ensures that they feel seen and heard, so that a care provider can also support and help them more quickly.

The professionals observed an increase of skills due to the training, such as, self-confidence, social skills, organise their affairs and independency to a certain extent. This was clearly in line with the reflections of the peer supporters and the participants themselves on the subject.

4.4.7 Increase reciprocity between peer-to-peer community workers and target groups

The professionals observed an increased reciprocity as they noticed how the peer supporters and target group got to know each other better through the project. They especially learned to understand each other's environment better. Throughout the training often given by the professionals the peers have increased their knowledge in how to cope with and react to people who don't understand their problems. Most of the professionals also increased their knowledge about the problems the participants face.

4.4.8 Increase empathy solidarity healthcare professionals

Empathy should be a basic attitude for a professional but often is not. Overall, there was a lot of empathy from professionals according to the peer supporters. However, it was also indicated that it is crucial for vulnerable people to still be assertive about their needs. Knowing the problems participants face and knowing how to translate them to other professionals and stakeholders increases empathy and solidarity.

4.4.9 Decrease stigmatization among professionals

There are clearly still a lot of stigmas present among professionals. Additionally, most of the participants in this pilot experienced stigmatization. It is not that this project has given new insights into this, but it does provide some awareness around this theme. They are often not taken seriously or the demand for care is minimized. Working with peer to peer the professional felt less stigma towards the participants, because of the low-threshold way of working.

Among partners who have been working with the training program for some time, prejudice is significantly less. Prejudices are inevitable. Being aware of it is already a first step that most professionals do seem to have taken. A good guidance here is "Don't judge a book by its cover".

5 Discussion, Limitations and Recommendations

Peer support is a powerful method in social inclusion (Cohen, Gottlieb & Underwood, 2000; Holt-Lundstad, Smith & Layton, 2010; Perry, Zulliger & Rogers, 2014), receiving strong emphasis in the World Health Organization's Global Health Workforce Network (2021). Economic analyses of peer support initiatives have shown economic benefits of this method to the society (Whitley, Everhart & Wright, 2006). Additionally, our project shows that peer support has far more consequences and impact then the economic one.

Results show that, thanks to peer support, VP gained more access to professional organizations fitting their needs. Although access to social services and health care was not an obstacle, the problem was confidence in both - one's own skills and professional help. Peer supporters have therefore played an important role in bridging the gap between individual groups and professional organizations, by making those individuals more confident in themselves and in other people. This is an important finding as it will help VP not only to find their way to professional organizations but as well to be more confident in asking for help.

These findings are also confirmed with quantitative part of our research. Compared to the start of the project, in the end of it a significant increase was found in VP's *self-esteem and perception of social support, and a small increase in mental well-being, resilience, self-reliance and social inclusion*. This means that the project slightly increased VP's abilities to develop and maintain mutually beneficial relationships (Tennant et al., 2007) and contributed to improvement in their coping mechanism such as successfully adapting to difficult or challenging life experiences. By taking part in the project VP acquired mental, emotional, and behavioral flexibility and learned how to adjust to external and internal demands in order to arrive at certain outcomes or solutions (Aburn, Gott, & Hoare, 2016).

An important finding is increase in self-esteem among VP which appears to be decisive for successful integration into society (Porter & Washington, 1993). During the course of the project peer supporters have been aware of the importance of this concept in increasing quality of VP's lives and were therefore specifically working on VP's self-image and self-esteem. Moreover, VP indicated to be more pleased with relationships they have gained. The results show significant increases in number of relatives and friends VP feel close to and would feel comfortable to ask for help, as compared to before start of the project. This is an important finding as it leads to less social isolation and makes VP feel more confident in building their social network.

The benefits of peer support method have also been found among peer supporters themselves. The project has contributed to confidence in themselves and their abilities. Peer supporters emphasize how much they've learned about their own coping mechanisms during the training. Moreover, throughout the project the peer supporters were faced with different frames of references and these experiences led to more knowledge about language, culture and interdependence. In addition, the project has expanded the network of peer supporters.

A relative high number of paid job peer-to-peer community workers after the program suggests that the program has been effective in creating employment opportunities for individuals within the community. It also shows the program's sustainability and long-term impact on the community, as these workers can continue to provide services and support after the program has ended.

Also professionals have benefited from the project. Thanks to increased collaboration with peer supporters, professionals seem to have gained more knowledge about the problems VP's face which consequently led to more understanding and engagement. One of the goals of the ENSURE project was to break the cycle of intergenerational transmission of problems of VP. The roots of this kind of the problems often lead back to the (early) childhood and most people are not aware of their presence. The ENSURE training gave the peer supporters and professionals an insight into the effects of early childhood on transmission of problems to another generation. Although research shows that peer support is an appreciated method in these cases (Taft et al., 2011; Cupples et al., 2011), the project was too short to confirm the effectiveness of peer support on this matter.

Another important goal was to increase empathy and solidarity among professionals. According to the results, both empathy and solidarity increased among all parties – professionals, stakeholders, peer supports and participants. This confirms previous findings of Lievett-Jones (2020) who calls these capacities empathic imagination and intelligence.

