Butterfly

Eating Disorders Peer Workforce Guidelines

Butterfly Foundation
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Contents

1. Glossary

The following terminology is used throughout these Guidelines.

'Carers' - refers to people who provide care to a person experiencing or recovering from an eating disorder and/or other mental health challenge, including those who may have fully recovered. A carer may be a family member such as a parent or spouse, extended family or kin, a friend, community member or any other type of supporter.

'Carer Peer Workers' – refers to Peer Workers as defined below but specifically refers to designated carer-to-carer individual or group peer work roles when used in these Guidelines.

'Co-design' – refers to the engagement of service or program beneficiaries in the design of projects, products, services, research and other outputs so that they better meet their intended purpose (drawing on the work of Roper, Grey & Cadogan, 2018).

'Co-production' – refers to a set of values and principles whereby beneficiaries of services and programs are involved in or leading the definition of problems, the design and delivery of solutions, and the evaluation of outcomes (drawing on the work of Roper, Grey & Cadogan, 2018). Co-production goes beyond collaboration as it seeks consumer leadership from the beginning of an initiative in the context of an equal partnership with service providers and other professionals. Co-production is made up of co-planning, co-design, co-delivery and co-evaluation.

'Guidelines' - refers to the Eating Disorders Peer Workforce Guidelines.

'Lived Experience' – refers to i) a person with their own experience of a mental health condition, which may include service use and either periods of recovery or full recovery; and ii) a person who has cared for or supported someone who has experienced/is experiencing a mental health condition. In these Guidelines 'Lived Experience' is used to refer specifically to experience of an eating disorder/eating disorders.

'Lived Experience Expertise' - refers to the application of what has been learned through lived experience to inform and influence individual, collective and systemic outcomes (drawing on the work of Byrne & Wykes, 2020).

'Lived Experience Workforce' – in these Guidelines this term is used as a catch-all term to refer to the wide field of lived experience roles which include peer workers, and also non-peer roles such as governance roles, advisory services, research roles, individual advocacy roles and systemic advocacy roles.

'Moral distress' – refers to a condition where a person knows the ethically correct action to take but they are constrained from taking that action. Moral distress can occur in ethically complex healthcare environments such as acute and critical care units.

'Peer workers' – refers to paid peer workers who draw upon their own personal lived experience of mental illness and recovery to support those who are accessing mental health care (sometimes called 'Recovery Peer Workers'). In these Guidelines this term is used to captures a broad range of peer roles, including but not limited to: peer support workers who offer one to one support, such as social support or meal support; peer worker roles which facilitate/co-facilitate group sessions, such as support or knowledge and skill building; recovery coaches; peer mentors, including those working in online and in-person mentoring programs; senior peer workers, and peer supervisors. In line with the purpose and scope of these Guidelines, other forms of lived experience work such as advocacy and advisory roles are excluded.

'Participants' – refers to people who are receiving or benefiting from the work of peer workers. In various settings this group of beneficiaries may be called different terms such as 'consumers', 'service users', 'mentees', 'patients' or 'people with lived and living experience'. It is noted that there are a range of views on this terminology and that different terms may be preferred in the context of specific health care and community settings.

'Peer drift' – refers to when a peer worker begins to inadvertently move away from their peer role and towards either a clinical or friendship stance. Peer drift can occur when there is a disconnect in the peer relationship or moving away from the values of peer support. It may be more likely to occur when a peer worker does not feel

supported in their recovery-oriented role and can lead to breaking of boundaries set by the peer work contract. For example, peer workers may become uncomfortable sharing their recovery story, and therefore focus on barriers, symptoms and diagnoses.

'Recovery' – in general, recovery refers to a process of change or a state of being where life is no longer dominated by eating disorder feelings, beliefs, thoughts and behaviours. However, there is no universally agreed definition of recovery from an eating disorder, including in relation to readiness to become a peer worker. There is emerging support for developing person-centred definitions that are driven by values, improved wellbeing and quality of life, rather than definitions driven by medicalised models based on symptom reduction.

'Volunteer peer workers' – peer workers who do not receive payment for their work, or as Volunteering Australia terms it, 'time willingly given for the common good and without financial gain' (Volunteering Australia, 2015). Volunteer peer workers will likely have a range of employee-like conditions such as position descriptions outlining a defined role and responsibilities, mandatory training, induction and supervision. Volunteers also have responsibilities to comply with policies such as child safety and workplace health and safety. Volunteers also have rights, which include the right to work in a safe and supportive environment with appropriate infrastructure and effective management practices (Volunteering Australia, 2015).

2. Introduction

Purpose of the Guidelines

Butterfly Foundation ('Butterfly') was funded by the Commonwealth Department of Health and Aged Care ('Department') to develop Eating Disorders Peer Workforce Guidelines. The development of these Guidelines follows on from the Department's funding of research to understand the landscape of peer work in the treatment and management of eating disorders (Butterfly Foundation, 2023). The Guidelines provide recommendations for good practice that are based on the best available evidence and expert perspectives, including the expertise of those with lived experience.

The purpose of the Guidelines is to support the development and professionalisation of the peer workforce for the care of people experiencing eating disorders and their carers, families, supports, and community. The Guidelines will outline strategies for embedding peer workers as partners in providing care within the health system, taking account of individual needs and preferences, and ensuring that participants can make informed decisions about their care.

Background

The broader context within which the Guidelines have been developed includes movement within mental health policy, driven by lived experience advocacy over recent years to value and invest in lived experience knowledge and skills, including through dedicated roles. Driven initially by the mental health consumer/survivor movement, there is now increasing recognition across all areas of the mental health service system of the need to balance learned experience (experts-by-profession) with lived experience (experts-by-experience). This recognition has occurred at Commonwealth and State and Territory levels of government within policy development and within practice through service/program development, delivery and review. At the National Level, this includes the Commonwealth Government funding of the National Mental Health Commission to create the National Lived Experience (Peer) Workforce Development Guidelines (2021) and accompanying resources. The Commonwealth Government has also announced funding for the establishment of two independent national mental health lived experience peak bodies – one representing consumers, and the other representing carers, families and kin (Department of Health and Aged Care, 2023).

Several state and territory peer workforce guidelines and frameworks have been developed in recent years. These include the Western Australian Western Australian Lived Experience (Peer) Workforces Framework (2022) and the Queensland Framework for the Development of the Mental Health Lived Experience Workforce (Byrne et

al., 2019). However, these guidelines to not specifically address eating disorders.

Eating Disorders Victoria has developed a position paper on Lived Experience and Peer Work, and Eating Disorders Queensland has created a co-designed Lived Experience Practice Framework (2023).

A list of these and other resources consulted in the development of these Guidelines is provided at Appendix A.

The eating disorder system of care as a whole has continued to evolve, with leadership and coordination at the national level by the National Eating Disorders Collaboration and the establishment of the Australian Eating Disorders Research and Translation Centre. The further development of the eating disorders lived experience workforce is a focus area of the National Eating Disorders Strategy 2023-2033 (Workforce Standard 3) (2023).

Significance of the Guidelines

A growing body of evidence has found that accessing peer support services has positive impacts on patient outcomes (Lewis & Foye, 2021; National voices and Nesta, 2015). A recent review found that the benefits of incorporating peer support services impacts not only the recipients of mental health services but extends to the peer support workers themselves and the whole health care system. The authors suggest that "as an evolving culture, peer support has the opportunity to forge not just mental health system change but social change as well" (Shalaby & Agyapong, 2020).

Despite this importance, those who access or seek to access peer support often face challenges in finding the support they need. For those seeking to work as paid peer workers, challenges include:

- Limited funding for peer worker roles and limited availability of positions
- Lack of or inconsistency in remuneration
- Inadequate formal training
- Limited learning and development opportunities for peer workers including peer supervision
- Challenges to maintaining personal wellbeing.

Funding is outside the scope of these Guidelines; however the other listed challenges are addressed elsewhere in this document.

While there are national peer work guidelines for the mental health sector as a whole and several state-based frameworks and guides, these Guidelines extend on the NEDC Peer Work Guide (2019) to incorporate recent system developments and extensive lived experience engagement.

Significance of the Guidelines

We heard from many people who wanted to access peer work but were not able to, whether due to lack of awareness (including lack of awareness from their health professionals), lack of services in their geographical area, or other barriers. These responses highlight the importance of better integrating peer work within levels of the stepped system of care and the need to increase referral pathways to peer work, either within a service or externally.

"Throughout the years after, there was no mention of peer workers, it is only from my own research." (Survey Question 31, response 22)

"I am a migrant to Australia. Developed my eating disorder prior to my arrival to Australia. When I arrived I was looking for support for my ED, and went to my GP and to psychologists to continue getting the help I needed. No one ever suggested peer work to me as an option." (Survey Question 31, response 10)

Aim of the Guidelines

The Guidelines will set out principles to guide eating disorder peer work and clarify minimum education and training standards to support the ongoing development and embedding of a safe, effective and sustainable peer workforce for eating disorders.

Target audience for the guidelines

- Decision makers involved in policy development and investment in the peer workforce
- Organisations and individuals involved in provision of eating disorders related prevention, clinical and support services
- Lived experience organisations and peak bodies advocating for system reform
- Organisations that currently have or seek to incorporate an eating disorders peer workforce
- Education and training institutions, and peak bodies

Other mental health organisations and service providers who employ generalist peer workers may also find elements of these Guidelines useful.

Areas covered by the Guidelines

The Guidelines will provide guiding principles for the development of all forms of eating disorders peer work. Guidance includes: key considerations (defining how eating disorder peer work extends on other types of mental health peer work); education and training requirements; recruitment and onboarding; supervision requirements; accountability and safe practice (including supporting peer worker wellbeing); integration with the care team; accessibility; and organisational culture.

3. Purpose and Scope

There is a thriving volunteer and paid eating disorders peer workforce in Australia, comprised of skilled individuals with lived experience. These Guidelines aim to support continuity and future growth of this workforce by outlining standards and principles informed by research and expert consultation. They provide guidance for organisations with or building peer workforces to respond safely to community needs.

The Guidelines support organisations at all stages of peer workforce development. Growing interest across Australia spotlights the timeliness of investment in guidance surrounding learned expertise and ethical inclusion of those with lived experience in service delivery.

Within scope

- While there are broad range of lived experience and lived expertise roles in Australia (see Glossary), these Guidelines only refer to roles that work directly with (or supervise those working directly with) a person receiving treatment from an eating disorder or with the people in their support network. This includes peer workers and carer peer workers. While it is acknowledged that Guidelines are likely required for other lived experience roles such as leadership, advocacy and research roles within the eating disorder field, these are outside of the scope of the current project.

- The Guidelines are intended to cover paid peer worker roles. However, depending on how they are funded, different organisations may or may not have the capacity to pay their lived experience workforce. While the Guidelines strongly recommend that all types of peer work are remunerated, it is acknowledged that some roles may be considered to be unpaid/voluntary/internship based. Therefore, several aspects of the Guidelines (such as the 'Guiding principles') will also apply to such volunteer roles.

Out of scope

- Broader lived experience workforce (e.g., advocacy, advisory roles, senior management roles)
- Detailed guidance for specific occupations within the health care ecosystem or parts of the system (e.g., guides for managers, executives or PHNs; case studies)
- Employment standards (e.g., specific recommendations on pay and conditions)
- Volunteer workforce guidance

4. Guideline development process

The Guidelines were developed based on a series of activities from October 2022 to September 2023, including collaboration through a sector Working Group, individual meetings and correspondence with stakeholders, a multi-stage lived experience engagement strategy, a review of existing lived experience guidelines and frameworks, and desktop research. These activities are summarised in Appendix B.

Review of findings from An eating disorder-focused peer workforce: Needs assessment (Butterfly Foundation, 2023)

Review of relevant state and territory lived experience and peer workforce frameworks and guidelines

Stakeholder engagement and primary research

- Ideation workshops with Butterfly Foundation's Lived Experience Community Insights Group
- Eating Disorders Peer Workforce Guidelines Working Group
- Online survey of people with lived experience of eating disorders
- Focus groups with peer workers and peer work supervisors

- Focus group with people who have accessed peer work
- Lived experience co-design workshop
- Working Group review of draft Guidelines
- Lived experience consultation group review of draft Guidelines
- A broader group of people with lived experience of peer work provided written feedback on the draft Guidelines

Review of final Guidelines

- Working Group review of Guidelines
- Butterfly Foundation Board's Safety and Quality Committee review of the Guidelines

- Review of the Guidelines by the Australian Government Department of Health and Aged Care

5. Guiding principles and key considerations

Guiding principles

The following eight principles were developed through two ideation workshops with a group of people with lived experience of eating disorders at the beginning of the project – Butterfly Foundation's Lived Experience Community Insights Group. The principles were refined by the Guidelines authors and presented to the Eating Disorders Peer Workforce Guidelines Working Group for discussion. The principles were ranked in order of importance by respondents to a lived experience survey, along with an opportunity to identify any gaps or new suggestions.

The following guiding principles were created as a result of this lived experience-led iterative process:

1. Adequate training and supervision, to ensure that peer workers have the skills and knowledge required to provide safe and effective support

2. A recovery-oriented approach, emphasising hope for recovery, self-determination and empowerment

3. Employing organisations are committed to culture change, including practices in place to ensure that peer workers are valued and respected

4. Prioritisation of peer workforce wellbeing and safety, with a clear scope of practice and access to sufficient support

5. Accessibility, including matching of peer workers to peer work recipients based on participant needs and presentation as much as possible and as appropriate

6. Professional and person-centred, including being non-judgemental, inclusive and trauma-informed

7. Accountable and safe practice, including maintaining appropriate professional boundaries

8. Integration within the care team, to serve the best interest of the participant

These Guidelines set out the conditions needed to bring these principles to life in support of a safe, effective and sustainable eating disorders peer workforce. The next section begins with an exploration of how eating disorders peer work extends on other types of mental health peer work, including what makes eating disorders peer workers unique.

Key considerations

Taking a recovery-oriented approach

The recovery-oriented approach in mental health care focuses on developing meaningful, fulfilling lives centred around individual strengths. This holistic wellbeing model emphasizes self-determined, personalised care over a conventional disorder-fixated approach. Implementing recovery orientation requires organisational commitment at all levels, appropriately supporting diverse workforces including those with lived expertise. Core practices foster hope, inclusion, personal goal-setting and empowerment.

In eating disorders, recovery orientation means compassionately supporting individuals to sustainably overcome illness and achieve wellness. Grounding services in hope and collaboration means celebrating agency in healing while addressing shame or frustration. Regardless of diagnosis or duration, the approach fundamentally fosters flexibility and control over finding meaning in life beyond disordered behaviours.

Peer workers' own lived experience

In Australia, peer workers provide vital mental health support with lived expertise uniquely fostering connection, hope and recovery. A large international review recently found that that the inclusion of people with lived experience of a specific health condition can lead to better health outcomes (National Voices and Nesta, 2015). Furthermore, recent research (Butterfly Foundation, 2023) and lived experience engagement undertaken for these Guidelines has highlighted that there are some unique considerations for peer work within the context of eating disorders. Factors to be considered in developing this workforce should include:

1. Specialised knowledge from lived eating disorders experience enables safe, compassionate support. If it is not possible to provide peer workers with eating disorders personal experience, they must have a lived experience of mental ill-health, be in recovery, and must undergo specialised training.

2. The sensitivity of peer workers and of individuals receiving care to triggers around eating, exercise and body image requires thoughtful language and non-judgment. Ensuring appropriate and ongoing training and supervision of peer workers is critical to address these nuanced aspects of eating disorders peer work.

3. Collaborating across the required multidisciplinary teams involved in eating disorder treatment necessitates an understanding of the role of each team member, the treatment process, terminology, and integration within a broader treatment team.

4. Eating disorder peer work often emphasises a recovery-oriented approach. Peer workers in this field promote hope, self-empowerment, and very importantly, the belief that recovery from an eating disorder is possible.

5. Eating disorders present unique challenges, including distorted body image, harmful dieting and compensatory behaviours, significant psychiatric risk, co-existing conditions, and serious medical complications. Addressing stigma, risks and complications needs tailored, informed interventions and resources.

While mental health peer work shares principles of lived experience and empathy, eating disorders support requires specialised understanding. Engagement revealed eating disorders peer workers should ideally have related lived expertise.

The carer peer workforce

In the mental health field, the inclusion of family members as partners of the treatment team has been highlighted as a significant aspect of shift from clinic-based practice to community-based service models (Shalaby & Agyapong, 2020). This shift has extended into the eating disorders sectors with families and loved ones being identified as instrumental to supporting someone through a journey to a strong recovery.
The carer peer workforce is an important part of the overall peer workforce and given this, families and loved ones entering the peer workforce need to be equipped with skills, resources, and support during this process.

Without access to this appropriate level of psychoeducation, skills-training, and support, carers and families can experience distress and lack of confidence to navigate the challenges faced when supporting someone with an eating disorder. Some of the key challenges experienced by carers identified in the literature (Beale, McMaster & Hillege, 2005; Butterfly Foundation, 2012; Fletcher et al, 2021; Treasure, 2009) and through the lived experience engagement undertaken for this project include, but are not limited to:

1. Navigating an unfamiliar journey: Caring for someone with an eating disorder can be a very unfamiliar journey, as aspects of the caring role can be counterintuitive to the usual relationship to the individual they are caring for. Carers often encounter difficulties accessing appropriate resources, information, and support services. Navigating the healthcare system can be complex and burdensome. A lack of awareness about available support services or being faced with limited services to access can leave carers feeling overwhelmed and unsure about how best to help their loved ones.

2. Emotional toll: Supporting a loved one's battle with an eating disorder can be emotionally exhausting and place an immense burden on the carer, and can contribute to carer's own mental health challenges.

