National Eating Disorders Collaboration

Developing a Peer Workforce for Eating Disorders

Codesign for Change

Part C1

Organisation Matters

'Developing a Peer Workforce for Eating Disorders' is a suite of evidence-informed practice guides designed to promote and facilitate the implementation of evidence-based peer work in treatment and support services for people with eating disorders.

The intended audiences for the Guide are:

- Health service executives, planners and decision makers
- Human resource professionals
- Health professionals with responsibility for implementation, supervision and working as part of an integrated team
- People with lived experience who are considering becoming peer workers.

Using this Guide

The Guide is presented in three parts:

Part A: Exploring the Evidence for Peer Work in Eating Disorder Settings

Part A provides a brief outline of the evidence reviewed in the development of this Guide.

Part B: Understanding Peer Work

Part B provides an introduction to peer work practices and the way in which peer work can enhance outcomes for people with eating disorders.

Part C: Organisation Matters

The four guides in Part C explore some of the organisational support strategies that have been found to assist in the development of safe and effective peer work initiatives. The documents in Part C may assist in the planning, implementation and evaluation of peer work initiatives. It may also provide useful content for training for peer workers and for clinicians.

C1. Codesign for Change This document

C2. Robust Recruitment

C3. Supporting Practice – Supervision and Training

C4. Introductory Training Resource

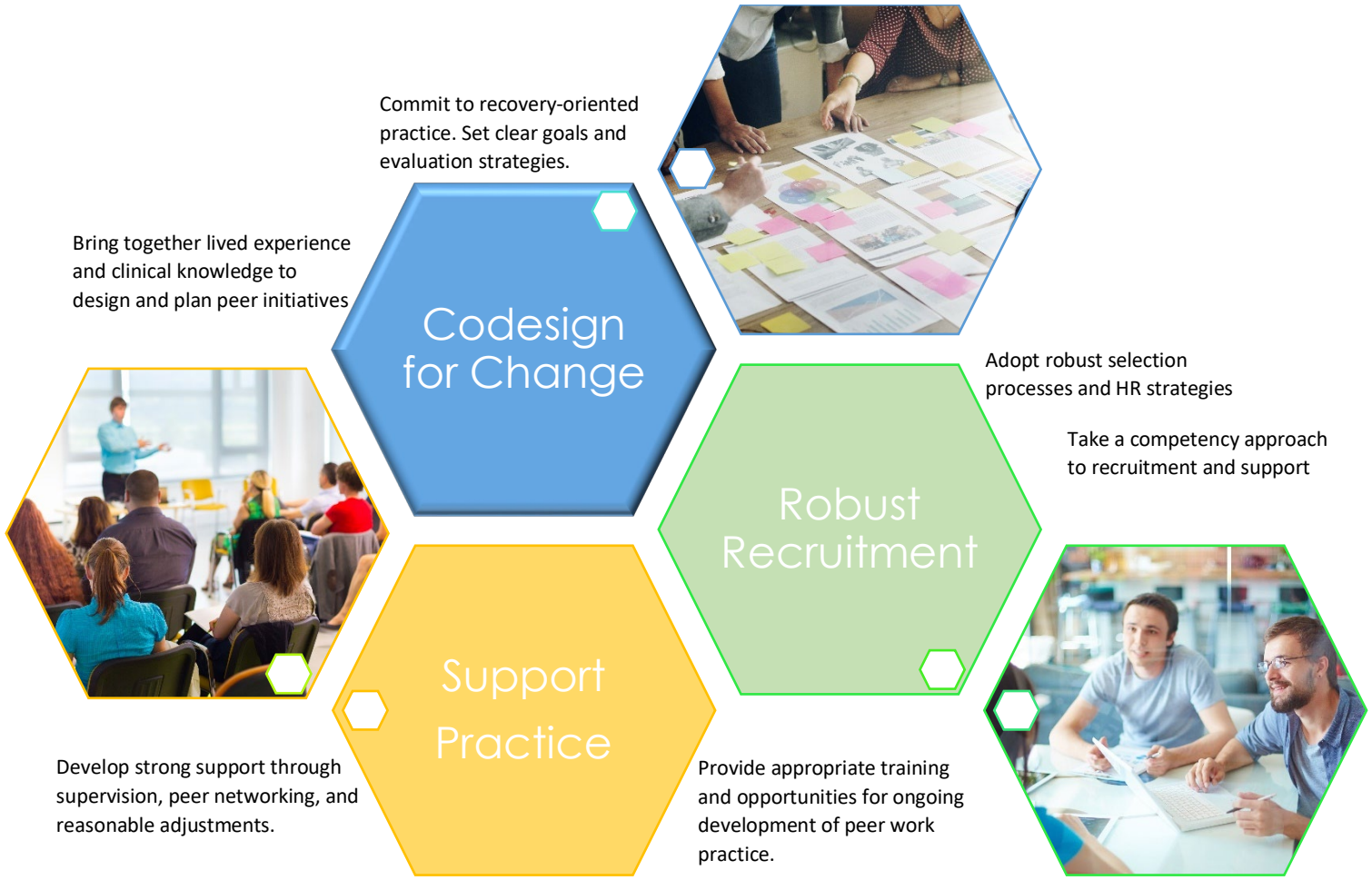

Figure 1: Organisational Steps Towards Safe Effective Peer Work

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Part C1. Codesign for Change

Recruitment of peer workers in the health workforce is a relatively new approach across the mental health sector (Repper and Carter, 2013), particularly for eating disorder services. Changes may be required to organisational processes to gain the greatest benefit from peer work roles.

"Achieving the benefits of peer work is dependent on organisational commitment to change and a skilled and supported peer workforce" (Byrne, O'Shea and Macdonald, 2018).

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).

The Challenges of Peer Work

Peer workers usually find their work satisfying and effective, however not all peer work roles are equally meaningful and beneficial. The challenges faced by people in peer work roles include lack of understanding of peer work roles, negative attitudes from other employees, organisational processes that are inadequate to support peer work (Vandewalle, Debyser, Beeckman et al., 2016) and mental health culture which may include stigmatising beliefs or practices (Gee, McGarty and Banfield, 2016).