Several limitations of the project must be mentioned. First of all the variety of groups included in the project and a small sample size makes the results not generalizable to any population of vulnerable groups. Although the results of the project are promising, the method should be repeated on a bigger sample taking into account control variables such as for example context of living or number of contacts with peer supporter. Secondly, the project has been severely affected by Covid-19. Due to the pandemic lots of contacts between peer supporters and VP have been delayed or did not take place. This had important consequences on the impact of peer support on mental health or reintegration of VP. We believe that with more (qualitative) contacts, the effects were more remarkable. Thirdly, different target groups have been taking part in the project, the effects on which we could not measure separately due to small sample sizes of each separate target group. We believe that peer support can have different effects depending on the vulnerability. This however needs to be investigated in future research.

Another limitation concerns peer supporter group. Peer supporters in our project varied in their background and whether or not they had received peer support training. Additionally, there was a lack of standardisation in the recruitment procedures for the participants. As such, a number of unmeasured confounding variables could have been relevant to the changes (or their lack) in mental functioning. Future research using more thorough screening procedures and randomization procedures are recommended. Additionally, there is a need to investigate the potential long-term effects of peer support on mental health outcomes, as well as the benefits of peer supporters themselves having access to relevant services.

Above all, the project has learned us that measuring effects of peer support is a very complicated task. The difficulty lied not only in the variation of the groups under consideration and a cross-national character of the study, but above all in the vulnerability of the respondents itself. The lack of trust among VP to other people as well as (often limited) literacy capabilities of the respondents were big obstacles in filling in validated questionnaires and taking part in round table discussions. This might have been an issue in ensuring the reliability and validity of the results. Future research should identify more common and feasible method of analyzing the effects on mental health of vulnerable groups of people, specifically with limited literacy capabilities.

6 Conclusions

There are numerous barriers to accessing professional health services by vulnerable groups, which highlights the importance of peer support as an affordable, accessible and easy-to-implement mental health resource. The results of the ENSURE project, show that peer support can be an effective tool in increasing the trust relationships between vulnerable people and professional help, mediated by peer supporters. Through ENSURE, professionals have regained awareness of prevailing stigmas about the vulnerable people which in turn helped to better understand the vulnerable target groups and encouraged unbiased viewing by the professional. Taking a low-threshold approach to contacts and not wanting to play the "professional" right away has played a crucial role in gaining VP's trust. The project helped in increasing a social network of VP and helped in gaining the VP's confidence, not only in the professionals but also in their own skills. VP as well as peer supporters have gained more self-confidence by interacting with others who are in the same situation and thus no longer feel isolated.

The results of our project indicate, that peer support may represent a valuable intervention for improving mental health outcomes among variety of vulnerable groups. Based on the learning points from the project, it is recommended that future research identifies more accessible ways of monitoring the interventions and evaluating its results, especially among vulnerable groups with low literacy capabilities. Moreover, feasibility and cost-effectiveness of formalized peer support services should be investigated.

Last but not least, it is important to mention that the support provided by volunteer mentors from externally developed peer support organizations should never duplicate or replace formal/professional support. Any support program that utilizes peer volunteers should provide training to the volunteers, such as the one developed by the ENSURE project, to ensure that they are capable of carrying out the peer support role in a responsible and culturally sensitive way.

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Appendix 1: Questionnaire items

measurements' abbreviations:

WEMWBS: Warwick-Edinburgh Mental Wellbeing Scale
SI: Luben Social Social Inclusion Scale
BRS: Brief Resilience Scale
ESEQ: Enablement Self Esteem Questionnaire
CEL: Loneliness Scale
GSE: General Self Efficacy
FSSQ: Funtional Social Support Questionnaire

1	WEMWBS	I've been feeling optimistic about the future.
2	WEMWBS	I've been feeling useful.
3	WEMWBS	I've been feeling relaxed.
4	WEMWBS	I've been feeling interested in other people.
5	WEMWBS	I've had energy to spare.
6	WEMWBS	I've been dealing with problems well.
7	WEMWBS	I've been thinking clearly.
8	WEMWBS	I've been feeling good about myself.
9	WEMWBS	I've been feeling close to other people.
10	WEMWBS	I've been feeling confident.
11	WEMWBS	I've been able to make up my own mind about things.
12	WEMWBS	I've been feeling loved.
13	WEMWBS	I've been interested in new things.
14	WEMWBS	I've been feeling cheerful.
1	SI	How many relatives do you see or hear from at least once a month?
2	SI	How many relatives do you feel at ease with that you can talk to about private matters?
3	SI	How many relatives do you feel close to such an extent that you could call on them for help?
4	SI	How many friends do you see or hear from at least once a month?
5	SI	How many friends do you feel at ease with that you can talk about private matters?
6	SI	How many friends do you feel close to such an extent that you could call on them for help?
1	BRS	I tend to bounce back quickly after hard times.
2	BRS	I have a hard time making it through stressful events.
3	BRS	It does not take me long to recover from a stressful event.
4	BRS	It is hard for me to snap back when something bad happens.
5	BRS	I usually come through difficult times with little trouble.