3. Blame: Carers of individuals with eating disorders can face unwarranted blame and guilt, as they may be unfairly held responsible for their loved one's illness, despite the complex and multifaceted nature of eating disorders. This blame can intensify the emotional burden on carers and hinder their ability to provide support to their loved one.

4. Stigma and lack of support: Carers of someone with an eating disorder often face stigma, with their role and experiences sometimes misunderstood or trivialised by others who may not fully grasp the complexities and impact of the condition on both the individual and their support network.

5. Isolation: Carers of someone with an eating disorder can feel isolated due to stigma, shame and lack of support. The lack of understanding from others of the family's experiences can reduce the supports that may otherwise be available when caring for someone with a significant illness.

6. Strained relationships: The demands of caring for someone with an eating disorder can strain relationships with that individual, as well as create conflict with partners, other children, and other family members.

> **Listening to Lived Experience**
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> "I thrived with the specific support I received in the online forum. It was parents and caregivers only. We had the unique understanding that children were all different. We could then wipe tears and encourage each other that 'the only way out was through' it had to be endured but recovery was possible. I held on so tight to those who had success and were always shining a light for me to follow out of the despair." (Survey Question 28, response 1)

Recognising, acknowledging and addressing these challenges is crucial to support and empower carers in their roles within the care team. Accessing carer-led programs can be immensely beneficial as such programs offer essential knowledge, tools, and support to carers to help them better understand and navigate the challenges of supporting someone with an eating disorder. Carers of those with eating disorders are an integral part of the care team as they are often tasked with refeeding their loved one, providing meal supervision and support, and other essential components of treatment (NEDC, 2018). The role of carers in the eating disorders care team is a crucial one and it is necessary to have programs that can support carers to be more confident in their ability to support the recovery of their loved one.

Numerous benefits of engaging in carer-led (or carer co-facilitated) programs such as skills-based programs, 1:1 peer work and support groups have been reported both in the literature (Hannah et al, 2022; Shepherd et al, 2013; Treasure & Nazar, 2016) and in lived experience engagement undertaken for these Guidelines. Some of the main benefits are summarised below:

1. Improved understanding: Carer-led skills training provides caregivers with a deeper understanding of eating disorders, including their causes, symptoms, and treatment options. This knowledge can help carers recognise warning signs, triggers, and potential relapse indicators, allowing for early intervention and support.

2. Enhanced communication: Effective communication is vital in supporting someone with an eating disorder. Carer-led skills training programs such as Collaborative Care Skills Workshops aim to teach carers how to communicate with their loved one in a supportive, non-judgmental, and non-confrontational manner. This helps to foster trust and open lines of communication between the carer and the individual with the eating disorder.

3. Increased confidence: Carer-led skills training can help carers become better equipped to support their loved one through various treatment phases and across treatment settings. Lived experience consultations and feedback from carer program providers indicate that supported carers are able to more confidently navigate the various challenges they face in their caring role.

4. Enhanced recovery outcomes: When carers are well-informed and actively involved in the treatment process, it can positively impact the individual's recovery outcomes. A supportive and informed caregiving environment can contribute to the overall success of the treatment plan.

5. Myth busting: Eating disorders are often accompanied by stigma and misconceptions. Carer-led skills training can help dispel myths and reduce stigma, creating a more supportive environment for both the carer and the individual with the eating disorder.

6. Maintaining the relationship: An aspect of learning about eating disorders involves understanding that the eating disorder is a separate entity to the individual's true self and recognising that the individual is not the illness itself. Such separation, while often intuitive, can sometimes understandably get lost in the daily struggles that carers face when supporting their loved ones. Skills-training and carer-led support programs provide a space to reset when there is a misalignment and can lead to increased empathy and compassion in carers. This allows them to be more patient and understanding in supporting their loved one, thus maintaining the relationship with their loved one which is at the core of the recovery journey.

7. Enhanced coping strategies: Caring for someone with an eating disorder can be emotionally and physically demanding. Carer-led skills training equips carers with coping strategies and self-care techniques to prevent burnout and maintain their wellbeing.

8. Access to a support network: Participating in carer-led skills training can introduce carers to other individuals facing similar challenges. This sense of community can be a valuable source of support and understanding. It acts as an antidote to the stigma and judgment often faced in the broader community and reduces feelings of isolation.

9. Timely identification of resources: Carer-led skills training can help carers identify and connect with resources, such as specialised treatment centres, therapists, guided self-help, psychoeducation, and support groups.

While there are many similarities between recovery peer workers, and carer peer workers, it is important to highlight that these are two distinct workforces that are independent from each other. The National Mental Health Commission recommends that these two workforces are not combined as they have a high potential to cause confusion, issues of boundaries and conflicts of interest (Byrne et al., 2021). Just as the recovery peer workforce is led by people who have a personal experience of an eating disorder, delivery of carer programs must be developed and lead by carers who supported someone through the recovery journey. Hodges et al (2022) summarise the roles in the figure below and it must be noted that these roles are to be filled by a lived experience carer workforce, not by peer workers with personal experience of an eating disorder or other professional staff (such as clinicians).

Personal Lived Experience Role

First-hand experiences and perspectives of mental health challenges, service use and diagnosis

Often first-hand experiences or marginalisation, loss of personal freedom and identity

work primarily with people accessing services

Greater emphasis on personal autonomy

Greater focus on confidentiality

Greater emphasis on individual process of healing/recovery

Family/ carer role

Draws on experiences and perspectives of witnessing, walking beside and supporting another person

Work primarily with family or significant others of people accessing services

Can expereince complexity in questions of safety and risk bs autonomy and choice

Greater emphasis on 'relational recovery' – a family-inclusive approach to recovery

Role Similarities

System navigation

Support personal recovery

Foster connection and rapport

Transform services for better outcomes

Individual and systems advocacy

Informed by lived experience

Relationships as core | Shared humanity

Empathy | Peer to peer support

Mutual respect | Hope

Listening to Lived Experience

Carer peer workers and carers who had accessed peer work strongly believed that an eating disorder carer peer worker should have direct experience with caring for someone with an eating disorder due to the uniqueness of the role.

"My peer worker was a parent and a carer, and I feel that nothing I said shocked her, everything I disclosed about me or what was happening at home, it felt like she was really experienced so it felt great to have someone who just got it and could then steer me in a direction to give me advice on what that might mean and supports." (Peer work participant, Focus group 2, response 22)

In summary, developing a carer peer workforce in Australia holds significant benefits for individuals affected by eating disorders, their families, and the broader healthcare system. Carers, who have first-hand experience supporting loved ones through the challenges of an eating disorder, possess unique insights and perspectives that can enhance the delivery of compassionate and empathetic care. They are also able to offer and hold hope for recovery and normalisation of the recovery experience. The establishment of a carer peer workforce in eating disorder services can promote collaboration within the care team, improve carer confidence, and foster hope among carers, ultimately improving treatment outcomes for individuals with an eating disorder.

For the purpose of these Guidelines, though it is acknowledged that the roles, responsibilities, and training needs of these two workforces are distinct from each other, the term 'peer worker' refers to both recovery peer workers and carer peer workers unless otherwise specified.

Embarking on a peer work career

People who have personally experienced an eating disorder or supported someone who has, have a unique understanding of what it is like to experience an eating disorder whilst navigating a complex system of care. This experience may enable a lived experience career that can range from being a face-to-face peer worker to leadership roles in organisations, mental health commissions or government policy advisory committees; with some people choosing to be involved in supporting others in their recovery journey in addition to their existing careers.

Irrespective of the type of work undertaken, each role or function has its own full range of skills that are required for anyone to perform well in that position (National Mental Health Commission, 2018). Therefore, it is important to articulate the minimum knowledge, skills and competencies required to undertake specific roles.

These Guidelines focus on the training needs of paid peer workers who provide direct support to individuals and apply the principle that irrespective of the employment contract someone is hired under (full-time, part-time, casual), the knowledge and skills required to work as a peer worker in the eating disorders field are the same. Lived experience consultations have indicated that people accessing peer work want to be assured that their peer worker is adequately trained, competent and confident in safe and effective service delivery. Further, they also want to have assurance that peer workers in the sector can be held accountable for their practice and there are mechanisms for participants to provide feedback about services and escalate concerns about practice. Hence the training/qualifications that have been articulated in these guidelines are indicative of what is considered to be a minimum requirement for safe and effective practice.

Listening to Lived Experience

Peer workers who participated in the consultations for these Guidelines had arrived at peer work as a career through various motivations and via a diversity of pathways.

"We need to figure out collectively in the eating disorder industry regarding what does it mean to be a peer worker or what does that role include." (Peer worker, Focus group 1, response 6)

Participants agreed that the Guidelines need to create a collective understanding of peer work while acknowledging individuals' differing life experiences, previous knowledge, qualifications, and motivations to become a peer worker when entering the workforce.

"I always wanted to work in the eating disorder field, it was more for me what do I want to do in that field? . . . I was close to becoming a clinician and then headed to the peer work space because I knew that was where I could be really open about my lived experience."
(Peer worker, Focus group 1, response 9)

Volunteer workforce

As the current project scope is to develop guidance for a paid peer workforce, these Guidelines will not outline training and development needs for the volunteer workforce in the eating disorders field in any detail. For equity reasons and with regard to employment law, it is critical that volunteer roles are genuine volunteer arrangements and not confused with those who are under a legal obligation to attend work, that is, employees or independent contractors.

As a guide, when volunteers are onboarded it should be clear that they are there to provide informal support, such as listening and sharing their lived experiences to offer hope and understanding. Their role may focus on providing emotional support and creating a safe environment for participants to share their feelings and challenges. The training and development needs for volunteers are expected to vary based on the specific role requirements and policies of the organisation.

Listening to Lived Experience

A strong theme that emerged from consultations was that peer workers should be financially reimbursed for their time by the organisation or service they are employed by where possible. However, the importance of having an accessible pathway into the workforce was also highlighted while making sure that volunteering was not endorsed as the only pathway for entry.

"I think there needs to be multiple entries into peer work because any way we formalise it, we are losing people. How I got into peer work personally was through the service I was using. I volunteered there and so I did some volunteer peer work . . . we weren't all going to go on and make this our jobs, but it gave people the opportunity to learn what peer work is, and that it is a possibility." (Peer work supervisor, Focus group 1, response 8)

Type of peer work and settings

The focus of these Guidelines is 'human facing' peer work, that is, work undertaken by people with a lived experience of an eating disorder providing direct support to someone on the recovery journey. This work can be done either in face-to-face or online.

People who have navigated their own recovery often want to help others, but not everyone wants to become a health professional. Integrating lived experience into the treatment setting and treating team can enrich the clinical knowledge of the team and lead to better patient reported outcomes. As outlined in the NEDC Stepped System of Care (NEDC, 2023, see Figure 1., below), a multidisciplinary care team approach is required, including medical and mental health professionals at a minimum, dietetic care as appropriate, and other mental health and medical input in line with the person's needs, including peer workers. Carer or other supports are also an integral part of the care team. This is required across the continuum of care and the important and ongoing role played by peer workers across the stepped system of care has also been highlighted.

"Peer support workers are ideally engaged early in the treatment and recovery process for a person experiencing an eating disorder, and/or their families and supports. Peer support workers may be involved in the care team across all levels of treatment, alongside community-based intensive and hospital treatment. They may also have a role in supporting ongoing eating disorder recovery." (NEDC, 2022)

Stepped System of Care for Eating Disorders

National Eating Disorders Collaboration

Principles; Guidelines; Lived experience; Research and evaluation

Involvement of person, family/supports and community

Prevention

Actions, programs, or policies that aim to reduce modifiable risk factors for eating disorders, and/or bolster protective factors, to reduce the likelihood that a person will experience an eating disorder. Eating disorder prevention actions, programs or policies may also seek to address the broader factors which impact on health, known as the social determinants of health.

Contexts: Whole of community response including: government; public health; schools and education settings; health and community services including primary care; sports, cultural, youth and other settings; lived experience organisations; media and social media; individuals, families, and communities.

Identification

Identification of warning signs or symptoms, and engagement with the person who may be experiencing an eating disorder, to support access to an initial response. In some instances, warning signs or symptoms may be self-identified, and the person may seek out an initial response themselves.

Contexts: Individuals and families; community services; schools and education settings; sports, cultural, youth and other settings; lived experience organisations; helplines and digital tools; public and private health and mental health services including general practice, community health services, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, emergency departments, eating disorder-specific services.

Initial Response

Completion of an initial assessment and preliminary diagnosis, and referral to the most appropriate treatment options based on the person's psychological, physical, nutritional, and psychosocial needs. This may include facilitating access to an appropriate intervention for a person experiencing sub-threshold eating/body image concerns. An initial response should also provide psychoeducation, support the person to engage with treatment, and encourage the involvement of the person's family/supports and community.

Contexts: Public and private health and mental health services including general practice, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, emergency departments, eating disorder-specific services.

Treatment

Community-based Treatment

Evidence-based mental health treatment delivered in the community, ranging from self-help and brief interventions to longer courses of treatment, in conjunction with medical monitoring and treatment, nutritional intervention, and coordinated access to a range of services and transition support as needed.

Contexts: Digital interventions; public and private health and mental health services including general practice, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, eating disorder-specific services.

Community-based Intensive Treatment

Evidence-based mental health treatment delivered in the community, at a higher level of frequency or intensity than community-based treatment, in conjunction with medical monitoring and treatment, nutritional intervention, and coordinated access to a range of services and transition support as needed. Community-based intensive treatment can be delivered in a number of forms, including day programs, intensive outpatient programs, and community or home outreach interventions.

Contexts: Public and private eating disorder-specific services; child and adolescent/youth and adult community mental health services.

Hospital and Residential Treatment

Admission to hospital for people who are at medical and/or psychiatric risk, or admission to a hospital or residential program for people who are medically stable but would benefit from a higher level of treatment and support than can be provided through community-based or community-based intensive treatment options. Hospital or residential treatment should also include coordinated access to a range of services and transition support as needed. Nutritional support and intervention are a key part of hospital and residential treatment.

Contexts: Medical and psychiatric inpatient units; eating disorder-specific inpatient units; emergency departments; hospital in the home; rehabilitation units; residential eating disorder services.

Psychosocial and Recovery Support

Psychosocial support refers to services and programs which support the broader psychological and social needs of the person experiencing or at risk of an eating disorder and their family/supports and community. Recovery support refers to services and programs which support a person experiencing an eating disorder to engage with or sustain recovery or improved quality of life and assist family/supports and community in their caring role. People experiencing eating disorders and their families/supports and communities may engage in a range of psychosocial and recovery support services and programs across the system of care, at different stages of their journey.

Contexts: Community and social services; health and mental health services including primary care, headspace, Head to Health; lived experience organisations; peer support services; helplines and digital resources.
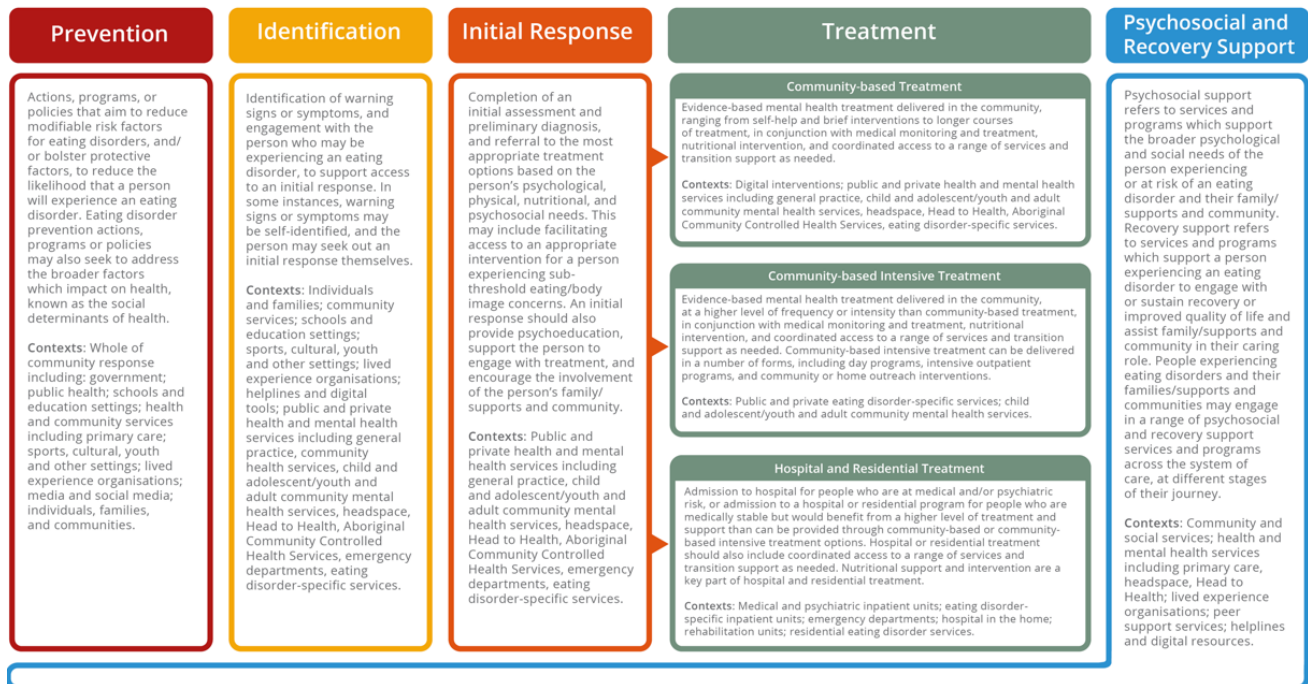
Figure 1: The stepped system of eating disorder care

In order to ensure best outcomes for participants, seamless integration and open communication between service providers is imperative. Traditionally, the peer workforce has been employed and trained within lived experience organisations. In an ideal state, peer work roles would be embedded within all health care settings across the continuum of care to ensure that people can access a trained peer workforce at all stages of their recovery journey. This work has already commenced with peer work roles increasingly being integrated into service settings as part of multidisciplinary teams, however clarification of role scope and training is required to strengthen this workforce.