'Work is very satisfying, but the environment in which I undertake the work is not.'
'The inherent cultural challenges in clinical settings can be disillusioning although the work with consumers makes it bearable' (Gill, unpublished data, 2018).

Factors in the organisation's environment that impact on the peer worker's safety and job satisfaction include:

- **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.
- **Reasonable adjustment**
  Lack of understanding of the adjustments that peer workers may need to their employment conditions, or a lack of willingness to accommodate the needs of the lived experience worker by adjusting procedures, has a direct impact on the worker's wellbeing, safety and effectiveness.
- **Isolation**
  Many peer workers feel isolated in their roles, especially where they are the sole lived experience worker in a clinical setting.

Avoiding the Pitfalls

Developing a supportive, recovery-oriented organisational culture and leadership helps to avoid the difficulties that can be associated with peer work for the peer worker and the organisation. Preparing a welcoming culture prior to employing peer workers can assist in avoiding the undesirable experiences described on the next page by the West Australian Peer Support Network (WAPSN, 2018).

The majority (78%) of sick leave taken for work-related reasons are attributable to peer workforce management problems, such as lack of role understanding, lack of executive support, poor supervision and lack of tailored/inclusive policies.

Disturbingly frequent experiences of stigma, discrimination and bullying in the workplace highlight the need for immediate attention to and improvement of peer workplaces to support the health, wellbeing and retention of peer workers. Peer workers do not have the same level of occupational representation that more established workforces do, and bring experiences to workplaces that have traditionally been seen as undesirable, problematic or risky from a human resource management perspective. There is a need for government and employers to support additional safeguarding mechanisms for safety and equality of peer workers in the workplace, described within the report recommendations.

The Peer Workforce Report (WAPSN, 2018)

http://www.comhwa.org.au/wp-content/uploads/2017/06/The-Peer-Workforce-Report-2018.pdf

http://www.comhwa.org.au/wapsn

Byrne, L. Happell, B. and Reid-Searl, K. (2016) Lived experience practitioners and the medical model: world's colliding? Journal of Mental Health, 25:3, 217-223, DOI: 10.3109/09638237.2015.1101428

Organising for success: what helps to make peer work effective?

The challenges for peer workers start before they are engaged. Existing policies, processes and practices of the organisation may make it difficult for peer workers. Reviewing these practices from a lived experience perspective before recruitment can make a difference to the success of the peer work role.