6	BRS	I tend to take a long time to get over set-backs in my life.
1	ESEQ	On the whole, I am satisfied with myself.
2	ESEQ	At times, I think I am no good at all.
3	ESEQ	I feel that I have a number of good qualities.
4	ESEQ	I am able to do things as well as most other people.
5	ESEQ	I feel I do not have much to be proud of.
6	ESEQ	I certainly feel useless at times.
7	ESEQ	I feel that i'm a person of worth, at least on an equal plane with others.
8	ESEQ	I wish I could have more respect for myself.
9	ESEQ	All in all, I am inclined to feel that I am a failure.
10	ESEQ	I take a positive attitude toward myself.
1	CEL	I am content with my friendships and relationships.
2	CEL	I have enough people I feel comfortable asking for help at any time.
3	CEL	My relationships are as satisfying as I would want them to be.
1	GSE	I can always manage to solve difficult problems if I try hard enough.
2	GSE	If someone opposes me, I can find the means and ways to get what I want.
3	GSE	It is easy for me to stick to my aims and accomplish my goals.
4	GSE	I am confident that I could deal efficiently with enexpected events.
5	GSE	Thanks to my resourcefulness, I know how to handle unforeseen situations.
6	GSE	I can solve most problems if I nivest the necessary effort.
7	GSE	I can remain calm when facing difficulties because I can rely on my coping abilities.
8	GSE	When I am contronted with a problem, I can usually find several solutions.
9	GSE	If I am in trouble, I can usually think of a solution.
10	GSE	I can usually handle whatever comes my way.
1	FSSQ	I have people who care what happens to me.
2	FSSQ	I get love and affection.
3	FSSQ	I get chances to talk to someone about problems at work or with my housework.
4	FSSQ	I get chances to talk to someone I trust about my personal or family problems.
5	FSSQ	I get chances to talk about money matters.
6	FSSQ	I get invitations to go out and do things with other people.
7	FSSQ	I get useful advice about important things in life.
8	FSSQ	I get help when I am sick in bed.

Appendix 2: Example questionnaire in English

Interreg 2 Seas Project Ensure

As part of the ENSURE project, we are conducting research on the impact of the project on well-being.
We would like to hear from you what your state of mind is at the beginning of this project.
You can only complete the survey once.
For questions about the study, please email us: valerie.bosmans@ap.be
We appreciate your input!

Informed consent

I declare that I have been informed of the nature, purpose, contribution, possible benefits and risks of the research and I know what is expected of me.

Please review any comment if you agree.

- ☐ I have taken note of the information form
- ☐ I have had sufficient time to think about participation and know how to reach the researchers for questions or comments
- ☐ I am aware that, since participation is anonymous, it is not possible to delete or modify my data afterwards
- ☐ I understand that participation is voluntary
- ☐ I know that my details and answers are handled confidentially
- ☐ I agree to process my data for publication
- ☐ I agree to keep my data for a period of 10 years in a secured folder of the University College Artesis Plantijn
- ☐ I know that I may withdraw at any time without consequences and I am aware of this

Code

Enter your personal code here:

Example of questions

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last two weeks. *

Please choose the appropriate response for each item:

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future.	○	○	○	○	○
I've been feeling useful.	○	○	○	○	○
I've been feeling relaxed.	○	○	○	○	○
I've been feeling interested in other people.	○	○	○	○	○
I've had energy to spare.	○	○	○	○	○
I've been dealing with problems well.	○	○	○	○	○
I've been thinking clearly.	○	○	○	○	○
I've been feeling good about myself.	○	○	○	○	○

Socio-demographic factors

What is your gender?

Choose one of the following answers

Please choose **only one** of the following:

- ☐ Men
- ☐ Female
- ☐ Gender fluid

In which year were you born?

Only numbers may be entered in this field.

Please write your answer here:

What is the highest level of school you have completed? *

Choose one of the following answers

Please choose **only one** of the following:

- ☐ Lower than primary school
- ☐ Primary school
- ☐ Secondary school
- ☐ Bachelor or higher

In which country were you born?
Choose one of the following answers
Please choose **only one** of the following:

- ☐ Belgium
- ☐ France
- ☐ The Netherlands
- ☐ United Kingdom
- ☐ Other

What is your mother tongue?
Choose one of the following answers
Please choose **only one** of the following:

- ☐ Dutch
- ☐ French
- ☐ English
- ☐ Spanish
- ☐ Turkish
- ☐ Arabic
- ☐ Other

Covid-19

To what extent have you suffered from the Covid 19 crisis?
Choose one of the following answers.
Please choose **only one** of the following:

- ☐ Not at all
- ☐ A little bit
- ☐ A lot
- ☐ Very much

Have you been in quarantaine?
Please choose **only one** of the following:

- ☐ Yes
- ☐ No

If Yes, How many days?
Only numbers may be entered in this field.
Please write your answer here:

Appendix 3: Consent form

Ensure

Consent participants

Informed consent

I declare that I have been informed of the nature, purpose, contribution, possible benefits and risks of the research and I know what is expected of me.

Please review any comment if you agree.

- ☐ I have taken note of the information form
- ☐ I have had sufficient time to think about participation and know how to reach the researchers for questions or comments
- ☐ I am aware that, since participation is anonymous, it is not possible to delete or modify my data afterwards
- ☐ I understand that participation is voluntary
- ☐ I know that my details and answers are handled confidentially
- ☐ I agree to process my data for publication
- ☐ I agree to keep my data for a period of 10 years in a secured folder of the University College Artesis Plantijn
- ☐ I know that I may withdraw at any time without consequences and I am aware of this

Date:

Appendix 4: Information sheet

Information and instruction participants ENSURE

Introduction

The AP University of Applied Sciences Antwerp and HZ University of Applied Sciences are researching the effects of peer support on [specific target group]. It is important to leave no one behind at this fragile stage. A buddy/peer can provide support complementary to professional help. ENSURE wants to reach all everybody, because everybody counts!