Similar to other psychosocial support/therapeutic approaches, peer work can be delivered in several ways. Deciding on the type of support will depend wholly on the needs of the person receiving the service based on their stage of recovery.

The NEDC (2019) outlined the "Peer Work Approach" with a list of ways in which a peer worker can support participants across the system of care. This has been summarised (and updated) in the table below.

Types of support peer workers can provide	Settings where Peer Workers provide services[1]			
	Inpatient and Residential Settings	Outpatient settings and Community-based organisations	Lived Experience Organisations	Independent Peer Workers/Coaches[2]
Intensive 24/7 access to support	Yes	Unlikely due to staffing costs	Unlikely due to staffing costs	Yes
Outreach and in-home support	Unlikely as outside hospital/residential scope	Yes	Yes	Yes
Intensive educational and/or support groups	Yes – during admission	Yes	Yes	Yes
Individual mentoring sessions	Yes	Yes	Yes	Yes
Casual 'catch up' sessions[3]	Yes – during admission	Yes	Yes	Yes

[1] *Organisations and PHNs should develop referral pathways and mechanisms to educate consumers and health care professionals about the peer workforce.*

[2] *Peer workers/Coaches working independently may provide all the listed levels of support, depending on their own practice model.*

[3] *Such sessions must remain goal-oriented to ensure professional boundaries are maintained and to avoid 'peer drift'*

A comment about job titles

Based on consultation with service providers during the course of developing these Guidelines, it has become apparent that job titles are currently used interchangeably in Australia based on the organisation. This is common practice in most industries and titles do not necessarily indicate the training or role of the individual. In order to reduce any subsequent confusion that participants might experience from differing titles across organisations, the Guidelines recommend that organisations ensure that their peer workforce meets the minimum education and training (outlined in next section) that applies to all peer workers providing person-facing/face-to-face care, irrespective of the service type or modality employed (group/individual support). This will enable someone trained in the provision of peer work to have transferable skills irrespective of service setting or type of work thus improving engagement in work, and offering the opportunity to enhance skills via supervision, professional development, and training opportunities. Another action required from organisations is to manage participant expectations by providing them with comprehensive information about the program they are about to commence and the roles/responsibilities of the person(s) they will be working with.

Considerations for working with children/adolescents

To date, most peer work programs are aimed at either adults who are experiencing an eating disorder or carer-led programs work with parents of either adults or children/adolescents who are experiencing an eating disorder. There are not many programs that offer peer work programs/support directly with children and adolescents who are experiencing the eating disorder. When creating peer work programs whereby peer workers work directly with the child or adolescent experiencing an eating disorder, it is crucial to consider the unique needs and sensitivities of this population to ensure that programs can be delivered in a safe manner, within the relevant Child Safety legislation and frameworks. Once suitable programs have been piloted and published outcomes are available, specialist training programs may need to be developed to ensure that peer workers receive specialised training on working with children and adolescents with eating disorders. They will also require ongoing supervision and support to ensure their competence and emotional wellbeing. In developing such programs, some key considerations include:

1. **Age-appropriate peer support:** Age-appropriate matching requirements (for example, matching someone in their early 20s working with a teen) will need to be carefully considered to ensure safety of both the peer worker and participant. Programs will need to clearly define what is age-appropriate and developmentally sensitive, taking into account the specific challenges and needs of different age groups within the child and adolescent population.

2. **Safety and boundaries:** Establish clear guidelines, policies and, procedures to maintain the safety and wellbeing of both the peer workers and the young individuals they support. Training of peer workers will need to emphasise the importance of appropriate boundaries in peer relationships.

3. **Family involvement:** All programs should recognise the importance of family support in the recovery process and integrate family involvement and open communication into the peer work programs. Project advisory group and lived experience engagement feedback during this project highlighted the importance of ensuring that families undergoing FBT are matched to those who have lived experience of successfully completing FBT.

4. **Cultural competence:** Be sensitive to the cultural backgrounds and diverse identities of young people and their families. Peer workers should be trained in cultural competence to provide inclusive and respectful support.

5. **Development of supportive materials:** Create age-appropriate materials and resources that can assist peer workers in their interactions with children and adolescents. These may include visual aids, interactive activities, and informative handouts.

6. **Confidentiality and privacy:** Ensure that confidentiality and privacy are upheld in all interactions between peer workers and the children or adolescents they support. Training will need to include components of child protection and reporting responsibilities.

7. **Peer worker wellbeing:** Prioritise the wellbeing of peer workers, as supporting children and adolescents with eating disorders can be emotionally demanding. Organisations should offer support, debriefing, and self-care resources for peer workers.

6. Education and training

In considering the formal qualifications and training required for safe and effective peer work, guidance needs to account for the breadth of peer worker roles and responsibilities. This includes a clear understanding of the differentiation in lived experience and lived experience expertise roles.

In the context of peer work in mental health, "lived experience" and "lived experience expertise" refer to different aspects of personal involvement with mental health challenges, and each brings unique strengths to the peer role. The following definitions have been adapted from a scoping paper (Hodges et al, 2022) that was jointly published by the National Mental Health Consumer and Carer Forum (NMHCCF) and the National PHN Mental Health Lived Experience Engagement Network (MHLEEN).

1. Lived experience

Lived experience refers to a person's direct personal experience of living with a mental health condition or going through a challenging life event, such as experiencing mental health difficulties, recovering from a mental illness, or facing significant life stressors. In the context of peer work, individuals with lived experience draw from their first-hand knowledge and understanding of the emotional, psychological, and social aspects of their own journey to empathise and connect with others facing similar challenges. Lived experience can provide a deep sense of relatability and authenticity, as lived experience peer workers can genuinely understand and validate the challenges and emotions of those they support.

2. Lived experience expertise

Lived experience expertise, on the other hand, refers to the specialised knowledge and skills acquired by individuals through their lived experience of mental health challenges. It goes beyond individual personal experience and includes the process of applying personal learning and insights to support individuals, services, and systems. Experience expertise occurs when the person undergoes a journey to learn how to use their experiences "in a way that is useful to other people" (Hodges et al, 2022).
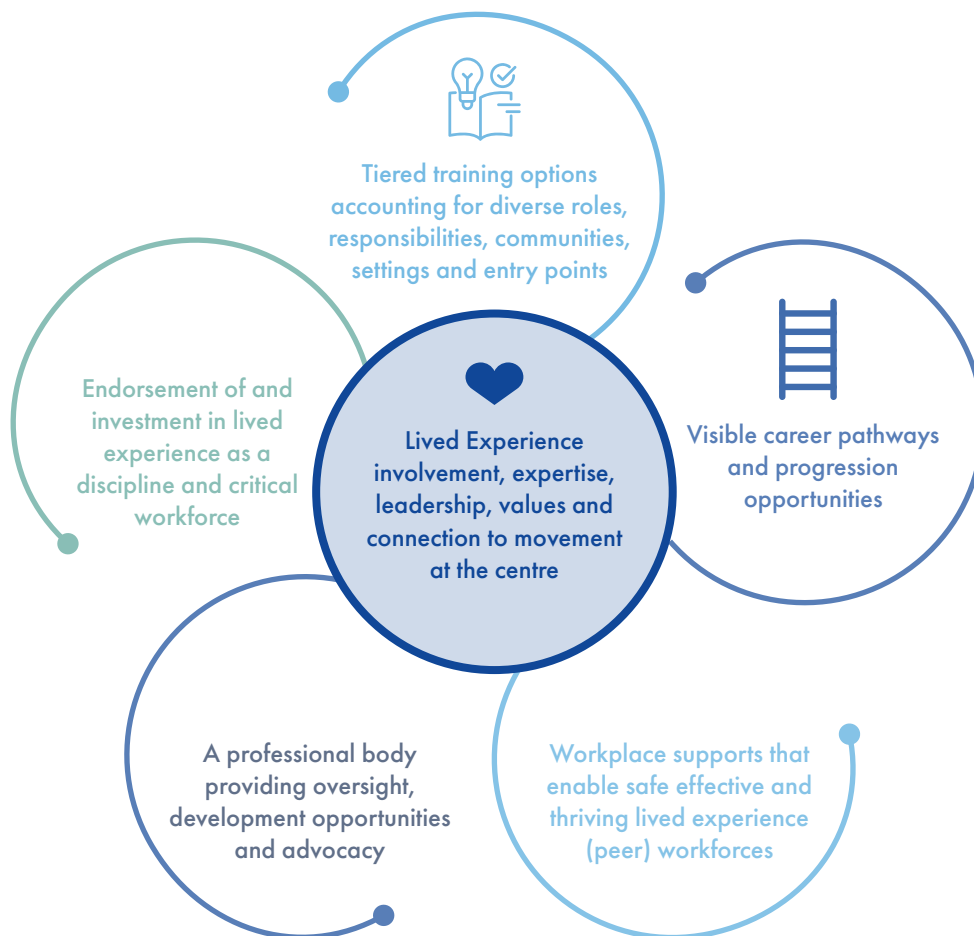
Listening to Lived Experience

Through journeying from experience to expertise, "the peer worker then learns more about themselves, so there is mutual growth and change through providing peer support . . . This is a key part of their ongoing expertise development." (Senior Peer Worker, Lived experience reviewer)

Participants in focus groups stated that a core component of safe and effective peer work practice involved peer workers translating lived experiences into lived expertise through developing "an ability to communicate the lived experience safely and productively." (Peer Worker, survey question 7, response number 5)

The figure below (from Hodges et al, 2022) illustrates the differentiation between these concepts.

Lived Experience
To reimagine and redefine ourselves, our place in the world and our future plans

Lived Experience Expertise
To use those experiences in a way that's useful to other people

Lived Experience Leadership
To speak up to influence community awareness, organisational culture, policy and politics; create space, pathways and inclusion with others; prompt and support change

Recommendations to implement a proposed model to enable the development of a sustainable and viable lived experience peer workforce were also made by Hodges et al, 2022. A model with five pillars was proposed and is depicted in the figure below.

Tiered training options accounting for diverse roles, responsibilities, communities, settings and entry points

Endorsement of and investment in lived experience as a discipline and critical workforce

Lived Experience involvement, expertise, leadership, values and connection to movement at the centre

Visible career pathways and progression opportunities

A professional body providing oversight, development opportunities and advocacy

Workplace supports that enable safe effective and thriving lived experience (peer) workforces

These Guidelines support the recommendations made by Hodges et al (2022) that overarching tiered training options should clearly articulate career progression, and that pathways should be developed for the mental health peer workforce. These Guidelines also support a call to revise the Certificate III and Certificate IV in Mental Health Peer Work with a focus on ensuring that co-production principles are applied to all course redevelopment efforts.

Listening to Lived Experience

The need to redevelop currently available courses was identified as a necessary next step. Reasons why the Certificate IV doesn't currently meet needs included accessibility; associated cost; time taken to complete the course; and at times lack of relevance of the topics covered. Despite this, there was also a very strong push to have a workforce that is formally trained and qualified to ensure safety of those accessing services.

"I had two quite different experiences [with peer workers from different organisations] which made me realise that the first person didn't have good training." (Peer work participant, Focus group 2, response 19)

Focus group participants also advocated for the need to have a mechanism to ensure consistency of training and accountability. The idea of having an overarching body appointed to be responsible for consistency and quality across training providers was also raised.

"If we have guidelines the quality of peer work won't just be based on the luck of where you go and what service you get. You might go into two different peer work services with the same intention but because one isn't accountable or doesn't have guidelines you might come out feeling worse." (Peer work participant, Focus group 2, response 30)

"A governing body to regulate peer workers." (Survey question 34, response number 10)

Since the eating disorders peer workforce will form part of the overarching and still emerging mental health peer workforce, it is recommended that training options and pathways remain the same across the lived experience workforce. As lived experience workforce training develops in the future, these training options should be extended to peer workers across the entire mental health field (including those working in the eating disorders field).

Creating training options to support specialisation has also been identified as being necessary and hugely beneficial in order to develop and extend the scope of opportunity available to the lived experience peer workforce. In this section, the Guidelines will therefore focus on proposing the minimum requirements to support training to work as a peer worker in the eating disorders sector (as an area of specialisation).

A tiered approach to roles and training

The current absence of a consistent training framework can lead to challenges in safely and effectively implementing a peer workforce across the country. The consistency provided by a single/unified training framework will enable peer workers to seek employment opportunities across organisations within the sector and have increased opportunities for career progression.

Hodges et al (2022) recommend taking a tiered approach to training that enables people with lived experience to gain introductory/entry-level skills by attending short courses or modules of training. Such training does not place a big burden on trainees in terms of cost or other resources and enables trainees to get involved with peer work in an effort to determine whether lived experience roles are right for them. As an individual's resolve to stay within the field grows, they can undertake more formal training and education in order to seek further growth and opportunities in more senior peer work, advocacy, or lived experience leadership.

Translating the tiered training model to professional practice emphasises the critical need for role clarity and clearly articulated scope of practice documentation to be developed for each role within any organisation.

Depending on their funding models, organisations may decide which peer work roles are for employees and which are voluntary arrangements. The aim of these Guidelines is not to stipulate what should or should not be paid roles (ideally, all types of peer work will be remunerated in a desired future state) but rather to highlight the different level of competency, skills, knowledge, and training required based on different roles.

The following tables map out tiers of peer work competencies adapted from NEDC (2019) and NEDC (2018). Role titles have been proposed as a guide only, based on existing roles across the sector, with the understanding that organisations will adopt role titles based on their own organisational governance and structure.

To differentiate between recovery-led and carer-led programs, organisations may choose to include terms such as "recovery" and "carer" based on their own practice framework.

Tier 1: Roles that harness power of lived experience

Possible role titles for recovery peer workers: Peer Mentor, Peer Support Worker, Lived Experience Mentor, Lived Experience Worker, Resilience Mentor, Peer Navigator, Peer Recovery Mentor, Recovery Mentor, Volunteer/Volunteer Peer Mentor.

Possible role titles for carer peer workers: Carer Peer Mentor, Carer Peer Support Worker, Carer Mentor, Carer Coach, Carer Navigator, Volunteer/Volunteer Carer Mentor.

Role responsibilities/tasks:

- **Mentoring and support:** Providing guidance, emotional support, and encouragement to the participant, fostering a nurturing and trusting relationship.

- **Positive role modelling:** Being a positive role model by demonstrating positive behaviours, values, and life skills to instil hope for recovery in the participant.

- **Listening and understanding:** Actively listening to the participant's concerns, experiences, and challenges without judgment, offering understanding and empathy.

- **Delivering evidence-based prevention programs**

- **Advocacy and resource referral:** Advocating for the participant 's needs and connecting them to relevant resources, such as further peer work support, social/education/occupational activities, or mental health services, to help enhance their wellbeing and opportunities.

- **Co-facilitation of support groups:** working with a peer worker (Level 2) in delivery of support groups. This could also include attending support groups to share their stories in a safe way.

- **Participating in speaking engagements, ambassador programs etc:** representing organisations in media; speaker programs including addressing audiences at conferences, students undertaking professional training in medicine, psychology, dietetics and other related disciplines.

- **Representing the organisation at events:** Providing supportive counselling/debriefing to participants attending sector-related events such as conferences, training workshops etc

Note: Many of the core competencies are shared between Peer and Carer workers but some training requirements might be unique. Organisations are encouraged to review the learning needs of their team based on role requirements.

Competency	Knowledge	Skills in Practice	Training
Knowledge and lived experience of recovery from an eating disorder[1]	• Experience of recovery is essential knowledge for a peer work role • General knowledge of the features and common treatments of eating disorders appropriate to the peer work role • Demonstrates a basic knowledge of the different experiences that people with eating disorders may have • Demonstrates an understanding of the personal individual nature of recovery and the different goals and experiences that people may have in recovery • Demonstrates awareness of setbacks as part of recovery; can differentiate setbacks from relapse or recurrence of illness • Demonstrates awareness that every person has personal strengths and resources that they can use to help them work through difficult situations • Understands the value of peer support for their own wellbeing	• Models recovery behaviours in their own life • Actively promotes awareness of recovery • Demonstrates awareness of own strengths • Active listening • Non-judgemental about others' experiences of eating disorders and recovery • Practices self-care • Has the ability to identify situations of personal risk and seek help • Knows the limits of personal expertise and when to seek advice or refer on to other colleagues in the care team	• Supportive counselling skills • InsideOut Institute Essentials training
Purposefully apply lived experience to promote and support recovery[1]	• Demonstrates ability to reflect and learn from personal experience and process emotions • Demonstrate awareness of personal attitudes, values and beliefs regarding eating disorders, mental illness, treatment, recovery and specific issues such as body image and weight • Demonstrates awareness of the limits of their personal expertise and when to seek advice or refer to other colleagues in the shared care team • Demonstrates ability to identify personal unmet needs	• Shares personal experiences safely and professionally • Shares information from their personal recovery that is strategically relevant to the current situation and the needs of the person/people they are speaking to • Identifies own learning needs and participates in on-going professional development activities	• Safe story telling • Public speaking • Media training (if required) • Team consultation
Establish relationships of mutual trust and respect[1]	• Shows empathy for individuals with eating disorders, acknowledging their fear, shame, and ambivalence towards change • Demonstrates familiarity with prevalent myths associated with eating disorders and how these affect the way people understand their experience • Demonstrates understanding of the stigma and self-stigma associated with eating disorders • Demonstrates awareness of inclusivity and ethical practice and recovery approaches	• Able to establish and maintain rapport and trust • Good verbal communication • Empathy and perspective-taking, in non-judgemental manner • Reflexive in responding to needs of others • Maintains professional boundaries & understand principles of privacy and confidentiality	• Crisis management and escalation • Trauma-informed care • Cultural awareness/Cultural Safety training • Diversity & Inclusion related training • LGBTQIA+ awareness and inclusion training • Specific training about working with families (for Carer roles)

[1] *Knowledge, skills and training adapted from NEDC (2019, Part C2)*

Tier 2: Roles that provide lived experience expertise

Possible role titles for recovery peer workers: Peer Worker, Lived Experience Peer Worker, Peer Program Facilitator, Peer Work Specialist, Recovery Coach, Lived Expertise Specialist/Worker, Recovery Navigator

Possible role titles for carer peer workers: Carer Peer Worker, Carer Coach Program Facilitator, Carer Specialist, Carer Coach, Lived Expertise Specialist/Worker

Role responsibilities/tasks:

These roles build on what Level 1 workers do to include the following (not an exhaustive list):

- **Leading facilitation of skills-based programs**

- **Motivational enhancement work:** either individually or in group

- **Lead facilitation of support groups** (virtual or face-to-face)

- **Providing meal support** to participants

- **Collaborative goal setting and goal review**

- **Case presentation and contributing to case discussion in MDT**

Note: Many of the core competencies are shared between Peer and Carer workers but some training requirements might be unique. Organisations are encouraged to review the learning needs of their team based on role requirements.