Factors that support implementation of peer work roles include:

- **Leaders and champions**
  Attitudes of senior managers are critical to success. Identify champions who will advocate for the integration of peer work.

- **Co-development and co-leadership**
  Peer workers are part of the continuum of consumer and carer participation. Involve people with lived experience in service design, evaluation, development and governance, including the development and leadership of peer work roles.

- **Adopt a change and development focus**
  Best practice for peer work is to integrate it with a strategic focus on developing recovery oriented and person-centred practice and improving responsiveness to service user needs.

- **Role clarity**
  Clearly describe the purpose and expectations of the peer work role. Develop position descriptions in consultation with lived experience representatives and within a consumer perspective and recovery-oriented framework.

- **Effective recruitment and on-boarding strategies**
  Recruit and train for competence and resilience. Robust but flexible strategies are required to help job candidates work with you in identifying the roles they are best suited to and to enable them to approach the role with confidence.

- **Practice development**
  Provide on-going practice supervision, mentoring support and access to competency-based training to enable the peer worker to develop their capabilities and confidence.

- **Networks of support**
  Where possible, engage more than one peer worker and enable them to work together, providing mutual support. Help peer workers to connect with external individuals or networks of peer workers.

- **Integration into the Organisation and Team**
  Provide ongoing education and support for clinical staff to help them to understand and work with peer workers. Confidence in the peer work role increases with frequent exposure to lived experience workers.

"Learning together – everyone involved in co-production will probably benefit from training in collaboration and co-production. Engaging all participants – those sharing from lived experience and those sharing from professional experience – in learning together provides an environment in which to develop trusting relationships." (Cook, 2016)

Take it Further: Suggested Reading

Byrne, L., Roennfeldt, H. and O'Shea, P. (2017). Identifying barriers to change: The lived experience worker as a valued member of the mental health team. Report to the Mental Health Commission of Queensland, June 2017.

Byrne, L., Roennfeldt, H., O'Shea, P. and Macdonald, F. (2018). Taking a Gamble for High Rewards? Management Perspectives on the Value of Mental Health Peer Workers. *Int. J. Environ. Res. Public Health*; 15; 746. doi:10.3390/ijerph15040746

Cleary, M., Raeburn, T., Escott, P., West, S. and Lopez, V. (2018), 'Walking the tightrope': The role of peer support workers in facilitating consumers' participation in decision-making. *Int J Mental Health Nurs*, 27: 1266-1272. doi:10.1111/inm.12474

Gee, A., McGarty, C. and Banfield, M. (2016) Barriers to genuine consumer and carer participation from the perspectives of Australian systemic mental health advocates. *Journal of Mental Health*; 25:3: 231-237. DOI: 10.3109/09638237.2015.1124383

Stomski, N.J. and Morrison, P. (2017). Participation in mental healthcare: a qualitative meta-synthesis *Int J Ment Health Syst*; 11:67.

A safe environment for everyone

Concerns raised by organisations and health professionals about peer work tend to focus on safety for the peer worker and for service users. Effective employment processes contribute to improved safety and quality of practice in peer work.

Best practice human resource management practice makes the workplace safe for all employees. Evidence supports a connection between workplace practices, culture and the mental wellbeing of employees. A psychologically safe workplace is one that promotes employee satisfaction and confidence, enabling them to achieve their potential for their own benefit and the benefit of the organisation and its service users (Fenton, Roncancio et al., 2014; LaMontagne, Keegel and Vallance, 2007).

The Mentally Healthy Workplace Alliance (Harvey et al., 2014) has identified evidence based risk and protective factors that need to be considered in the design of a psychologically safe workplace. These include: job design and levels of agency; supportive team environments; organisational factors such as support strategies, remuneration, perceived organisational justice; and a safe workplace free from bullying, stigma and harassment.

Co-Development

"Designing and delivering services and systems in an equal and reciprocal relationship between professionals, people using services, their families and their community" (Adapted from NEF, 2011).