If you are participating in this study, you should know that:

- This study was evaluated by an independent ethics advisory committee (SHW_19_34). The ethical committees have the task of protecting those who participate in clinical trials. They check that your rights as a participant in a study are respected; whether the study is scientifically relevant and ethical. The ethics committees shall deliver an advise on this subject in accordance with Belgian law of 7 May 2004. You should in no way regard the positive advise of the ethics committees as an incentive to participate in this investigation.
- Data obtained from this study are not provided to third parties (published, neither presented in talks, or by mutual agreement) in such a way that the results or other findings can be traced back to you as a participant. We will handle your answers confidentially and will do everything we can to ensure your anonymity. Your data is encrypted as much as possible, and in any case it will not be disclosed to persons other than those involved in the conduct of the investigations. Of course, the data will be anonymised after the data collection and publication will always be published anonymously. We will not demand your IP address, which you personally link to your internet address, when we have received your replies. This data is destroyed so that we can keep and process your responses anonymously.
- Your participation in this study means that you agree that the researchers collect data about you, and you have the right to ask the researchers what data is being collected and for which it is being used. You have the right to look into and preserve your own answers; this can be done by printing out your own answers. We would like to stress once again that we will handle your answers confidentially and process them anonymously.
- Because your participation is anonymous and no personal data is collected that makes you identifiable. As a result, it is also not possible to view your data or to adjust it afterwards.
- Participation may be refused at any time and you reserve the right to withdraw from the investigation at any time without any further disadvantages or consequences. Participation is entirely voluntary. The researchers have a known identity and can be reached for comment or questions.
- You will not receive any compensation for your participation in this research. However, your participation will also not entail any additional costs.
- Your participation in this study will not pose any health risk. But your participation will also bring a personal benefit. The questions we ask you sometimes have a very personal character. If you notice that these questions trigger emotions such as anger or sadness and you prefer to stop filling out the questionnaire, simply stop filling out the questionnaire.
- Results will be announced online:

Contact

If you would like additional information, but also in the case of questions or comments, please contact the researchers: Corrine Keemink (corrine.keemink@ap.be), Inge Meyvis (inge.meyvis@ap.be) and Valerie Bosmans (valerie.bosmans@ap.be).

The researchers state that they have written the necessary information on this investigation using this information document. They confirm that there has been no pressure on the participant to agree to participate in this investigation and to be prepared to answer any additional questions.

They confirm to work in accordance with the ethical principles set out in the Helsinki Declaration, "Good Clinical Practice" and the Belgian Law of 7 May 2004 on experiments on the human person.

Appendix 5: Information sheet guardian/parent

Information and instruction participants ENSURE

Introduction

The AP University of Applied Sciences Antwerp and the HZ university of applied sciences is researching the effects of peer support on migrants. You are the parent/guardian of a migrant minor that will participate in the ENSURE project, therefore, we would like to inform you about the project.

ENSURE finds it important to leave no one behind at this fragile stage. A buddy/peer can provide support complementary to professional help. ENSURE wants to reach all everybody, because everybody counts!

If you are participating in this study, you should know that:

- This study was evaluated by an independent ethics advisory committee (SHW_19_34). The ethical committees have the task of protecting those who participate in clinical trials. They check that your rights as a participant in a study are respected; whether the study is scientifically relevant and ethical. The ethics committees shall deliver an advise on this subject in accordance with Belgian law of 7 May 2004. You should in no way regard the positive advise of the ethics committees as an incentive to participate in this investigation.
- Data obtained from this study are not provided to third parties (published, neither presented in talks, or by mutual agreement) in such a way that the results or other findings can be traced back to you as a participant. We will handle your answers confidentially and will do everything we can to ensure your anonymity. Your data is encrypted as much as possible, and in any case it will not be disclosed to persons other than those involved in the conduct of the investigations. Of course, the data will be anonymised after the data collection and publication will always be published anonymously. We will not demand your IP address, which you personally link to your internet address, when we have received your replies. This data is destroyed so that we can keep and process your responses anonymously.
- Your participation in this study means that you agree that the researchers collect data about you, and you have the right to ask the researchers what data is being collected and for which it is being used. You have the right to look into and preserve your own answers; this can be done by printing out your own answers. We would like to stress once again that we will handle your answers confidentially and process them anonymously.
- Because your participation is anonymous and no personal data is collected that makes you identifiable. As a result, it is also not possible to view your data or to adjust it afterwards.
- Participation may be refused at any time and you reserve the right to withdraw from the investigation at any time without any further disadvantages or consequences. Participation is entirely voluntary. The researchers have a known identity and can be reached for comment or questions.
- You will not receive any compensation for your participation in this research. However, your participation will also not entail any additional costs.

- Your participation in this study will not pose any health risk. But your participation will also bring a personal benefit. The questions we ask you sometimes have a very personal character. If you notice that these questions trigger emotions such as anger or sadness and you prefer to stop filling out the questionnaire, simply stop filling out the questionnaire.
- Results will be announced online:

Contact

If you would like additional information, but also in the case of questions or comments, please contact the researchers: Corrine Keemink (corrine.keemink@ap.be), Inge Meyvis (inge.meyvis@ap.be) and Valerie Bosmans (valerie.bosmans@ap.be).

The researchers state that they have written the necessary information on this investigation using this information document.