Competency	Knowledge	Skills in Practice	Training
Work collaboratively to enhance recovery outcomes[1]	• Understanding of challenges related to managing self-stigma, shame, fear, and ambivalence • Understands diverse recovery goals, perspectives, and approaches of both individuals and service providers in care provision • Understands roles and responsibilities of different members of the treatment team • Has an understanding of continuous improvement processes of mental health services and systems • Has an understanding of professional conduct, appropriate to organisational (or industry-based) Code of Conduct	• Able to identify strategies to deal with challenges related to managing self-stigma, shame, fear, and ambivalence • Willing to work collaboratively within the broader treatment team and health system	• Trauma-informed care • Suicide prevention • Meal support training • Group facilitation skills • Motivational Enhancement training • Accurate record keeping • Intentional Peer Support • Crisis management and escalation • Practising in a trauma-informed manner • Utilising supervision • Collaborative Care Skills Training (for Carers) • BLS First Aid (Optional) • InsideOut Institute Essentials training • NEDC Eating Disorder Core Skills: eLearning for Mental Health Professionals
• Competencies 1-6 and related knowledge and skills identified as part of National Practice Standards for Eating Disorders[2] • Lived Experience focus group participants recommended that for peer work roles, Competency Area 2 needs to change from "Ability to identify warning signs of eating disorders and disordered eating and conduct initial assessment within the scope of role" to "Ability to identify warning signs of eating disorders and disordered eating and ask brief screening questions within the scope of role". • Apart from this, all other competencies were deemed to be applicable and relevant to peer work roles.			

[1] *Knowledge, skills and training adapted from NEDC (2019, Part C2)*

[2] *Core competencies identified as part of National Practice Standards for Eating Disorders, published by NEDC (2018)*

Tier 3: Lived expertise team leader/Supervisory roles

Possible role titles for recovery peer workers: Peer Work Leader, Peer Work Supervisor, Peer Work Coordinator, Lived Experience Program Lead, Peer Work/Support Specialist Lead, Senior Peer Mentor

Possible role titles for carer peer workers: Care Peer Work Leader, Carer Peer Work Supervisor, Carer Program Coordinator, Carer Lived Experience Program Lead, Carer Peer Work/Support Specialist Lead, Senior Carer Peer Mentor

Role responsibilities/tasks:

These roles build on what Level 2 workers do to include the following (not an exhaustive list):

- **Team leadership:** Provide overall leadership and direction to the peer work team, ensuring that team members are aligned with the organisation's goals and objectives.

- **Supervision and support:** Offer guidance, mentorship, and supervision to peer workers, ensuring they have the necessary resources and support to effectively carry out their roles.

- **Program development and evaluation:** Collaborate with stakeholders to develop and implement peer work programs, and regularly assess and evaluate their effectiveness and impact.

- **Quality assurance:** Ensure that peer work services adhere to best practices, ethical standards, and quality assurance guidelines, promoting the delivery of high-quality support to individuals served.

- **Collaboration and advocacy:** Foster collaboration with other departments and external partners, advocating for the inclusion of peer support services and promoting the value of lived experience expertise in mental health care.

Note: Many of the core competencies are shared between Peer and Carer workers but some training requirements might be unique. Organisations are encouraged to review the learning needs of their team based on role requirements.

Competency	Knowledge	Skills in Practice	Training
Ability to provide supervision to peer workers in the team[1]	• Has extensive practice experience, through which they are able to demonstrate sound knowledge of the underpinning foundations, values and principles of Lived Experience work • Has first-hand experience in the same or a similar role to the Supervisee • Knowledge and understanding of the supervisory relationship and trauma-informed in addressing the relationship • Understands professional boundaries, confidentiality, and ethical considerations in peer work • Encourages and facilitates reflective practice among peer workers to helps enhance their self-awareness, growth, and effectiveness in supporting others • Emphasises and models the importance of self-care and wellbeing	• Has interpersonal competence and able to create an empathetic and supportive environment for supervision, reinforcing and modelling peer work principles in action • Able to provide constructive feedback, offer support, set goals, and facilitate reflective discussions • Able to promote self-efficacy and decision-making	• Consumer Perspective Supervision[2] • Carer Perspective Supervision[3]

Competency	Knowledge	Skills in Practice	Training
Ability to provide effective leadership and direction to the peer work team		• Able to lead, inspire, and motivate the peer work team, fostering a positive and cohesive work environment • Strong verbal and written communication skills • Able to provide mentorship and coaching to peer workers, supporting their professional growth and development • Generic skills that are relevant to team leadership roles	• Leadership development programs • People/Team management training • Giving and receiving feedback training
Competent in developing and implementing peer work programs		• Able to plan and develop peer work programs, including setting goals, creating action plans, and organising resources	• Project management training
Ability to conduct program evaluation and monitor outcomes	• Stays informed about the latest developments in mental health care, recovery-oriented practices, and peer support research • Knowledge of basic data analysis and reporting methodologies • Knowledge of continuous improvement strategies	• Safety and quality monitoring and reporting • Engaging in continuous improvement cycles	• Regular attendance at relevant conferences • Data analysis/Turning data into information training • Relevant training in Clinical/Care Governance

[1] *Adapted from Lived Experience Workforce Program (2022). Mental Health Peer Supervision Framework. Mental Health Coalition of SA. This paper further elaborates roles and responsibilities related to Peer Work Supervision which can be adapted by organisations.*

[2][3] *Knowledge, skills, and competencies required to work within these frameworks have been outlined in* Consumer Perspective Supervision *and* Carer Perspective Supervision

Listening to Lived Experience

While focus group participants spoke highly of the current training frameworks available, there was general consensus among all focus group participants about the limitations of Certificate IV in Peer Work, Intentional Peer Support and Consumer Perspective Supervision. Current mental health training, such as Intentional Peer Support, was viewed as helpful although not always mindful of the specificity of eating disorders and eating disorders services.

7. Recruitment and onboarding

Recruitment of eating disorders peer workers should follow the same good practice strategies used in recruiting into other roles (NEDC, 2019). In developing recruitment strategies for peer work roles, some specific issues for organisations to consider include the following.

Lived experience with eating disorders

Organisations should prioritise candidates who have personal lived experience with eating disorders (or carer lived experience for carer peer workers). Organisational recruitment strategies should include a plan to ensure that the diversity of eating disorder presentations and populations are represented in the peer workforce.

a. Where it is not possible for organisations to recruit candidates with a personal lived experience of an eating disorder, organisations may choose to appoint candidates with a lived experience of a mental health disorder and provide them with eating disorder-specific training. Organisations may consider offering varying types of employment contracts based on team structure and within the applicable regulation.

b. Participants should be able to make an informed decision about whether or not they want to work with a peer worker who doesn't have lived experience of an eating disorder.

Listening to Lived Experience

Survey respondents and focus group participants voiced that the peer workforce should be a diverse workforce incorporating a variation of previous knowledge, eating disorder presentations, lived experiences, experiences with the eating disorder system of care including treatment, and recovery journeys. While for some organisations and services, it is not possible to employ a variety of peer workers, especially in some regional and remote locations, peer workers should be competent in applying an intersectional lens to peer support and should have the ability to work with a diversity of peer work participants in an inclusive, ethical, and supportive manner. If a peer worker does not have a lived experience of an eating disorder or relatable experience, the worker may be trained by someone who does have a lived experience of an eating disorder or other intersecting experiences.

Recovery progress and resilience

Organisations should seek to employ candidates who have demonstrated progress and resilience in their recovery, as this can provide hope and inspiration to those they support. This can be potentially challenging and contentious as there is no current unanimously agreed definition of recovery. Hence, it can fall to each organisation to ascertain an acceptable definition that aligns with their governance and values. To assist organisations in determining their definition of recovery for recruitment purposes, the nuances that need to be taken into account when making decisions are summarised below.

c. **Integrating lived experience perspectives in defining recovery.** It is important that people with a lived experience are considered the experts in their own recovery. As Kenny et al (2022) note, "By discounting lived experience views, we run the risk of missing key considerations in eating disorder recovery, assuming that one size fits all, and invalidating individuals whose experiences are not represented (typically those in already underrepresented in the eating disorder field and marginalize groups)".

d. **Exercising caution in relation to definitions based on the medical model.**
Such definitions (e.g., Bardone-Cone, 2010; Khalsa et al, 2017) place a strong emphasis on weight restoration, absence of symptoms, and return to pre-morbid functioning. Such criteria (or category) based models don't always align with lived experience perspectives of recovery which focus more on the personal experience of recovery. In line with the work of Kenny et al (2022), people who with lived experience were engaged with during the Guidelines development:

   i. Spoke of the need for "recovery [to be] experienced as a self-constructed process that cannot be defined or prescribed by others"

   ii. Highlighted that recovery has a different meaning to individuals, and therefore can't be circumscribed by sets of criteria that do not take diversity of recovery experience into account.

   iii. Since categories simply cannot capture everyone's experience, some people's experience of recovery could potentially be invalidated if they don't "fit into" specific criteria. Specified times for recovery to be recognised, such as two years, were challenged.

   iv. Identified benefits to the research community of having a consensus definition but challenged its clinical utility.

   v. Likened criteria-based recovery definition to striving for another "literally unattainable goal".

   vi. Spoke of the non-linear nature of recovery and the notion that a single set of criteria at one-time point does not necessarily give the full picture of any individual's journey.

Despite the above noted concerns with criteria-based definitions, participants in the Kenny et al (2022) study also highlighted the need and value of knowing that full recovery is possible, as this provides hope and direction. The importance of accounting for individual experience, personal development and growth into definitions of recovery was also emphasised in the lived experience engagement undertaken for these Guidelines.

In considering definitions, it is important to conceptualise recovery beyond weight, behaviours, and thoughts, to encompass psychological wellbeing, improved coping, identity outside of the eating disorder, self-perception and acceptance, level of functioning in day-to-day life, improved social functioning, and an improved relationship with food and exercise (Kenny et al, 2022; Wetzler et al, 2019).

e. **Challenges of specifying duration of recovery.** In current practice, there is a requirement that candidates declare a specific period of time of recovery, usually 18-24 months (NEDC, 2019; Beveridge et al, 2018). A recent study has reported that both service users and therapists struggled with the idea of fixed timeframe for recovery, stipulated as 12 months for those with Anorexia Nervosa (McDonald et al, 2021). Services users in this study had concerns that 12 months without symptoms was too short

and oversimplified the recovery process. There were also concerns that having fixed durations might inadvertently harm someone's recovery as a fixed duration doesn't account for the individual nature of recovery. In line with this, participants in the Kenny et al (2022) study also spoke of symptom-based recovery criteria evoking eating disorder thinking patterns such as perfectionism and feelings of comparison with others (which are thinking patterns linked to both development and maintenance of an eating disorder). Fear of relapsing and its consequences was mentioned by the lived experience participants engaged during the Guidelines development process.

Since recovery is a complex and multifaceted phenomenon, a recovery-oriented model that centres on each individual's varied and unique experience should be adopted in clinical settings (Kenny et al, 2022). Though there is no research/literature that explores the definition of recovery for recruitment purposes, Kenny et al.'s argument for taking a person-centred approach can be generalised to the recruitment of peer workers with a lived experience. NEDC (2019) also highlight that since recovery is not a linear experience, the period of time (of recovery) may be less important than the candidate's demonstrated competency and resilience at the time of recruitment.

In their recruitment process, organisations must create a safe environment that allows candidates to have open discussions about their recovery journey. Since many employed people seek professional mental health support to maintain wellbeing, a person seeking employment as a peer worker should not be assessed as unsuitable for employment if they are accessing mental health treatment.

It has been suggested that in order to do this work, peer workers need to have made some sense of their own mental health challenges and have achieved some emotional distance from their experience:

"There is no perfect state of 'being recovered'. Lived experience of recovery means that the person:

- Has engaged in the recovery process of motivated change

- Is currently able to manage their own wellbeing

- Can reflect on what they have been through and learn from their experience

- Can stand back from their experience to consider the wide range of different experiences that other people may have

- Identify when their own wellbeing is at risk and ask for help when they need it" (NEDC,2019, Part B, p 14).

It was widely agreed that rather than focus on arbitrary time-based requirements for demonstrating recovery, the focus should be on a candidate's own assessment of readiness to take on the role, including their ability to self-disclose lived experiences safely, self-awareness in understanding when they need to seek support, and ability to seek support when needed. The importance of peer workers being able to model and support the non-linear recovery journey was also highlighted.

"I think a key value is belief in recovery and an understanding of what that can look like for different people. I think it is an attribute for people to hold space for that." (Peer work participant, co-design group, response 27).

"There needs to be some level of understanding about you own point in recovery that I don't think any time mark can [make] concrete" (Peer work participant, Focus group 2, response 13).

"I would love to be working with a peer worker who is not "recovered" in the traditional sense but is able to teach me skills, and techniques, and draw from their own lived experiences to support me in my recovery" (Peer work participant, Focus group 2, response 11).

When recruiting family members or carers for peer work roles, NEDC (2019, Part C2, p19) recommend that "the focus should be on the same strengths as other peer workers: competency for the role, resilience and the ability to model hope and recovery. The stage of recovery of the person they support is not necessarily an indicator of the readiness of the family member or other supporter to be a peer worker".

Interview processes

Similar to recruitment of any other role, a comprehensive interview process is required to ensure that candidates are suitable for the role. In recruiting peer workers, there is an additional element of ensuring that potential candidates are sufficiently prepared for the emotional challenges of the role. Hence it is very important that a robust interview process is in place to enable both the organisation and applicant to ensure the right fit for any type of peer work role. To assess suitability, the assessment process could involve the following steps:

- Offer to meet or speak to applicants 1:1 for an informal chat prior to the lodging of applications

- Consider including a 'personal essay' style response as a part of the written application – this is a reflective exercise for candidates (Sample reflective questions for candidates to ask themselves were developed by the NEDC (2019) and have been included in Appendix C)

- Ensure shortlisted applicants are provided all necessary information about the interview panel

- Interview panel should include at least one professional who is qualified and trained in peer work so that they can make informed decisions about candidate suitability. The panel should consist of at least one senior peer worker. If a senior peer worker is not available internally, it is recommended that the organisation pay for a suitable external person to be included in the interview panel.

- Give all unsuccessful candidates (whether shortlisted or not) constructive feedback about how to strengthen their applications.

- Sample interview for candidates to consider have been developed by the NEDC (2019) and have been included in Appendix C.

Onboarding and ongoing human resources management

Peer workers should have the same rights and benefits as all other staff employed by the organisation, under relevant state or federal employment standards. This includes ensuring comprehensive onboarding practices, opportunity to participate in organisational performance review cycles, access to ongoing supervision and professional development, appropriate recognition and reward processes, privacy and confidentiality, access to benefits and leave entitlements, working in a supportive work environment, reasonable adjustments, and flexible work arrangements as required by law and in line with organisational policies and procedures.

By considering the factors above during the recruitment process, organisations can build a team of eating disorders peer workers who can provide valuable support to individuals on their journey to recovery.

In summary, these Guidelines recommend that organisations take a competency-based approach in selection and recruitment. Having had a lived experience of an eating disorder is in itself not sufficient to be a good peer worker – the journey from "lived experience" to "lived experience expertise" must be considered. Organisations should ensure that outlined competencies (see 'Education and Training' section) are met by potential peer workers. Further, organisations could prioritise individuals who have completed (or are undertaking) relevant training or certifications in peer support and eating disorders. While this workforce is developing, organisations should consider including cost of training and upskilling strong candidates as part of their annual budget planning and over the longer term, including the cost of training in their funding submissions to grant-makers.

Checklist

○ Prioritise candidates who have personal lived experience with eating disorders.

○ Seek candidates who have demonstrated progress and resilience in their recovery

○ Develop position description with scope of role (Examples are provided in Appendix D)

○ Have inherent requirements outlined as part of position description

○ Develop a comprehensive application and interview process including opportunities for applicants to ask questions and get constructive feedback

○ Onboarding schedule that includes meetings with key staff, mandatory training to be completed and signed off, plan for shadowing, clear framework for assessing competence and confidence prior to working independently, supervision plan outlined.

○ Have policies in place around employee wellbeing and clear processes to monitor and minimise risk of burnout in all staff (including peer workforce).