People with lived experience, their families and other supporters are able to provide unique knowledge and perspective to contribute to the development of better services and better treatment outcomes (Boyle, Slay and Stephens, 2010). Co-production is a way of making sure that the people who will be affected by a decision about health service provision are integral to the decision-making process. It enables stakeholders to work together in equal partnership for shared decision making. Best practice in co-production involves people with lived experience from the beginning of project development (Pinfold, et al., 2015).

The following principles of co-design have been identified by people with lived experience in the general mental health sector (Co-Design Initiative, 2016) and in the literature on co-production (Pinfold et al., 2015).

- **Equity** – Co-production is collaborative promoting an equitable partnership between stakeholders
- **Inclusion** – Co-production is inclusive, supporting the involvement of all stakeholders
- **Capacity Building** – Co-production ensures skill development and capability building for all participants
- **Learning** – Participants in co-production commit to learning from each other
- **Purpose** – Co-production works towards real outcomes that are meaningful for all participants
- **Innovation** – There are opportunities for creativity and exploration of alternative solutions

  (Adapted from the Co-Design Initiative, 2016)

This approach provides a way to overcome the differences in experience and language of the stakeholders in the mental health system. Exploratory, creative discussion approach helps people with lived experience, families and other supporters and health professionals and policy makers to find shared meaning and purpose (Co-Design Initiative, 2016).

"Co-design is a place to start an honest conversation between all the people involved in the mental health system, meeting as equals with a common interest" (Co-Design Initiative, 2016).

"It is easy to reduce good practice to a check list of 'dos and don'ts'. This is not a desirable approach to co-production as it reduces the potential for equal and reciprocal partnership relationships. We suggest instead that keeping approaches simple, based on explicit logic, with learning and change identified as core to the project's purpose, provides a good starting point" (Cook, 2016).

Creating an environment for change

Creating an environment in which everyone feels comfortable and has a voice involves something more than planning a committee meeting. When people with lived experience, family members and other supporters come into the usual way of decision making in an organisation, they can feel uncomfortable even when the meeting is specifically created to enable participation.

"When you start your involvement in co-production you are walking into a project that already exists. Other people have defined what will happen and how it will happen. Coming into this context as the 'outsider' can feel quite intimidating. You are uncertain about your role and where your voice lies in a room filled with professionals. There is often an assumption that you will know what is happening; an assumption of a level playing field that does not exist. It can sometimes seem as if the voice of some people is being preferenced over others. You can easily end up feeling like a second-class citizen without anyone intending this to happen" (Cook, 2016).

Co-production needs to start at the beginning of a process – before the first agenda is determined and before program decisions have been made. Training and support for all participants regardless of their life experience or professional background can help to create the inclusive culture and practices needed to make best use of the expertise of lived experience.

> "There is a need for training and continuous development for those who engage with people with lived experience, their families and other support people both in the mental health sector and in other areas such as education, disability, employment, police and justice. This is not easy: processes of co-design, co-production and co-commissioning take time, and often new skills. Investment in integrated leadership development applicable to all staff at all stages of their career is important. It was felt the mechanisms, structures and strategies needed to implement safe and effective engagement and participation need to be complemented by comprehensive, sustainable and widespread cultural change."
> (NMHC, 2018)

Taking it Further: Suggested Reading

Co-Design Initiative (2016). Co-design: Shared perspectives on authentic co-design. https://auspwn.files.wordpress.com/2016/05/codesign-shared-perspectives-report-vf1-5-040616.pdf?_cldee=am9uYXRoYW4uaGFybXNAYXJhZm1pLm9yZw%3d%3d

National Mental Health Commission (NMHC) (2018). Sit beside me, not above me: Supporting safe and effective engagement and participation of people with lived experience. Australian Government, Canberra. https://mentalhealthcommission.gov.au/media/253244/Sit%20beside%20me,%20not%20above%20me%20-%20Supporting%20safe%20and%20effective%20engagement%20a....pdf

NSW Lived Experience Framework. NSW Mental Health Commission. www.nswmentalhealthcommission.com.au

An Example of Co-development of Training in an Eating Disorder Service

The Victorian Centre of Excellence in Eating Disorders (CEED) has co-produced and presented workshops for both clinicians and carers, including a joint seminar for carers and clinicians to share perspectives and improve the ability of carers and clinicians to support the person with the eating disorder towards recovery. It was apparent through the feedback that this occurred effectively.