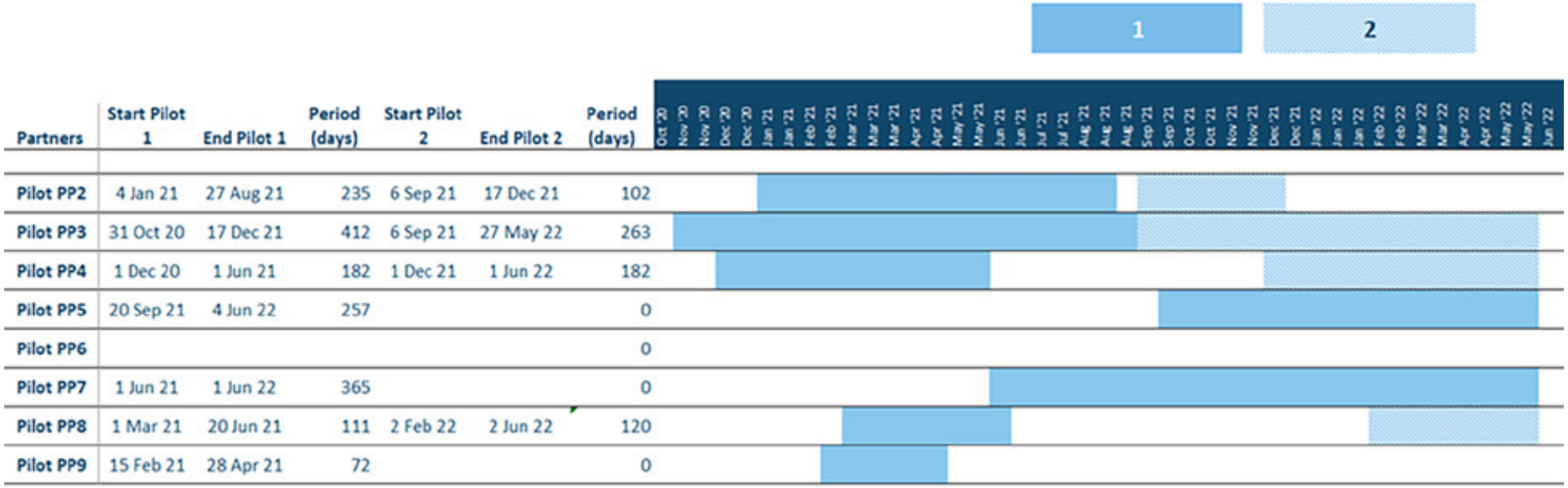
They confirm that there has been no pressure on the participant to agree to participate in this investigation and to be prepared to answer any additional questions.

They confirm to work in accordance with the ethical principles set out in the Helsinki Declaration, "Good Clinical Practice" and the Belgian Law of 7 May 2004 on experiments on the human person.

Appendix 6: Overall planning

Based on the information given in de timeframe (January) this timeline was created.

Ensure



Partners	Start Pilot 1	End Pilot 1	Period (days)	Start Pilot 2	End Pilot 2	Period (days)
Pilot PP2	4 Jan 21	27 Aug 21	235	6 Sep 21	17 Dec 21	102
Pilot PP3	31 Oct 20	17 Dec 21	412	6 Sep 21	27 May 22	263
Pilot PP4	1 Dec 20	1 Jun 21	182	1 Dec 21	1 Jun 22	182
Pilot PP5	20 Sep 21	4 Jun 22	257			0
Pilot PP6						0
Pilot PP7	1 Jun 21	1 Jun 22	365			0
Pilot PP8	1 Mar 21	20 Jun 21	111	2 Feb 22	2 Jun 22	120
Pilot PP9	15 Feb 21	28 Apr 21	72			0

Appendix 7: Operationalization of concepts = Interview Questions

Concept: Self-efficacy

Questions:

1 To what extent the ENSURE pilot has contributed to your **confidence in your own abilities** as a professional to work with vulnerable target groups (***specific target group per pilot partner***)? What makes you think this way?

2 Do you think that your contribution enables(ed) participants (***specific name of your target group, e.g. statushouders***) to successfully complete the (ENSURE) peer-to-peer pilot? In what way?

Concept: Breaking of intergenerational transmissions of problems

Introduction:

In case of vulnerability we often speak of 'intergenerational transmission of problems'. This means that the problems such as for instance being in care, poor parenting, violence, substance abuse, low aspirations, aggression, non-attendance in school and few or no qualifications are transferred from one generation to another. Often the roots of this kind of behavior are to be found in the (early) childhood.

Questions:

3 Have you noticed that the peers (you are/were interacting with or you have heard of) (could) have (had) problems like these? Can you give examples?

4 To what extent do you consider the ENSURE peer-to-peer methodology successful for breaking this cycle? Can you give example

Concept: Increased collaboration between stakeholders & peer supporters, giving better access to VP & giving VP the support they need

Questions:

5 During the period of the pilot, have you been aware of the collaboration of the peer supporters with other stakeholders (for instance, peer supporter being in bringing VP in contact with institutions such as ..... ***examples per pilot partner***)?

5.1 if yes:

5.1.1 How do you assess this collaboration?

5.1.2 What are your thoughts of it?

5.1.3 Any points for improvement?

5.1.4 To what extent do you feel like this collaboration (*between peer supporters and other stakeholders*) has increased the **access of professional help to VPs**?

5.1.5 And the other way round: to what extent do you feel like this collaboration (*between peer supporters and other stakeholders*) has increased the **access of VPs to professional help**?