○ Develop a policy around wellness check for all staff (including peer workers) that identifies how to support the mental health of all staff including early mitigation strategies e.g. reduced duties for a period of time. (Note: the goal of such a process is early identification and prevention and is different to processes around creating reasonable adjustments for roles. The focus here is to foster a culture of psychological safety in the workplace whereby line managers can proactively check-in about the mental health and wellbeing of employees as standard practice. Such a work environment will enable all staff to feel supported in disclosing mental health challenges without fear of repercussion/job loss etc).

Listening to Lived Experience

Organisations should create an environment of trust that acknowledges that peer workers are the experts of themselves, and their experiences, and to avoid treating peer workers as 'fragile'.

"Not treating a peer worker like they are unable to support themselves or unable to seek help . . . checking in with the peer worker but also having that expectation that the peer worker will reach out for support externally." (Peer work supervisor, Co-design group, response 47)

At the same time, the critical importance of having robust organisational practices to support peer workers' wellbeing and confidence was also highlighted. Some highlighted practices included regular debriefing opportunities, ongoing supervision, learning needs based professional development, clear position descriptions, clarity around scope of their role, flexible work arrangements, job security, and focus on wellbeing and psychological safety in the workplace.

8. Supervision requirements

Clinical supervision in mental health is a formal and structured process where a qualified and experienced supervisor provides guidance and oversight to mental health professionals. It involves regular meetings to review and discuss cases, professional development, and personal growth. Clinical supervision of health professionals has been associated with effectiveness of care, through increased compliance with processes associated with better outcomes and adherence to ethical practice (Snowdon, Leggat & Taylor, 2017). Supervision plays a crucial role in ensuring that mental health practitioners are equipped with the necessary skills, knowledge, and support to provide evidence-based and ethical care to individuals seeking mental health support (Meza et al, 2023). Furthermore, effective clinical supervision can support health care workers through times of work-related stress and organisational change process, with additional benefits of reducing rates of burnout and improving engagement and satisfaction (Martin et al, 2022).

Just as connecting with the right care team is important for a person accessing services, accessing supervision from the right person is crucial for those working in the mental health field and has been shown to impact healthcare organisational outcomes (Martin et al, 2021). A robust supervision system coupled with ongoing access to training and education has been suggested as a pathway for creating a "positive and risk-free environment" for peer workers (Shalaby & Agyapong, 2020). Peer-led supervision in the eating disorders field combines the professional knowledge and skills of supervisors with the unique perspective and insight of peers who have overcome eating disorders. This approach can enhance the effectiveness of supervision, improve outcomes for individuals with eating disorders, and contribute to a more compassionate and recovery-oriented mental health system. In order to improve learning outcomes for peer workers and service outcomes for participants, supervision needs to be tailored to the role and experience level of the peer worker.

Extending on the work of the NEDC Developing Practice module (NEDC 2019, Part C3) and based on engagement with those working as peer workers and supervisors, it is recommended that peer workers have access to three types of supervision:

- Eating disorders peer workers have access to supervision provided by a senior eating disorder peer worker.

- Where a senior eating disorder peer worker is not available within the service, the eating disorder peer worker has access to supervision from a general mental health peer worker supervisor.

  o Such supervision was identified by people with lived experience as having immense value as all peer workers understand the unique systemic challenges that arise when working as a peer worker in largely medical/psychotherapy-oriented models.

- If both of the above are not available, a clinical supervisor with a commitment to recovery-oriented practice and a good understanding of peer work could be acceptable with mutual agreement (NEDC, 2019).

- A supervision plan needs to be established at the commencement of a supervision contract and reviewed regularly. This is standard practice in other disciplines and should extend to peer work in order to ensure that supervision is intentional, purposeful, and remains goal oriented (example provided in Appendix E). The overarching goal of supervision is to create a supportive and structured framework for supervision that addresses both professional and personal aspects of the peer worker's role.

- A direct line manager should not provide individual supervision (engage an external supervisor if this is not possible within the organisation).

- Mechanisms should be developed to evaluate supervision – this can involve extending on what is current practice in other disciplines, e.g., psychology, counselling, and social work.

Group peer supervision

- Eating disorder peer workers should have regular access to group peer supervision that is peer led and is guided by peer workers who have completed training in relevant supervision frameworks e.g., Consumer Perspective Supervision.

- Where eating disorder-specific is not accessible, enabling engagement in a community of practice style model of group supervision/group engagement was highlighted.

Access to team and clinical supervision

- Peer workers working in eating disorder services should also be included in team supervision as well as have access to a clinical supervisor to discuss any specific clinical issues that may come up (for example, a carer peer worker spoke of the value of accessing a clinician to get a deeper understanding of family systems when working with families).

NEDC (2019) Developing Practice module further highlights:

"Regardless of the supervisor's background, they need to be trained to provide quality supervision that is specific to the role of peer worker. The peer supervisor should have a fundamental understanding of the principles of recovery and the role of peer support services in building and sustaining recovery goals."

Listening to Lived Experience

People working in lived experience peer work roles strongly advocated for the importance of supervision, recommending that peer work supervision should be lived experience-led, mandatory and regular (at least once a month).

"Peer specific supervision, to be offered by a specialised Peer Lead (or other) that has undergone Peer work supervisor training." (Survey Question 9, response 2)

"Supervision is a must! I have grown so much as a facilitator and person from the experience - but I would say Peer Support specific supervision is important." (Survey Question 9, response 10)

Peer workers also identified the importance of having access to a clinician-led supervision or undertaking co-reflection alongside a treatment team as an adjunct to peer-led supervision.

"Consult with clinicians about the conversations I am having, and suggestions I am offering, to ensure I am not going against best practice recommendations." (Survey question 12, response 2)

"It's very helpful to know what the rest of the team is doing and not what the direction of the care is that we are going to be giving to the consumer." (Peer worker, Focus group 1, response 27)

Benefits of group supervision also extend beyond addressing themes that arise in peer work to support lived experience workers to feel more connected to each other and support the development and maturity of the lived experience workforce.

"Organisations may also want to hold group supervision for all staff with lived experience (peer roles and non-peer roles) to develop a community of practice and bring together experiences that help all staff with lived experience grow and develop. It can open up dialogue and is a great way to advance the lived experience space and can support smaller organisations that are just starting out." (Senior Peer Worker, Lived experience reviewer)

Checklist

○ Peer workers have access to regular and ongoing supervision.

○ Carer peer workers have access to carer lived experience supervision.

○ Peer worker workloads support attending supervision as part of their contracted work hours and/or within mutually agreed time-in-lieu arrangements.

○ All supervisors are paid for the provision of supervision by ensuring that in-house supervision time is included in senior peer workers workload.

○ Externally engaged supervisors are paid for providing supervision.

○ Supervision plans or contracts are utilised to establish clear goals for supervision. Appendix E provides a sample template.

○ Career development opportunities are clear with pathways for peer workers to progress to providing supervision/taking on supervisory roles being clearly articulated in annual performance reviews.

○ Review of supervision is incorporated into continuous improvement cycles within the organisation.

○ Policies in place to review utility and effectiveness of supervision (through collation of qualitative and quantitative feedback from all supervisees).

○ Processes (and policies) in place at organisational level to ensure that supervision is being provided and accessed regularly, with clear mechanisms in place to address any decrease in frequency due to workloads or changes in service delivery.

9. Integration with care team

What is a care team?

NEDC (2022) recommends that every person living with an eating disorder has access to a care team. As depicted in the Figure 2 (below), the care team consists of the person living with an eating disorder and all people who will be involved in providing care, support, and/or treatment. The person living with the eating disorder and their family and supports are central to the care team. Treatment plans should always be developed within a person-centred, family and culture-sensitive, and recovery-oriented framework (NEDC, 2018). This involves sharing information and decision-making among all care team members, including the individual with the eating disorder, their families, and supports.

Person

Family, supports, community

Minimum treatment team: medical practitioner and mental health professional

Psychosocial and recovery support including peer support

Dietitian, psychiatrist and paediatrician as needed

Other health professionals as needed
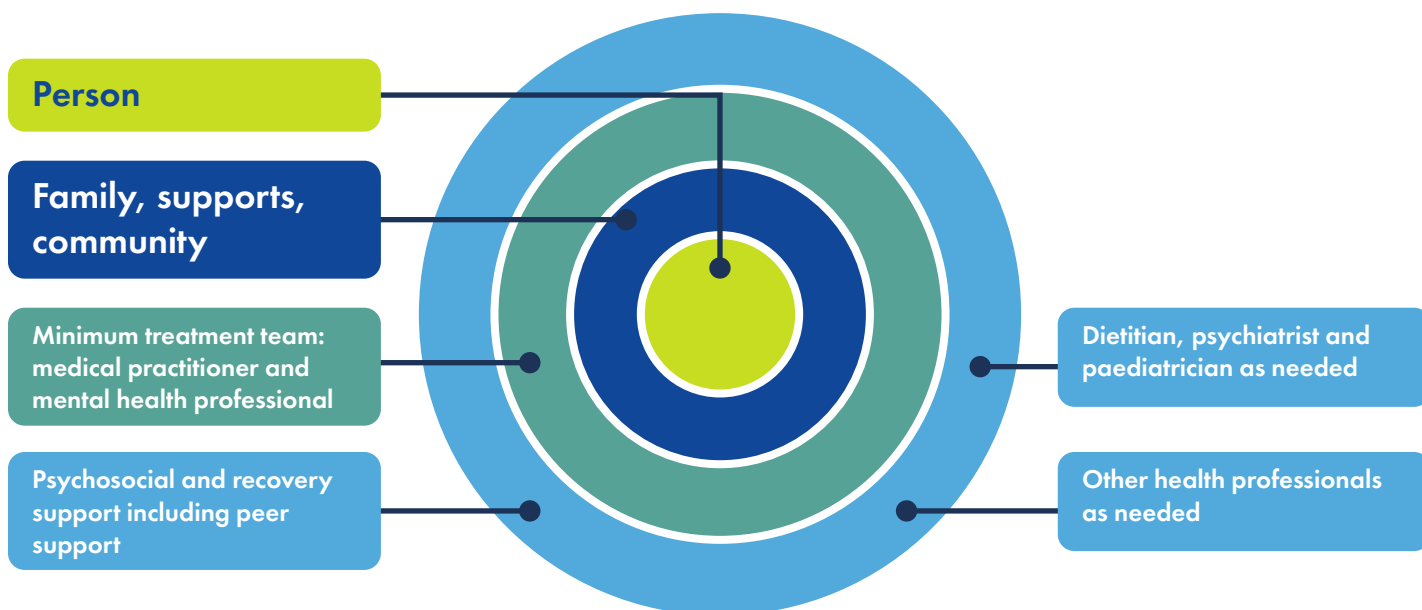
Figure 2: The eating disorder care team

Taking a multidisciplinary team (MDT) approach is essential in the treatment of eating disorders as it enables a holistic, individualised, and coordinated approach to care (Heruc et al, 2020). By combining the expertise of professionals from different disciplines, the MDT enhances treatment effectiveness and contributes to the overall wellbeing and recovery of individuals with eating disorders. Lived experience peer workers bring a unique perspective, empathy, and understanding to the team, fostering a more supportive and non-judgmental therapeutic environment. Their involvement in collaborative decision-making, peer support, and advocacy benefits participants and promotes a person-centred approach to treatment.

In the context of MDTs a power imbalance can sometimes arise, particularly when certain disciplines or roles hold more authority or influence than others (Zajac et al, 2021). This imbalance may lead to unequal decision-making and limited input from some team members. For example, medical professionals may have greater decision-making authority compared to peers from non-medical disciplines. While it is important that ultimate responsibility and accountability for patient care is clear for all team members, such a distinction can create a power imbalance, thus hindering effective collaboration and exchange of valuable insights, potentially impacting the overall quality of patient care (power relationships are discussed further in section 11).

In teams where such power imbalances exist, peer workers may face challenges related to their level of authority and influence within the MDT compared to other professionals. Due to the hierarchical nature of some healthcare settings, peer workers might experience marginalisation or have their input undervalued, despite their valuable

insights and unique contributions. This can result in reduced confidence in sharing their perspectives and ideas, limiting their ability to advocate effectively for the needs of individuals with similar experiences. To ensure a truly collaborative and inclusive MDT, it is essential to actively address and dismantle power imbalances, creating an organisational culture in which all team members' voices and perspectives are respected and valued equally, and their expertise is fully integrated into the collaborative decision-making process.

Empowering peer workers in the MDT

Training can be provided to peer workers to enhance their abilities to effectively contribute in case reviews and team meetings. The specific training may vary based on organisational policies, but some overarching skills and training could include:

1. Role clarity and identity: Training can help peer workers understand their role and identity within the MDT. The rest of the team will also need to be trained and educated to enable them to listen with respect and incorporate peer worker feedback in decision-making.

2. Case presentation and documentation: Providing guidance on case presentation and documentation can assist peer workers in presenting relevant information in a clear and concise manner.

3. Understanding of evidence-based practices: Training in evidence-based practices and treatment modalities equips peer workers with a foundation of knowledge to contribute meaningfully to discussions on treatment planning and intervention strategies.

4. Professional boundaries and confidentiality: Training on maintaining professional boundaries and confidentiality enables peer workers to contribute ethically and responsibly.

5. Collaborative decision-making: Education on collaborative decision-making fosters skills in working effectively with other team members, ensuring peer workers can actively participate in joint treatment planning.

6. Communication and advocacy skills: Training can focus on improving communication and advocacy skills, allowing peer workers to articulate their perspectives confidently and effectively advocate for the needs of the participant, including challenging stigmatising views that can be held by the care team.

7. Ongoing supervision and reflection: Training on giving and receiving feedback, as well as reflective practices, empowers peer workers to continuously improve their contributions within the MDT.

Whole of team education

It should be highlighted that no matter how well trained a peer worker is, in order for them to be truly effective in their role, organisations must be committed to transforming their culture to genuinely value and incorporate lived experience perspectives. This culture shift fosters an inclusive, empathetic, and supportive environment, leading to improved outcomes and services for individuals seeking support for their mental health and wellbeing. While peer workers should receive training to be able to contribute more effectively, power imbalances and team dynamics must be addressed and psychoeducation about all roles within the MDT must be provided to the whole team. The role of culture is explored further in section 11.

Checklist

○ Peer workers are invited to attend case review meetings.

○ Training and support is provided to peer workers to contribute to MDT/case reviews.

○ Whole team is provided education about role of peer worker in MDT decision-making.

○ Case review chairing is rotated within team, with peer worker having equal opportunity to chair.

○ Develop case review/MDT meeting template as a reminder to actively seek peer worker input (Appendix F provides a sample template).

○ Develop clear process for addressing power imbalances within MDT decision-making (relevant to health service and community settings).

○ Care coordination can be shared in primary care settings, with duty of care and risk management accountability clearly outlined between primary care team members.

Listening to Lived Experience

The importance of clearly articulating the scope of the peer work role, and differentiating peer workers' responsibilities was highlighted. Peer worker effectiveness in their role was strongly linked to how well they were integrated into the MDT. When both a peer worker and other members of the MDT understood and valued the boundaries of the peer role, it was easier for all team members to stay within the scope of their roles avoiding confusion and possible 'peer drift'. Lack of guidance and consistency across organisational practice can mean that the boundaries of peer work practice become blurred.

"That's a really interesting balance for the need for the peer worker to be a friend to the client but needing to present professionally and with professional boundaries such as turning up at the right time and not doing something else as someone is talking and meeting emotional needs in that way but not being the psychiatrist or psychologist. That's a real challenge." (Peer work participant, Focus group 2, response 21)

"It can be really hard to find that balance because it feels like a friendship but it is professional and has boundaries but you are connected on that level and I just remember that being something that was so empowering for the mentee to feel that 'I don't have to go through this alone' and I would love if peer work could expand more into that scope of could we be there to help them get groceries, could we be there to help them pick out an outfit for a really important event that's coming up and that could be recognised by a psychologist at a really at risk time and then a peer worker is then there to navigate that space that is outside of scope for a psychologist and dietitian. It's like how can we be that space between the clinician and the friend – and that could be applied in a lot of different ways." (Peer worker, Focus group 1, response 28)

10. Accountability and safe practice

In order to improve the accountability and safety of peer workforce roles, changes need to be made at the system, organisation, and individual levels.

Systems level

Recent mental health sector consultation on the lived experience workforce has recommended the following areas of development in order to increase accountability to and reporting on the lived experience (peer) workforce (Hodges et al 2022, p 50):

- Visibility of and accountability to/for lived experience (peer) workforce has to be increased in existing governance and accreditation processes;

- Clearly articulate and develop a 'Scope of Practice' and/or industry practice standards for lived experience (peer) roles;

- Lived experience (peer) workforce roles need to be defined and classified in key workplace awards/agreements and classification systems, including the Australian and New Zealand Standard Classification of Occupations (ANZSCO);

- Reporting requirements on the growth and impact of lived experience (peer) workforce across jurisdictions and nationally has to be improved. This includes within the mental health workforce section of reporting completed by the Australian Institute of Health and Welfare (AIHW) on mental health services in Australia.

Consultation undertaken for these Guidelines found broad support for the need to review current systems, policies, and funding models such that peer work can be undertaken with sound governance that protects the rights and accountability of peer workers and safeguards those accessing services. However, providing recommendations for system level changes are outside the purview of these Guidelines. It is acknowledged that such work has been initiated by other organisations (e.g., the Lived Experience Governance Framework developed by Hodges et al, 2023).