Concept: Bridging the gap between VPs unmet needs and professional organizations

One of the main objectives of the ENSURE project was to bridge the gap between VP's unmet needs and professional organizations.

Questions:

6 Do you know of peers that have actually started to access professional support?
   6.1 **If yes**, can you give examples?
   6.2 **if not**, do you think they might feel more comfortable in the future to use it? (*to be more open for help?*)

Concept: Personal development for peer support volunteers leading to engagement with the labor market

Questions:

7 How do you assess the **personal development of peer supporters**, as a result of our peer-to-peer project?
   7.1 **If yes**, can you give examples of that? (*what qualities did they develop as a result of the project*)
8 Do you think that the participation in the project has **increased their chances on the labor market** (*such as getting a particular job or an internship*)?
   8.1 **if yes**, can you give examples?

Concept: Increase professional and non-professional support (support volunteers)

Questions:

9 To what extend you consider the peer-to-peer methodology in this study contributing to the support VPs receive both professionally and non-professionally? Explain

Concept: Increase knowledge and transferable skills peer-to-peer community workers and target groups

Questions:

10 To what extent do you think VPs have gained knowledge and skills by participating in this project?
   10.1 **if yes:** give examples (*what knowledge, what skills?*)
11 To what extent do you think peer supporters have gained knowledge and skills by participating in this project?
   11,1 **if yes:** give examples (*what knowledge, what skills?*)

Concept: Increase reciprocity between peer-to-peer community workers and target groups

Questions:

12 How do you rate the reciprocity (mutual understanding, cooperation) between VPs and peer supporters?
   12.1 To what extent has this increased as the project progressed?

Concept: Increase empathy solidarity (*healthcare*) professionals

Questions:

13 To what extent can you empathize with the experiences of the VPs?
   13.1 How has the project contributed to this?

Concept: Decrease stigmatization among professionals

Questions:

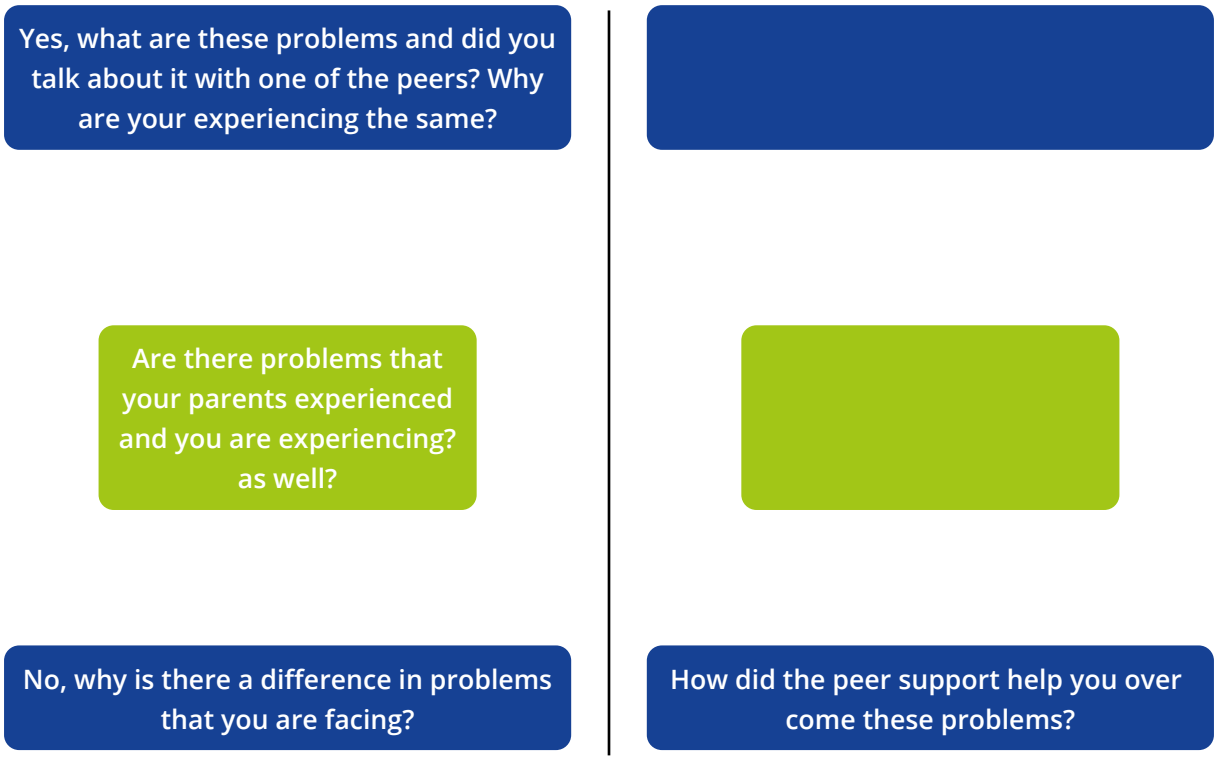
14 Do you think there is/was a certain way of 'stigmatization' of vulnerable group of people among professionals? Please, give examples