Organisational level

The safety and effectiveness of peer work are directly influenced by appropriate job roles, effective recruitment, workplace culture, provision of ongoing support to the peer workers and integration of peer work with the service's strategic commitments (Gillard and Holley, 2014, from NEDC 2019 Part C1). This level of organisational commitment to improving the governance of lived experience roles is required in order to strengthen the peer workforce and create an environment for success. Factors that are known to directly and negatively impact peer workers job satisfaction include: low pay; stigma; unclear work roles; alienation; skill deficits; and lack of training opportunities (Shalaby & Agyapong, 2020).

Factors that can impact a peer worker's ability to engage in safe and effective practice include (NEDC, 2019, Part C1):

- "The organisation's culture: medical models of service, lack of recovery orientation in practice, and rigid approaches to risk management.

- Role definition: Poorly understood roles or overly prescriptive roles, and lack of any real connection with the purpose and measurable outcomes of the service.

- Power imbalance: a lack of respect for lived experience work and a lack of agency in their role. Some peer workers describe being treated more like patients than members of the work team.

- Stigma, bullying and harassment: Frequent experiences of stigmatisation, discrimination and bullying in the workplace place the peer worker's health, wellbeing and workplace retention at risk. These experiences are common for peer workers in the mental health sector.

- Isolation: Many peer workers feel isolated in their roles, especially where they are the sole lived experience worker in a clinical setting."

Addressing the above factors at an organisational level have also been demonstrated to be significant predictors of job satisfaction and contributed to increased retention rates (Shalaby & Agyapong, 2020).

The NEDC Peer Work Approach framework also highlights that a i) lack of understanding of the reasonable adjustments that peer workers may need to their employment conditions, or ii) a lack of willingness to adjust procedures to accommodate the needs of the lived experience worker, has a direct impact on the worker's wellbeing, safety and effectiveness. However, it has been cautioned elsewhere that all accommodations must be provided as part of a whole of workforce benefit, and not exclusive to lived experience workers (Hodges et al, 2022). Lived experience engagement undertaken for these Guidelines showed concern that the unintended consequences of needing to design additional accommodations for the peer workforce might prevent employers from adopting and developing these roles. Given the potential to disadvantage the peer workforce, this is an area that needs to be further considered when organisations are developing inherent requirements and reasonable adjustments to peer work roles. We recommend that co-design principles are applied in developing the inherent requirements and reasonable adjustments for each role within their organisation.

In addition to above, many of the factors outlined in previous sections are the types of organisational changes that need to occur in order to make peer work more accountable and safer. These factors are summarised as action points in the checklist below.

Checklist

○ Develop clear job descriptions for lived experience peer worker roles that outline their responsibilities, reporting lines, and accountability within the organisation.

○ Develop inherent requirements and reasonable adjustments for each role within the organisation with co-design principles.

○ Develop a comprehensive application and interview process to ensure that candidates with the right training and experience are hired.

○ Provide regular and ongoing supervision, training, and support to lived experience peer workers, with a view to ensure staff wellbeing, skill development, and adherence to organisational policies.

○ Provide opportunities to "buddy" with a senior peer worker as part of orientation.

○ Review staff seating allocation to ensure peer workers have easy access to other team members.

○ Encourage collaboration and communication between lived experience peer workers and other mental health professionals to ensure integrated and coordinated care for service users.

○ Review organisational policies on risk management, escalation, and incident reporting to clearly outline pathways for peer workers to escalate concerns around deterioration and risk.

○ Ensure organisational policies clearly articulate safe practice around risk screening and management for off-site peer work activities such as safe locations, home visits, travelling together, meeting in public spaces etc.

○ Develop an information sheet about the peer work program to be provided to participants at the service or for promoting the service (to improve referral pathways). Appendix G provides a template for an information sheet.

○ Develop an agreement form for engaging with peer worker, including clear goals for engagement, safety planning, and termination. Appendix H provides a template for an agreement form.

○ Prioritise collecting data around participant experience of service (both qualitative and quantitative measures, e.g. PREMS/PROMS or 'Your Experience of Service' survey style feedback).

○ Peer work roles and responsibilities are included in organisational care (or clinical) governance framework which clearly articulates accountability and reporting flow from 'floor to board' and 'board to floor'.

○ Establish feedback mechanisms for participants and staff to provide input on the effectiveness of lived experience peer worker roles and identify areas for improvement.

> **Listening to Lived Experience**
>
> The need for inclusion of peer work delivered services in safety and quality monitoring and reporting at an organisational level was repeatedly highlighted in our lived experience engagement.
>
> "At my service there were good documents but there must not have been accountability from higher (to use them). It might have been good to discuss it in a trio or with someone more senior there who might offer more suggestions on goals or just offer some accountability for things to be completed in the first one or two sessions." (Peer Work participant, Focus Group 2, response 29)

Individual level

In addition to working within organisations that inculcate and promote the culture of safety and quality, peer workers can also take personal responsibility to ensure that their practice is conducted in a way that is accountable and keeps participants safe. Some ways in which peer workers can achieve this have been summarised as action points in the checklist below.

Checklist

○ Engage in continuous learning and professional development to stay updated on best practices and ethical guidelines.

○ Engage in regular supervision and reflective practice to evaluate interactions, assess ethical dilemmas, be mindful of 'peer drift', and identify areas for improvement.

○ Prioritise personal wellbeing and self-care to maintain emotional resilience and prevent burnout.

○ Promote ethical conduct and the maintenance of appropriate boundaries in peer support relationships.

○ Maintain strict confidentiality about personal information shared by individuals, following organisational policies and legal requirements.

○ Irrespective of treatment setting, work collaboratively with other treatment providers and family or carers involved in the care team.

○ Encourage individuals to provide feedback or raise complaints, ensuring transparency and responsiveness to their concerns.

○ Maintain accurate records of interactions and progress, ensuring accountability and transparency.

Listening to Lived Experience

A common theme emerged in lived experience consultations around inadequate clinical governance, especially relating to risk escalation, crisis management, and incident reporting. Peer workers highlighted lack of consensus within teams around duty of care and escalation processes. Not knowing when, how and who to escalate risk to often left peer workers trying to manage risk beyond their role scope. Examples of good governance and safe practice included workplaces where peer workers knew exactly who to report risk to and how to access support.

"Part of working as one of two peer workers with a whole suite of clinicians is that there are none of the risks, so we are very lucky that any time there is a certain risk they have key workers, mental health nurses, clinicians, everyone else is essentially holding that risk around us." (Peer Worker, Focus group 1, response 34)

Peer workers employed in community-based organisations or private settings also highlighted the necessity of having a shared understanding within the care team of how risk is managed.

"You wouldn't want someone who is not seeing a GP, not seeing a psychologist, and just seeing you as a peer worker with all of that responsibility. Being a part of that multidisciplinary team whether it's inpatient, outpatient or within a community team you still need them to be linked in with other people and I think it is unsafe for them to just see you because if something does happen, you can't just hold that." (Peer Worker, Focus group 1, response 36)

"We had a requirement in our group that we had to be seeking external support/clinical psychologists. Our peer support worker had really good boundaries around what we could and couldn't say and she would say this is out of my scope and I thought that was really good that we all needed to have our own external and professional support and my psychologist really approved of that too." (Peer Work Participant, Focus group 2, response 24)

Listening to Lived Experience

A recurrent theme was the need to have clearly articulated "contracts" for engaging in peer work support, with purpose, goals, boundaries, duration of support and termination/handover processes clearly articulated.

"I think it's hard for someone accessing services to know what to expect if there aren't guidelines there about what it's about, what is expected of me and what is expected of my peer worker." (Peer work participant, focus group 2, response 31)

"As a peer support worker, the first thing I did was [set] goals and then coming back to those goals so there is something concrete that you have talked about and established and that we are working toward something, or that there is something you have identified yourself that you want to work on". (Peer worker, Focus group 2, response 27).

"Unfortunately for me, my peer support worker decided to leave the organisation so we finished, and they said you can talk to this one or that one (peer worker) and I felt quite deflated because they knew everything about me now and then I had to do it all again with someone else so you can't help and if people leave. It was really intense and a big commitment." (Carer who had accessed peer support, focus group 2, response 54).

11. Organisational culture

Organisational culture refers to a system of shared meaning that has developed over time involving assumptions, values and beliefs. This system supports the structures within organisations by setting out which behaviours are and are not appropriate, often through a shared perception of "how things are done around here". Culture is perpetuated by all employees within workplaces, however the values of senior leaders and managers are critical in that "leaders' values become followers' practices" (Hofstede, 1998).

Organisational culture is therefore foundational to the operation of organisational structures, including the ways in which employees are onboarded, how employees are supported to fulfill the requirements of their roles, and how employees relate to each other and with the external people that the organisation interacts with. For organisations employing eating disorders peer workers the features of their culture will shape the experience of peer workers – including affecting recruitment and retention – and may have a flow-on impact to peer work participants.

Values are at the heart of the development of a supportive organisational culture. For the peer workforce, these encompass what the National Lived Experience (Peer) Workforce Development Guidelines refer to as core values, including "respecting and understanding the value of inclusion and the impact of exclusion" (Byrne et al., 2021, 22).

Several dimensions of culture should be addressed at an organisational level in order to support the effective implementation of the advice offered in these Guidelines. These include the addressing relations of power, access and equity issues, addressing stigma and adopting an intersectional approach.

Managing power relationships

As noted in the section above (Integration with care team), to genuinely value and incorporate peer workers as part of the professional eating disorders workforce, employing organisations must foster an inclusive and supportive environment. Central to this is attention to the power relationships within and across organisations, and between members of the MDT.

Power imbalances between members of teams can work against the achievement of participant goals, and limit the effectiveness of peer work. Feedback from current peer workers consulted for these Guidelines highlighted experiences of good practice in this regard as well as experiences of marginalisation and exclusion where they did not feel respected as part of the MDT. A supportive organisational culture is therefore critical to enable safe negotiating of these relationships.

Listening to Lived Experience

Peer workers identified having negative experiences within teams due to their roles not being understood, valued or inherent power imbalances.

"Being dismissed as non-clinical and not having an evidence base to my arguments." (Question 11, response 2)

"Feeling 'ornamental'. Simultaneously being treated as fragile at the same time as being expected to be an exemplary practitioner at all times." (Question 11, response 8)

". . . things can get difficult and sometimes when peers are used as tokens and pieces to try and convince someone to do something." (Peer worker, Focus group 1, response 23)

Such experiences can be situated within a long history of psychiatric and psychological practice, where mental health expertise is understood as the sole domain of clinically trained professionals. The consumer/survivor mental health movement has challenged and continues to challenge this conceptualisation, through a centering of lived experience expertise and trauma-informed practice.

As the recognition of the importance of consumer and carer voices has grown in recent years, organisations have needed to embed the values of social justice and equity of access to ensure their services are inclusive of the whole community, and review assumptions about the communities they serve in their operational model and in their direction-setting. For organisations that have been founded on lived experience this culture may already be strong, and the challenge may be how to retain this legacy in the context of various accreditation standards (such as the National Safety and Quality Health Service Standards).

To facilitate a culture of psychological safety, equality and respect, organisations should aim to embed lived experience views throughout their organisation, including at the structural level through: work organisation, policies and procedures; through cultural symbols and artefacts such as storytelling/sharing opportunities; reflective opportunities in staff meetings; digital content (externally facing and internal platforms); and recognition activities.

Examples of how to do this include:

- Embed co-production principles in the development of all workplace policies, procedures and forms which affect the peer workforce. Examples include co-designing a lived experience practice framework, co-developing onboarding procedures, reviewing and contributing to interview questions for recruitment, and co-producing implementing program reviews and evaluations

- Involve peer workers in the development of policies and procedures across the organisation, including participating in Strategic Plan development and implementation, and reviews of governance documentation to ensure the work of organisations is grounded in the wisdom of lived experience

- Whole of staff training around the value of lived experience knowledge

- Create designated roles for lived experience representation on board or board sub-committees

- Incorporate an acknowledgement of lived experience into meeting protocols (note these should be separate to Acknowledgements of Country)

- Provide opportunities for higher-level leadership among peer workers (e.g., periods of acting in roles while other staff are on leave or when positions are vacant; opportunities to 'shadow' executive staff at meetings and other forums to increase exposure to other types of work and to expand professional networks)

- Employee recognition schemes where peer workforce knowledge and skills are valued, celebrated and rewarded

- Regularly review actions such as the above to determine how well they are working and whether any changes are needed in line with developing practice within the sector.

Supporting equity of access for peer work participants

The core peer workforce value of "justice/human rights" outlined by the National Lived Experience (Peer) Workforce Development Guidelines is framed as "recognising that equal access to resources and support is an important factor in everyone's recovery and healing" (Byrne et al., 2021, 22).

Given the wide number and complexity of eating disorder presentations across the Australian population, it is essential that peer workers are able to work across several diagnoses and with people from all walks of life. The skill of aggregating one's personal experience with the experience of others is a critical part of the journey from lived experience to lived experience expertise.

However, lived experience engagement conducted for these Guidelines showed a preference among those seeking peer support for a peer worker with similar experience to their own.

We therefore recommend that where possible and as appropriate, peer workers be matched to participants on the basis of diagnosis. As individual peer workers amass experience with a diversity of participants over time, matching may also include their practice wisdom in relation to several diagnoses.

Matching in terms of stages in the treatment and recovery journey is also critical, for the peer work participant and the peer worker in terms of their capacity to provide the level of support needed.

However, it is also important to consider other dimensions of individual experience in the matching process, including (but not limited to) factors such as gender, age, cultural background, disability, gender identity, sexuality, and neurodiversity, and how these experiences and identities have affected equality of opportunity and equality of outcomes in the content of a person's journey to recovery from an eating disorder. As Byrne et al (2021, 22) explain:

"Understanding the impact of social justice/inequity on identity and opportunity e.g. race, culture, sexual orientation . . . Recognising the consumer movement as a response to the history of social injustice and discrimination towards people with lived experience. Recognising how Lived Experience work is connected to the human rights movement and upholding the human rights of people with lived experience."

This point was also emphasised by some contributors to the lived experience engagement process undertaken for these Guidelines.

Addressing stigma

Despite increasing education and awareness in recent years, public stigma and misconceptions around eating disorders still prevail (Butterfly Foundation, 2022). Increased exposure to stigmatising attitudes predicts negative psychological, social, and physical outcomes for people with eating disorders as it increases social isolation, reduces help-seeking behaviours, and further exacerbates symptoms of eating disorders (Brelet et al., 2021). In the eating disorders peer workforce, stigma may manifest within the beliefs and attitudes of peer workers, and among people who may benefit from participating in peer work in the form of self-stigma, which may in turn prevent them from seeking peer support.

Stigma was cited by several people with lived experience a barrier to accessing suitable peer work. Stigma reduction can be addressed within organisations by supporting lived experience leadership roles (as discussed earlier in this section), through reflective practice by peer workers in relation to their own experiences of stigma during their recovery, and by peer workers providing opportunities for participants to challenge any self-stigma they may be experiencing while in recovery.

Listening to Lived Experience

People with lived experience suggested that reduced access to peer work in combination with self-stigma could discourage people from accessing peer work.

"With eating disorders there is so much shame and stigma that you put on yourself so even if your peer worker is bad, you might not be likely to speak up or think I deserve better because you are in that self-depreciating mindset so the standardisation of care would be awesome." (Peer Work participant, Focus Group 2, response 32)

Applying an intersectional lens

Applying an intersectional lens to peer support responds to the diversity of individuals, including co-occurring conditions, neurodiversity, physical issues, and experiences of marginalisation that interact with eating disorders. People seeking support for eating disorders will have diverse backgrounds, including minority groups who may need additional assistance, including access to interpreters and assistive technology, as well as recognition of culturally specific concepts relating to mental health that may not fit with dominant culture, and prior or anticipated experiences of racism or other structural barriers (Ethnic Communities' Council of Victoria, 2021). Assessing the cultural competence of organisations and workers is necessary to enable accessible peer support.

For Aboriginal and Torres Strait Islander people, connection to community is critical for peer work. Situated within the broader concept of Social and Emotional Wellbeing, peer work needs to be culturally embedded. Advice from the National Lived Experience (Peer) Workforce Development Guidelines for peer work with Aboriginal and Torres Strait Islander communities includes growing awareness through building relationships and dialogue with local services and individuals (Bryne et al, 2021). Benefits include providing support and working with others, but stigma and lack of cultural safety are challenges.

Research into the varied and intersecting needs of these and other cohorts, including the most efficacious way to respond to them in the context of eating disorder care, is still emerging. However several guides and frameworks have been developed to build both the responsiveness of the larger system of care and the broader mental health workforce. A list of these and other specialist resources is at Appendix A.

Practical ways to apply an intersectional perspective within the peer workforce include:

- Training on diversity

- Inclusive recruitment

- Assessing biases

- Partnering with representative bodies

- Translating the findings of research on experiences of marginalised groups into practice.

Organisations should understand peer workers' and participants' identities and how inequality limits effective treatment, while networking externally to address issues of access. As the eating disorder peer workforce grows, standards for different cohorts may develop.

Checklist

○ Review lived experience representation within organisational governance

○ Whole of staff leaning activities in relation to the value of lived experience knowledge and regular reflective practice on this topic

○ Include an assessment of knowledge and skills related to intersectionality and cultural competence in regular staff surveys to identify areas for improvement

○ Invest in training and development opportunities to improve employee knowledge and capability across cohorts of people who are traditional under-served within the eating disorder system of care

○ Review recruitment policies and procedures for biases against minority or marginalised cohorts

○ Dedicate time for staff engagement with diverse local health services and professional networks to build relationships of trust and goodwill with a view to establish mutually beneficial knowledge exchange

○ Encourage individuals to provide feedback or raise complaints in relation to any exclusionary or discriminatory practices, ensuring transparency, fairness, and responsiveness to their concerns.