15 To what extent has the project made you more aware of this stigmatization?

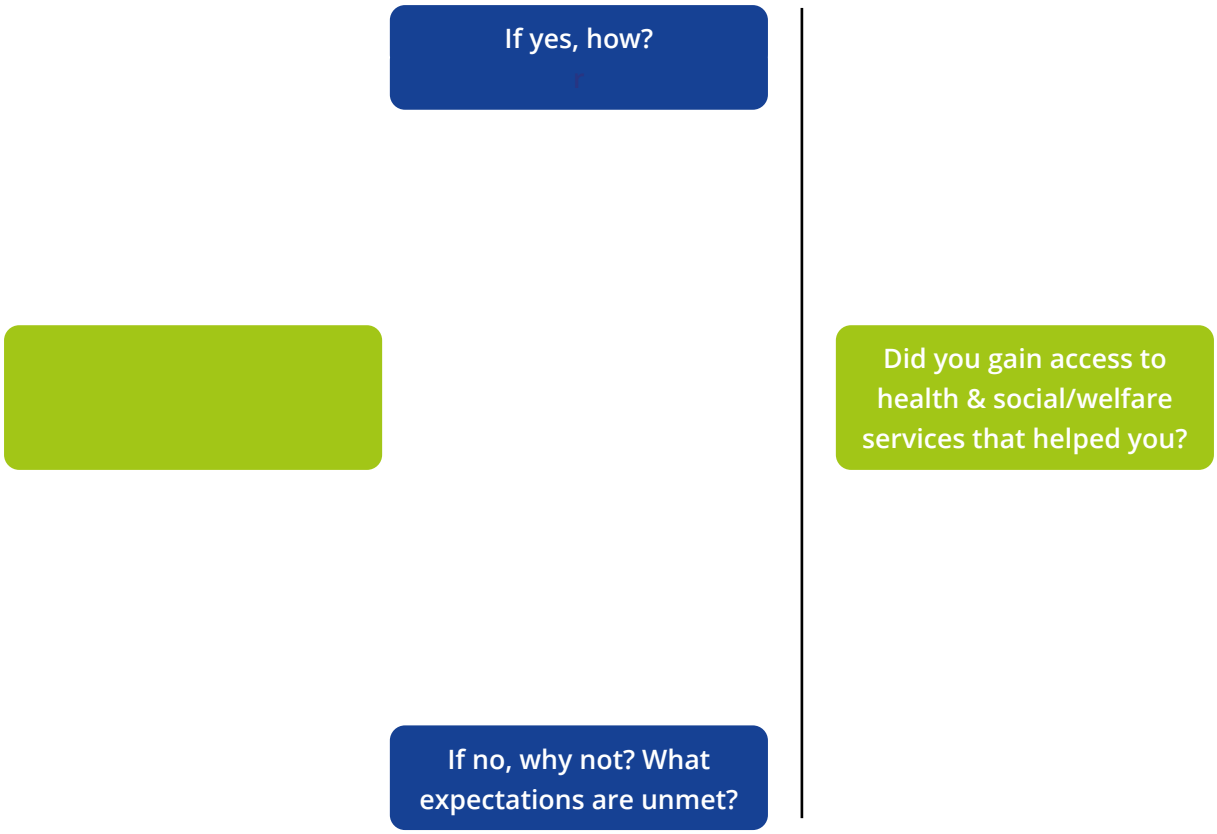
15.1 **If yes**, do you feel like you have changed your behavior according to that? (please give examples)

Appendix 8: Mind map round table discussions

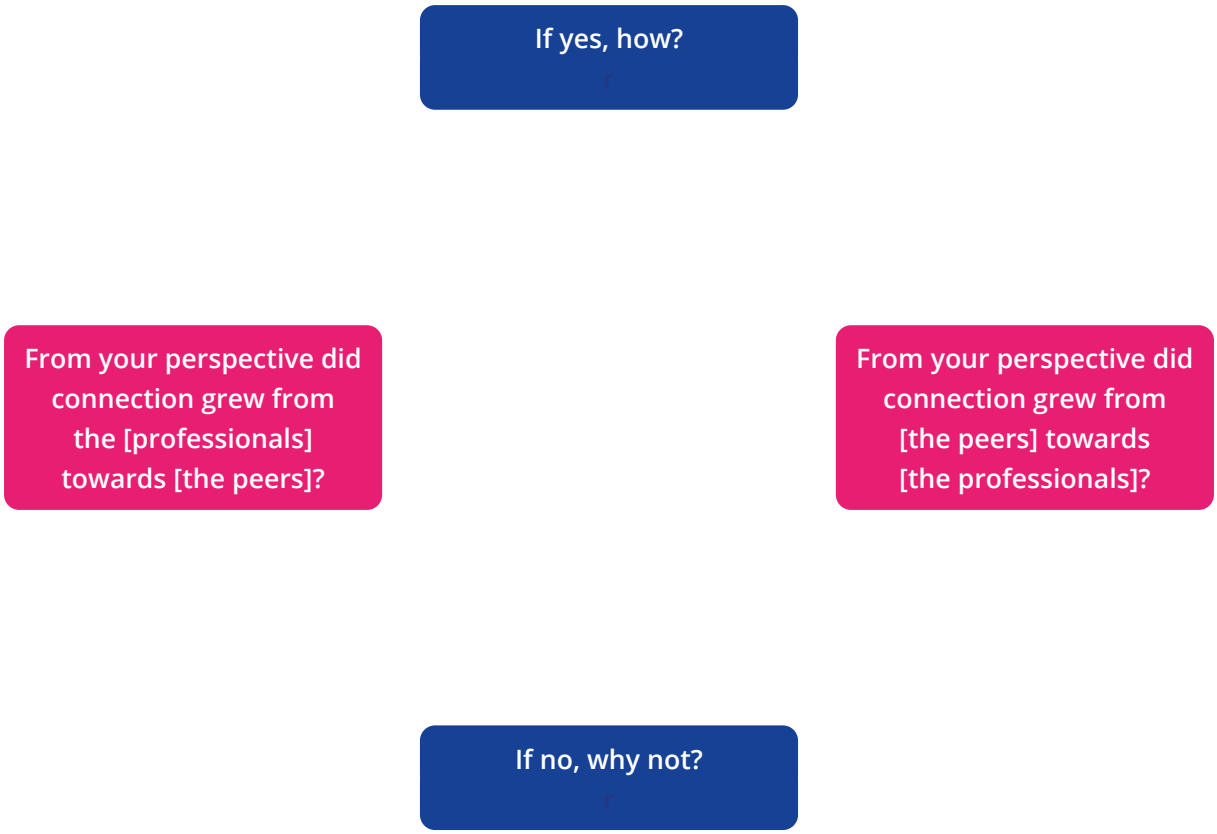
1 Breaking of intergenerational transmission of problems