12. Acknowledgements

The Project Team gratefully acknowledges the work of the many individuals who contributed to these Guidelines, including those who participated in their professional capacity, those who shared their own personal experience or their experience as a carer of someone with experience of an eating disorder, and those who 'wear many hats'. We hope that these Guidelines go some way to furthering the professionalisation and growth of the eating disorders peer workforce, and through that contribute to recovery outcomes.

We conclude with the following insights from a peer worker and one of the contributors to these Guidelines:

"I didn't know much about peer work, but I knew that the presence of someone with lived experience would have made the world of difference in my recovery. I felt that I had reached a point where I was ready to take the next step in my journey and utilise my own experience . . . I feel that my participation in the program has reinforced the skills that I learnt during my own recovery, and I have continued to improve my relationship with food, my body and movement . . .

Within my role, I have regular opportunities to engage in recovery-focused activities and partake in dialogue that challenges societal rules and expectations around our bodies. I have continued to reflect upon my lived experience and in the process, I have learnt more about myself, my values and my experience of an eating disorder. I am incredibly passionate about the power of lived experience and look forward to seeing its advancement within the eating disorder sector." (Clare, 2023)

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14. Appendices – Further information and practical resources

Appendix A: List of peer workforce resources

Eating disorders-specific peer workforce resources

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Appendix B: Guideline development, organisations and people consulted

Guideline development process:

- Review of the findings from Kantar Public research report: An eating disorder-focused peer workforce: Needs assessment (Butterfly Foundation, 2023). This report was commissioned by Butterfly Foundation in 2021-22. It consisted of a rapid literature review and 38 qualitative interviews with a range of informants including peer workers, people with eating disorders supported by peer workers, clinicians, and sector organisations (state, national and international).

- Stakeholder engagement and primary research.

  - Co-planning/ideation workshops with Butterfly Foundation's Lived Experience Community Insights Group (LECIG) (two meetings: October 2022 and February 2023)

  - Eating Disorders Peer Workforce Guidelines Working Group meetings and correspondence from March-September 2023. The Working Group provided advice on project scope, guiding principles, lived experience engagement strategy, insights from the operation of existing peer work programs, interpretation of survey and focus group findings, and review of draft sections of the Guidelines (see Appendix B for the list of organisations and individuals involved).

  - Meeting with National Mental Health Commission (March 2023).

  - Meeting with peer work program lead, Alfred Health Child and Youth Mental Health Service (July 2023)

  - Online survey of people with lived experience in relation to eating disorder peer work (101 completions). Of those who completed the survey, 21 were peer workers, 7 were peer supervisors, 22 were people who accessed peer work as part of their recovery, 8 carers and family members who have accessed peer work, and 43 people who have not been able to access peer work. Survey questions and concepts were informed by a person with lived experience undertaking a student placement at Butterfly.

  - Focus groups: Participants were recruited from the survey. One focus group consisted of peer workers and supervisors (8 participants). This group focused on the training and education of peer workers, the lived experience of peer workers, supervision, working in a multidisciplinary team, and accountable and safe practice. Another focus group consisted of people who have accessed peer work (7 participants). This group focused on training and education of peer workers, accessing peer work and best practice.

  - Lived experience co-design workshop (9 participants): A section of survey and focus group data relating to 'What values, qualities, knowledge, experiences, and competencies does an eating disorder peer worker need to deliver safe and quality peer work?' was themed, grouped and prioritised by participants.

  - The focus groups and co-design workshop were co-facilitated by two people with lived experience who had personally accessed peer work. Several meetings were held with these individuals to co-develop the approach to these discussions.

  - Analysis of quantitative and qualitative data (including coding and thematic exploration)

  - Working Group review of draft Guidelines (August 2023) and final Guidelines (September 2023)

  - Lived experience consultation group review of draft Guidelines (8 participants) (August 2023). A broader group of people with lived experience of peer work provided written feedback on the draft Guidelines (in total, 9 people with lived experience provided written feedback).

  - The Butterfly Foundation Board's Safety and Quality Committee also reviewed the Guidelines (this Committee includes people with lived experience and clinicians).

- Review of relevant state and territory lived experience and peer workforce frameworks and guidelines (see Appendix A)

- Additional desktop research by the Butterfly Foundation Project Team.

Eating Disorders Peer Workforce Guidelines Working Group:

Dr Sarah Squire (Co-Chair), Head of Knowledge, Research & Policy, Butterfly Foundation

Ms Shannon Calvert (Co-Chair), Lived Experience Educator & Adviser

Dr Andrew Wallis, SCHN Eating Disorder Service Network Lead, Sydney Children's Hospitals Network

Ms Jade Gooding, CEO, Australia & New Zealand Academy for Eating Disorders

Ms Olivia Soha, Director and Certified Eating Disorder Recovery Coach, Uncovery

Ms Megan Peart, Carer representative with experience of peer work

Ms Lisa Jones, Lived experience representative and senior peer mentor

Dr Ranjani Utpala, Clinical Psychologist and Project Consultant

Dr Emma Spiel, Workforce Development Coordinator, National Eating Disorders Collaboration (NEDC)

Ms Belinda Caldwell, CEO, Eating Disorders Victoria

Ms Jane Rowan, Executive Director, Eating Disorders Families Australia

Ms Hannah Beighton, Nurse Unit Manager, Wandi Nerida Residential Care

Associate Professor Genevieve Pepin, Australian Eating Disorders Research and Translation Centre

Dr Michelle Williams, Paediatrician, Paediatric and Adolescent Eating Disorder Service, Hobart

Ms Bliss Jackman, Team Leader, Lived Experience Victorian Centre of Excellence in Eating (CEED)

Lived experience focus groups, co-design group, and consultation group (review of draft Guidelines):

Several group discussions and workshops were held online with people with lived experience of eating disorders living and working in urban and regional areas across the states of New South Wales, Victoria, Queensland, Western Australia, Tasmania and the Northern Territory. These groups included people who have previously or are currently working as peer workers and carer peer workers across several settings (in a variety of positions), people who have been peer work participants, and people who are interested in accessing peer work but have been unable to do so. Members of these groups were formed via expressions of interest from survey respondents and from the Butterly Collective (Butterfly's national lived experience network).

- Catherine Walther
- Katelyn Keenan
- Sophie Smith
- Hannah Woolley
- Jeanette Chan
- Annie Jones
- Leanne Treloar
- Diana Sepulveda
- Clare Dehring
- Juliette McAleer
- Nic Juniper
- Vicki Hams
- Lisa Jones
- Gabi Cleaver

- Nadia Myers
- Clare Harris
- Leila Heinrich
- Kamania Butler
- Alison Parkinson
- Julia Quin
- Sarah Walker
- Stefan Tegelj
- Rachael Duck
- Quiney Lin
- Zahraa Alhirz
- Shannon De Luca

This list does not include participants (n =3) who wished to remain anonymous.

Additional consultation and communications

The project team held meetings with and/or engaged via email with the following stakeholders:

Dr Michelle Blanchard, National Mental Health Commission

Noelene Armstrong, Northern Territory Lived Experience Network

Rachel Barbara-May, Alfred Child & Youth Mental Health Service

Belinda Chelius, Eating Disorders Queensland

Appendix C: Sample interview questions (from NEDC, 2019)

Here are some questions that might prove helpful depending on the position's roles and responsibilities:

- What have you learned from your experience of an eating disorder?
- Has peer support or a peer worker played a role in your own recovery?
- How do you think your lived experience could be useful for someone else who is working through their own recovery?
- How do you think you might use your story in your work?
- What sort of situations do you find difficult or distressing? How do you handle these situations?
- What do you do to take care of yourself?

Reflective questions that can be included in the position description/package to prompt candidates to reflect on their motivations. These can be used as a starting point in initial discussions during recruitment or organisations may choose to employ a "personal essay" style approach as part of their recruitment process. The following questions were developed by (NEDC, 2019, Part C2, pp. 22).

Am I ready for peer work?

The following checklist may help peer work candidates decide if this is the right 'next step' for them in their recovery.

- Can I talk about my experience of eating difficulties and the struggles I have been through without being distressed?
- Can I reflect on difficult times and still be available and present for other people?
- Is my physical health stable at the moment?
- Have I learned from my experience of illness, and can I speak about the process of recovery and why it was worth it?
- Am I open to learning new skills like how to effectively facilitate a group and work in a safe way?
- Do I have the time, energy and availability to participate in training, group sessions and debriefing?
- Do I have a support network and self-care strategies in place? Have I demonstrated in the past that I will use these when I need them?
- Do I know my own indicators of risk? Am I able to ask for help or withdraw from the group when I am at risk?
- Am I comfortable with the fact that there is no 'one size fits all' way to recover from an eating disorder and that everyone needs to change at their own pace and in their own way? Can I avoid comparisons of ED experiences?
- Am I comfortable with the idea that recovery is always possible while still acknowledging that the process is often difficult and distressing?
- Am I committed to taking care of myself?

Appendix D: Sample position descriptions

These two position descriptions are offered as a guide only.

Role Title	Peer Mentor
Reports to	Manager, Peer Support Programs
Purpose of the role	The primary purpose of this role is to provide hope for recovery and peer support through 1:1 mentoring with adults who are being supported by an eating disorders treatment team. The role aims to provide safe, supportive and recovery-focused peer support, drawing on your lived experience of recovery from an eating disorder and your commitment to safely sharing your own experience and knowledge of eating disorders and related issues such as managing self-stigma, shame, fear and ambivalence to: • Help participants to set, review and achieve recovery goals (such as meal planning, grocery shopping or developing new interests) • Support participants to access other forms of information and support, including community engagement and creative activities • Support participant motivation and skill development, including assisting participants to prepare to re-engage with activities such as study, work or other independent activities.
Accountabilities and responsibilities	• Undertake induction and training in the organisation's Lived Experience Practice Framework, including any professional development as required • Work collaboratively with the Manager to ensure uninterrupted service delivery for provision of mentoring to participants. • Appropriately and safely draw on own experiences with regard to the participant's motivation and goals, collaborating with the participant to identify their strengths and individual support needs • Keep accurate and up to date records of contact with program participants, including progress against self-directed objectives. • Assist in reporting data around engagement to the Manager along with feedback on outcomes and on any significant issues. • Assess for warning signs and red flags and escalate if needed • Attend team meetings and regular de-briefing and supervision
Selection criteria	**Essential** • Lived experience of an eating disorder. • Recovery from an eating disorder (minimum of two years). • An understanding of eating disorders and disordered eating, body image and related issues and of their impact on the individuals • Understanding of the role of professional treatment, including how multidisciplinary teams operate • Well-developed interpersonal and communication skills with a caring and empathetic approach and ability to establish rapport. • Insight and understanding of the wide range of issues that are commonly present for people with eating disorders and their families/partners and caregivers, including knowledge of risk and protective factors. • A clear understanding of professional boundaries, confidentiality, privacy principles and practices. • An understanding of common co-morbid conditions with eating disorders and an ability to provide support and referrals as needed. • A commitment to the value of peer support within mental health recovery and a good understanding of best practice principles for supporting those with an eating disorder • An understanding of the value of self-care and ability to enact own self-care strategies in times of stress

Selection criteria	**Desirable** • Prior experience in providing 1:1 peer support in a mental health or community health context. • Able to meet relevant NEDC core competencies as per the National Practice Standards for Eating Disorders • Experience in a similar not-for-profit or charitable NGO environment. • Qualification in mental health and/or peer work
Other requirements	**At all times:** • Conduct yourself in a professional manner. • Have exceptional interpersonal relationship skills and a positive attitude • Strive to act in accordance with the vision, mission and objectives of the organisation • Follow the organisation's policies and procedures. • Adhere to the organisation's Child Safe Policy and contribute to a culture of child safety • Follow/participate in occupational health and safety measures. • Act considerately around the workplace and have regard for the wellbeing of fellow staff, volunteers and service users. • It is a requirement of all positions that the person has a Working With Children Check clearance (pass) and Police check. • All staff should be aware of and actively uphold the organisational values

Role Title	Peer Support Facilitator (Carer)
Reports to	Manager, Carer Support Team
Purpose of the role	The primary purpose of this role is to provide hope for recovery and peer support through various activities working directly with people currently caring for a loved one, family member, partner or friend experiencing an eating disorder. The role aims to provide safe, supportive and recovery-focused environments, drawing on your lived experience of being a carer to facilitate support. Our group-based programs provide: • Information about eating disorders, the recovery process and how to manage the stress of caring for someone with an eating disorder • Skills to better relate to a loved one and how to foster a recovery-orientated environment • An opportunity for carers to know they are not alone, receiving support and hope from, and offering support and hope to, other members of the group.
Accountabilities and responsibilities	• Work collaboratively with the Manager to ensure uninterrupted service delivery for provision of carer support groups and programs. • Appropriately and safely share and discuss common experiences with group and program participants, assisting to initiate, establish and maintain supportive relationships within the groups. • Co-facilitate group programs, including delivery of education and awareness activities. • Keep accurate and up to date records of attendance at support groups, individual mentorships, health records, and programs facilitated. • Work collaboratively with internal and external services that support carers as required • Assist in reporting data around engagement and service usage to the Manager along with feedback on outcomes and on any significant issues. • Attend team meetings and supervision with a supervisor.
Selection criteria	**Essential** • Lived experience of caring for someone with an eating disorder. • Peer support facilitators who have experienced caring for a person with an eating disorder who has been recovered for at least 18 months. • An understanding of eating disorders and disordered eating, body image and related issues and of their impact both on the individual experiencing the issue and, on their families, friends partners and other carers. • Well-developed interpersonal and communication skills with a caring and empathetic approach and ability to establish rapport. • Insight and understanding of the wide range of issues that are commonly present for people with eating disorders and their families/partners and caregivers. • A clear understanding of professional boundaries, confidentiality, privacy principles and practices. • An understanding of common co-morbid conditions with eating disorders and an ability to provide support and referrals as needed. • A good understanding of best practice principles for supporting those with or caring for someone with an eating disorder.

Selection criteria	**Desirable** • Prior experience in providing peer support or facilitating groups in a mental health or community health context. • Previous participation in an eating disorder carer peer support program • Able to meet relevant NEDC core competencies as per the National Practice Standards for Eating Disorders • Experience in a similar not-for-profit or charitable NGO environment. • A qualification in peer support, such as Intentional Peer Support or a Certificate IV in Peer Support.
Other requirements	**At all times:** • Conduct yourself in a professional manner • Have exceptional oral communication skills, interpersonal relationship skills and a positive attitude • Strive to act in accordance with the vision, mission and objectives of the organisation • Follow the organisation's policies and procedures. • Adhere to the organisation's Child Safe Policy and contribute to a culture of child safety • Follow/participate in occupational health and safety measures. • Act considerately around the workplace and have regard for the wellbeing of fellow staff, volunteers and service users. • It is a requirement of all positions that the person has a Working With Children Check clearance (pass) and Police check. • All staff should be aware of and actively uphold the organisational values

Appendix E: Supervision plan template

Supervision Session Template for Eating Disorder Peer Workers

Date and Time: _____ Supervisor: _____ Peer Worker: _____

_____ _____ _____

1. Check-In:

- Begin the session with a brief check-in to see how the peer worker is doing personally and professionally. Encourage open and honest communication.

2. Case Review:

- Discuss any specific cases or client interactions that the peer worker would like guidance or feedback on.
- Explore challenges, successes, and strategies employed during the peer worker's interactions with individuals with eating disorders.
- Address any ethical considerations or boundary issues that may have arisen, keeping the possibility of 'peer drift' in mind.
- Address issues arising around scope and level of responsibility of the role.

3. Professional Development:

- Discuss any training opportunities, workshops, or resources that may be beneficial for the peer worker's growth in the eating disorders or general mental health field. Important to consider broader mental health context due to high rate of co-existing conditions.
- Explore areas of interest or specialisation within the field and how the peer worker can pursue further learning or professional development, including webinars.
- Identify and explore peer networking opportunities/group peer supervision.
- Review upcoming local/international conferences and opportunity to access bursaries/scholarships that can be accessed.

4. Personal Development and Self-Care:

- Address the peer worker's emotional well-being and self-care practices.
- Explore any challenges or stressors related to their work.
- Discuss strategies for maintaining a healthy work-life balance and managing the emotional impact of supporting individuals with eating disorders.

5. Support and Supervision Needs:

- Provide an opportunity for the peer worker to express any specific support or supervision needs they may have.
- Discuss any concerns or questions related to their role as a peer worker in the eating disorder field - allow space for organisation related/system specific challenges that may be arising.

6. Wrap-Up:

- Summarise the key points discussed during the session.
- Identify action steps or goals for the peer worker to work on before the next supervision session.

Appendix F: MDT/Case review template

Date:

[Date of the meeting]

Participant Label:

[Attach patient label/equivalent]

Participant ID:

[Medical Record Number/Unique Identifier]

Attendees:

[List the names and roles of all care team members present
at the meeting, including participant and family/other supports]

Apologies:

[List the names and roles of all care team members not present at the meeting]

Purpose of the Meeting:

[Briefly state the purpose of the MDT meeting, e.g., to review progress
and discuss treatment plan updates since last meeting 4 weeks ago]

Review of Previous Meeting Minutes:

[Provide a summary of the key points discussed in the previous case review]

Progress Overview:

[Summarise each person's perspective of current status, progress towards each
treatment goal, and any recent developments since the last meeting. Not everyone
will have all listed professionals, and these can be adapted as appropriate]

Participant Input:

Peer Worker Input:

[Encourage the peer worker to provide their feedback on the participant's current status,
and progress towards treatment goals, including any suggestions or adjustments based
on their observations and insights]

Mental Health Professional Input:

Dietetic Input:

Nursing team input:

Medical team Input:

Other team Input (e.g. other allied health, expressive therapists etc):

Discussion and Recommendations:

Discussion Points:

[Encourage the peer worker to provide their feedback on the participant's current status, and progress towards treatment goals, including any suggestions or adjustments based on their observations and insights]

Recommendations:

[Record any recommendations or action items resulting from the discussion, including those provided by the peer worker]

Next Steps and Follow-Up:

Action Items:

[List all action items identified during the meeting, along with responsible team members and due dates. Ensure communication strategy to absent care team members is included]

Follow-Up Plan:

[Outline the plan for ongoing communication and updates between care team members before the next meeting]

Next Meeting Date:

[Set the date for the next case review meeting. Frequency will be determined by the service setting and need of the participant]

*Note: This template is intended as a general guide and can be customised to suit the specific needs and preferences of the care team. Prompts have been included to ensure that the peer worker's feedback and contributions are actively elicited and recorded as an integral part of the participant's progress review and treatment planning process.

Appendix G: Peer work information sheet

What is a Peer Worker?

A Peer Worker is a member of the care team who draws on their own personal experience of difficulties and recovery to help them relate to you as a person, and support your journey of recovery by listening, inspiring hope, role modelling recovery, sharing information, and providing a safe, stable point of contact during your recovery.

Peer workers at this organisation have completed training in various components of peer work including:

Note: Organisations might choose to list what training their peer workers have completed.

Our peer workers also receive ongoing supervision and support in their work and are a valued member of the team. Our peer workers provide support in various ways including (organisations can change based on their services):

1. Running groups

2. Providing meal support

3. Providing one-to-one support

By engaging with a peer worker, you will learn about each other and build a relationship based on mutual respect, trust, safety, and cooperation. This relationship offers you the unique opportunity to develop a supportive relationship with someone who has worked through similar challenges in their own lives. Our Peer Workers will use their personal experience of recovery to help you to set your own recovery goals and support you to move towards those goals.

Working from a strength's perspective, the Peer Worker plays an important role, helping you to:

- Reduce feelings of social isolation

- Share from experience and develop self-awareness

- Develop and sustain hope and motivation for change or sustained recovery

- Define and work towards personal goals

- Learn practical strategies for recovery

- Enjoy social contact and daily activities

- Negotiate setbacks in recovery

- Develop self-esteem and taking pride in their achievements

Our Peer Workers will:

- Develop a safe and trusting relationship with you

- Provide encouragement and support, in a nurturing and respectful manner

- Contribute to your growth and goal setting

- Teach you relevant skills to help you achieve your goals

- Review and respond to your changing needs and goals

- Work with you as part of your care team to support your recovery

Our Peer Workers will not:

- Meet all your needs

- Tell you what to do. But they may be able to share helpful information from their own experience.

- Provide counselling or professional treatment. Peer work is an additional support for you in your recovery journey.

- Replace your friendships and are not a friend. Like other members of your professional care team, peer workers work with professional boundaries in place and the duration of the relationship may be limited based on your support needs. You will have an opportunity to discuss this further when you first meet your peer worker.

    Note: Organisations may choose to specify time limitation based on their model of care.

- Provide crisis support. When you start working with your peer worker, you will agree on when they are available to be contacted and work with you to develop a plan for crisis support.

Is peer work support right for you?

Working with a peer worker may be the right choice for you if:

- You want to make changes in your life by participating in treatment or sustaining your wellbeing after treatment

- You have a GP and/or Mental Health Professional

- You are in good general health

- You feel isolated and need someone to listen to you

- You are looking for an opportunity to share your experience with someone who has similar experiences, set goals and learn new ways to move forward in your recovery journey.

What will be offered to you?

- In the initial intake, we will ask you some questions to help find the right peer worker for you.

- Your peer worker will meet with you either weekly or fortnightly. The frequency of these appointments can be reviewed based on your needs.

- You will meet your peer worker either in person (at a location that you agree on beforehand) or through a pre-arranged phone or video call.

- You will set specific goals with your peer worker and identify specific areas of challenges that you want support with. This might be in relation to meal support, completing food challenges, working through communication barriers, help with meal planning/food shopping etc.

- Deciding when and where you will meet is one of the first things that you will negotiate with your Peer Worker.

What are your responsibilities?

When you engage in one-to-one peer work, you are entering into a partnership and hence you will have an active role to play. You and your Peer Worker will work together to develop an agreement that will spell out what each of you will do to help the relationship to develop as you work on your recovery goals. This agreement is intended to help keep on track and be able to review your progress.

Your agreement will include:

- Your objectives and what you would like to achieve, with specific timelines identified. As part of this process, you may be asked to write down a paragraph about yourself and your goals.

- When and where you will meet and how long each session will be

- The type of contact that you prefer (e.g. face to face, telephone) and at least one alternative

- How and when you will review the relationship and what you will do if you experience challenges that you cannot resolve together

- Your preferred contact details and emergency contact details

- A privacy and confidentiality statement

- The finishing date for your individual peer work support

- A statement of the mutual commitments made by you and your peer worker.

Usually, you and your peer worker will be asked to agree to things like:

- Keeping to the scheduled meeting times

- Letting each other know if you need to make any changes to meeting arrangements

- Checking your emails or phone messages

- Respecting each other's time and avoiding contact outside the agreed meeting schedule

- Building the relationship together

- Maintaining each other's privacy and confidentiality

- Sharing honestly with each other from your experience

- Listening respectfully to each other

- Working together to set goals and resolve problems

- Taking responsibility for your own actions and choices

- Reflecting and learning through the experience of mentoring

- Letting the Program Coordinator know of any issues or concerns as soon as they come up

Program basics

In this section, organisations can outline specific details about the program including but not limited to:

- Duration for which one-to-one support might be offered (e.g. X months) and number of sessions per week and length of each session (e.g. once/week for 1 hour).

- Details about how to express interest/refer self for the program

- Any program non-negotiables (e.g. medical monitoring/GP review, expected engagement with other members of treatment team, abusive language/aggressive behaviour, lateness, non-attendance, costs).

- Mechanisms to provide feedback about the service.

Appendix H: Peer work agreement form

Peer Work Participant: [Name]

Peer Worker: [Name]

Organisation Name (if applicable):

Date:

Purpose:

The purpose of this Agreement is to establish a framework for the provision of one-on-one peer support. Both the participant and peer worker acknowledge the voluntary nature of this relationship and commit to working together in a goal-oriented manner, with a recovery-focus.

Roles and Responsibilities:

_____ [Peer Worker Name] will:

- Share personal insights from their own lived experience in a responsible and safe manner.

- Listen actively and empathetically to the concerns and experiences of the Participant.

- Respect the boundaries and preferences of the Participant.

- Refrain from giving medical or therapeutic advice.

- Maintain confidentiality and not share any personal information discussed during the support sessions without explicit consent, unless there are concerns for safety.

- Recognise the limits of their own expertise and knowledge.

- Be honest and provide constructive feedback to the participant.

- Other agreed roles/responsibilities:
  ○
  ○
  ○

_____ [Participant] will:

- Engage openly and honestly in discussions about their current ED-related experiences and challenges.

- Respect the boundaries of the Peer Worker and acknowledge that they are not a trained therapist or medical professional.

- Understand that the peer work relationship is not a substitute for professional therapy or medical treatment.

- Maintain confidentiality regarding the personal information and experiences shared by the Peer Worker.

- Take responsibility for their own well-being and decisions based on the discussions during the support sessions.

- Be open about any feedback provided by the peer worker and discuss own responses to feedback provided in a respectful and open manner.

- Engage with a treatment team as required by the peer worker/organisation they work for.

- Other agreed roles/responsibilities:
  ○
  ○
  ○

Meeting Frequency and Duration:

A suitable schedule for meetings and the expected duration of each session will be stipulated here. Flexibility will be maintained in case adjustments are needed due to unforeseen circumstances. Location can be specified or will change based on needs. Number of sessions should also be stipulated with mid-point review identified.

Peer work individual support will be provided for _____ (state timeframe), commencing on _____ (date). At mid-point, we will review the identified goals and progress to evaluate whether the remaining timeframe needs to be reviewed. Any decisions around early ending or requests to extend should be discussed with the rest of the professional care team.

Sessions will occur (choose one):

Weekly on _____ (day of week) at _____ (time) for _____ (duration)

Fortnightly on _____ (day of week) at _____ (time) for _____ (duration)

Monthly on _____ (day of week) at _____ (time) for _____ (duration)

If unable to commit to all session times at outset, a date for the next meeting can be agreed with the peer worker.

Session times, once agreed, should not be cancelled by either party unless this is unavoidable. If a participant needs to reschedule a session, please do so by contacting _____[outline process for how this can be done].

Communication and Contact:

Communication methods (in-person, phone, video call, etc.) and preferred modes of contact (email, phone, messaging apps) will be determined by both parties based on their availability and relevant organisational policies where applicable. Options for who to contact in case of crisis/emergency should be outlined.

Goals:

Collaborative goal setting with view to identify at least 3 action-oriented goals (e.g. SMART goals)

1. Goal:

2. Goal:

3. Goal:

Non-negotiables and Program Rules:

Organisations to include program non-negotiables, including but not limited to compliance with medical review requirements, physical health goals, attendance to other treatment appointments etc. In this section, consequences of repeated lateness, non-attendance, repeated session cancellations can also be addressed.

- Non-negotiable 1:

- Non-negotiable 2:

- Non-negotiable 3:

- Non-negotiable 4:

- Non-negotiable 5:

Ending Peer Work Relationship:

Clear outline conditions around when and how the relationship will be ended. If change in peer worker for any reason, how handover will be managed (either internally in organisation or with primary care team)

By signing below, both parties agree to the terms of this Agreement and to work together in a spirit of mutual respect and support.

Peer Work Participant Signature

Peer Work Participant Name

Date

Peer Worker Signature

Peer Worker Name

Date

Eating Disorders Peer Workforce Guidelines

Butterfly

Guideline Development

Review of findings from An eating disorder-focused peer workforce: Needs assessment (Butterfly Foundation, 2023)

Review of relevant state and territory lived experience and peer workforce frameworks and guidelines

Stakeholder engagement and primary research

- Ideation workshops with Butterfly Foundation's Lived Experience Community Insights Group
- Eating Disorders Peer Workforce Guidelines Working Group
- Online survey of people with lived experience of eating disorders
- Focus groups with peer workers and peer work supervisors

- Focus group with people who have accessed peer work
- Lived experience co-design workshop
- Working Group review of draft Guidelines
- Lived experience consultation group review of draft Guidelines
- A broader group of people with lived experience of peer work provided written feedback on the draft Guidelines

Review of final Guidelines

- Working Group review of Guidelines
- Butterfly Foundation Board's Safety and Quality Committee review of the Guidelines

- Review of the Guidelines by the Australian Government Department of Health and Aged Care

To learn more, read the full Eating Disorder Peer Workforce Guidelines

Eating Disorders Peer Workforce Guidelines

Butterfly

Guiding principles

1. Adequate training and supervision, to ensure that peer workers have the skills and knowledge required to provide safe and effective support

2. A recovery-oriented approach, emphasising hope for recovery, self-determination and empowerment

3. Employing organisations are committed to culture change, including practices in place to ensure that peer workers are valued and respected

4. Prioritisation of peer workforce wellbeing and safety, with a clear scope of practice and access to sufficient support

5. Accessibility, including matching of peer workers to peer work recipients based on participant needs and presentation as much as possible and as appropriate

6. Professional and person-centred, including being non-judgemental, inclusive and trauma-informed

7. Accountable and safe practice, including maintaining appropriate professional boundaries

8. Integration within the care team, to serve the best interest of the participant

To learn more, read the full Eating Disorder Peer Workforce Guidelines

Eating Disorders Peer Workforce Guidelines

Butterfly

Checklists

Recruitment and onboarding

○ Prioritise candidates who have personal lived experience with eating disorders.

○ Seek candidates who have demonstrated progress and resilience in their recovery

○ Develop position description with scope of role (Examples are provided in Appendix D)

○ Have inherent requirements outlined as part of position description

○ Develop a comprehensive application and interview process including opportunities for applicants to ask questions and get constructive feedback

○ Onboarding schedule that includes meetings with key staff, mandatory training to be completed and signed off, plan for shadowing, clear framework for assessing competence and confidence prior to working independently, supervision plan outlined.

○ Have policies in place around employee wellbeing and clear processes to monitor and minimise risk of burnout in all staff (including peer workforce).

○ Develop a policy around wellness check for all staff (including peer workers) that identifies how to support the mental health of all staff including early mitigation strategies e.g. reduced duties for a period of time. (Note: the goal of such a process is early identification and prevention and is different to processes around creating reasonable adjustments for roles. The focus here is to foster a culture of psychological safety in the workplace whereby line managers can proactively check-in about the mental health and wellbeing of employees as standard practice. Such a work environment will enable all staff to feel supported in disclosing mental health challenges without fear of repercussion/job loss etc).

To learn more, read the full Eating Disorder Peer Workforce Guidelines

Supervision requirements

○ Peer workers have access to regular and ongoing supervision.

○ Carer peer workers have access to carer lived experience supervision.

○ Peer worker workloads support attending supervision as part of their contracted work hours and/or within mutually agreed time-in-lieu arrangements.

○ All supervisors are paid for the provision of supervision by ensuring that in-house supervision time is included in senior peer workers workload.

○ Externally engaged supervisors are paid for providing supervision.

○ Supervision plans or contracts are utilised to establish clear goals for supervision. Appendix E provides a sample template.

○ Career development opportunities are clear with pathways for peer workers to progress to providing supervision/taking on supervisory roles being clearly articulated in annual performance reviews.

○ Review of supervision is incorporated into continuous improvement cycles within the organisation.

○ Policies in place to review utility and effectiveness of supervision (through collation of qualitative and quantitative feedback from all supervisees).

○ Processes (and policies) in place at organisational level to ensure that supervision is being provided and accessed regularly, with clear mechanisms in place to address any decrease in frequency due to workloads or changes in service delivery.

Integration with care team

○ Peer workers are invited to attend case review meetings.

○ Training and support is provided to peer workers to contribute to MDT/case reviews.

○ Whole team is provided education about role of peer worker in MDT decision-making.

○ Case review chairing is rotated within team, with peer worker having equal opportunity to chair.

○ Develop case review/MDT meeting template as a reminder to actively seek peer worker input (Appendix F provides a sample template).

○ Develop clear process for addressing power imbalances within MDT decision-making (relevant to health service and community settings).

○ Care coordination can be shared in primary care settings, with duty of care and risk management accountability clearly outlined between primary care team members.

Accountability and safe practice

Organisational level

○ Develop clear job descriptions for lived experience peer worker roles that outline their responsibilities, reporting lines, and accountability within the organisation.

○ Develop inherent requirements and reasonable adjustments for each role within the organisation with co-design principles.

○ Develop a comprehensive application and interview process to ensure that candidates with the right training and experience are hired.

○ Provide regular and ongoing supervision, training, and support to lived experience peer workers, with a view to ensure staff wellbeing, skill development, and adherence to organisational policies.

○ Provide opportunities to "buddy" with a senior peer worker as part of orientation.

○ Review staff seating allocation to ensure peer workers have easy access to other team members.

○ Encourage collaboration and communication between lived experience peer workers and other mental health professionals to ensure integrated and coordinated care for service users.

○ Review organisational policies on risk management, escalation, and incident reporting to clearly outline pathways for peer workers to escalate concerns around deterioration and risk.

○ Ensure organisational policies clearly articulate safe practice around risk screening and management for off-site peer work activities such as safe locations, home visits, travelling together, meeting in public spaces etc.

○ Develop an information sheet about the peer work program to be provided to participants at the service or for promoting the service (to improve referral pathways).

○ Develop an agreement form for engaging with peer worker, including clear goals for engagement, safety planning, and termination.

○ Prioritise collecting data around participant experience of service (both qualitative and quantitative measures, e.g. PREMS/PROMS or 'Your Experience of Service' survey style feedback).

○ Peer work roles and responsibilities are included in organisational care (or clinical) governance framework which clearly articulates accountability and reporting flow from 'floor to board' and 'board to floor'.

○ Establish feedback mechanisms for participants and staff to provide input on the effectiveness of lived experience peer worker roles and identify areas for improvement.

Accountability and safe practice

Individual level

○ Engage in continuous learning and professional development to stay updated on best practices and ethical guidelines.

○ Engage in regular supervision and reflective practice to evaluate interactions, assess ethical dilemmas, be mindful of 'peer drift', and identify areas for improvement.

○ Prioritise personal wellbeing and self-care to maintain emotional resilience and prevent burnout.

○ Promote ethical conduct and the maintenance of appropriate boundaries in peer support relationships.

○ Maintain strict confidentiality about personal information shared by individuals, following organisational policies and legal requirements.

○ Irrespective of treatment setting, work collaboratively with other treatment providers and family or carers involved in the care team.

○ Encourage individuals to provide feedback or raise complaints, ensuring transparency and responsiveness to their concerns.

○ Maintain accurate records of interactions and progress, ensuring accountability and transparency.

Organisational culture

○ Review lived experience representation within organisational governance

○ Whole of staff leaning activities in relation to the value of lived experience knowledge and regular reflective practice on this topic

○ Include an assessment of knowledge and skills related to intersectionality and cultural competence in regular staff surveys to identify areas for improvement

○ Invest in training and development opportunities to improve employee knowledge and capability across cohorts of people who are traditional under-served within the eating disorder system of care

○ Review recruitment policies and procedures for biases against minority or marginalised cohorts

○ Dedicate time for staff engagement with diverse local health services and professional networks to build relationships of trust and goodwill with a view to establish mutually beneficial knowledge exchange

○ Encourage individuals to provide feedback or raise complaints in relation to any exclusionary or discriminatory practices, ensuring transparency, fairness, and responsiveness to their concerns.