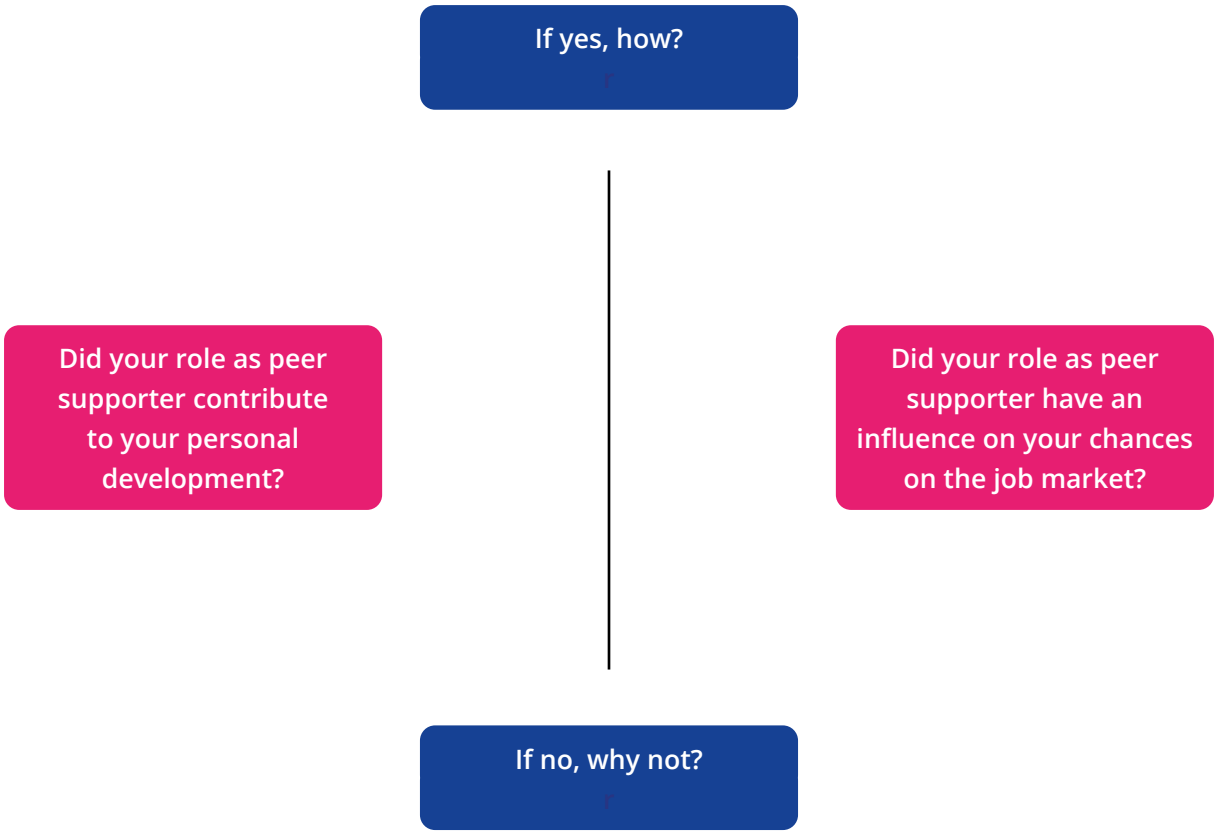
2 Bridging the gap between VP's unmet needs and professional organisations – 5. Increase access and use of health & social/welfare services



3 Increased collaboration between stakeholders & peer supporters giving better access to VP & giving the support they need + Increase professional and non-professional support (support volunteers)



4 Personal development for peer support volunteers leading to engagement with the labour market



5 Increase knowledge and transferable skills peer-to-peer community workers

If yes, how?

Did you have the chance to learn from the project?

If no, why not? And what could have helped you?

6 Increase reciprocity between peer-to-peer community workers and target groups

If yes, how did the peer-to-peer support contribute?

Did you feel as if you got to understand [peer supporter] better throughout the project?

Did you feel as if you got to understand [peer] better throughout the project?

If no, why not? And how could this have been supported?

7 Increase empathy solidarity healthcare professionals

If yes, how? And what did you learn?

Did you experience during the project that [professionals] are more attentive to your situation?

Did you experience during the project that [professionals] are more attentive to the personal situations of the peers?

If no, why not?

8 Decrease stigmatisation among (health/social welfare professionals)