The workshop was developed by a senior clinician and a Carer Consultant through consultation. Focus group themes were:

- Recovery: What is it? What is the process? How long does it take? How do you know when someone is recovered?
- Relapse prevention – what can carers do?
- Clinicians and Carers - different roles and contribution in treatment
- Transition from the paediatric to the adult system
- Navigating the system, especially at beginning of journey

As a result of the focus group ideas, a session was developed entitled "Developing a Roadmap for Recovery in Youth Eating Disorders: a joint carer and clinician approach."

"Having developed many workshops in my other professional life, it was very interesting to see the differences in developing a workshop where the co-developers are coming from two different perspectives around the one topic. My feeling is that we ended up with a far more robust workshop than we would have had just one of our perspectives been used.

"The most common experience during development of the workshop was where we were melding the research and theory with practical experience. An example would be where a lot of the recovery material around mental health was focussed on 'living with' the illness, whereas my focus as a carer of a young person with an eating disorder was on removal of the eating disorder from our child's life. Another example was where recovery was defined as weight restoration, EDE scores within 1 standard mean of normal etc – whereas recovery for me was 'ability to eat a wide-range of foods in a wide range of settings with minimal anxiety' and a return to 'normal' personality/life. The process of toing and froing over the workshop materials really honed a product which reflected both the clinician/professional knowledge base and the carer perspective." (Carer Consultant)

Victorian Centre of Excellence for Eating Disorders (CEED) www.ceed.org.au

Purposeful Change

"Supporting personal recovery requires a transformation of the mental health system" (Slade, Amering et.al, 2014).

A peer workforce has been identified as an essential factor in moving away from a medical model of service delivery and developing recovery-oriented service approaches (Byrne et al., 2016). Peer work roles challenge some of the ways in which mental health services have traditionally been organised (Jacobsen, Trojanowski and Dewa, 2012), opening the door to continuous change in response to people's experience with the service. Peer workers are a significant resource for services that want to identify barriers to engagement and recovery for the people who use their current services (NMHCCF, 2010).

Strategic Questions

Some initial questions to get started could be:

- What is the overall aim of implementing a peer workforce plan?
- Where will peer work sit in your organisation and range of services?
- How does peer work fit with your strategic plan? Is the organisational leadership committed to implanting a peer workforce plan?
- Is recovery oriented and person-centred practice a priority? How far has the organisation gone in implementing these approaches? What else is needed to embed these approaches in practice?
- How will peer work complement and integrate with existing roles?
- What external and internal influences may impact on the employment of peer workers? Are there any constraints, e.g. resources, budget, timeframes, previous negative experience?
- Are there any risks, e.g. lack of knowledge about peer work?
- Who are the key stakeholders who need to get involved in the planning? Do you currently have peer workers, peer leaders or peer consultants? Who will champion the peer workforce plan?
- Are key stakeholders ready to undergo change?

Planning for a Peer Workforce

Like any other business decision, employing one peer worker or creating a more ambitious peer workforce plan starts with planning. The initial scope of the Peer Work Plan will focus on the major objectives, stakeholders and what is in and out of scope.

Get people involved in planning as early as possible. Start a conversation across your organisation about why a peer workforce is needed and wanted. Invite stakeholders to a workshop to discuss these questions and start the planning process together.

Are there any areas where you need to invest more time and effort to get ready for a peer workforce?

Planning is helpful but it should not become an end itself. The overarching message from those who have made a commitment to lived experience workforce development was 'just do it' (Byrne, Roennfeldt and O'Shea, 2017).

The Peer Work Hub Employer's toolkit provides useful self-assessment tools to help you to identify areas of development for your organisation in preparation for the engagement of a peer workforce.

Employer's Guide to Implementing a Peer Workforce. Toolkit. http://peerworkhub.com.au/resources/downloads/

Peer Leaders and Champions

Peer work sits in the continuum of consumer participation, from individual involvement in decisions about their own health and treatment to consumer representation on governance groups. Peer work roles should not be implemented in isolation from this broad commitment to partnering with the expertise of lived experience.

- **Engage lived experience leaders**
  Engaging people with lived experience in senior management roles and on Boards and Committees provides a knowledge framework from which peer work roles and broader implementation of recovery-oriented practice can grow through experimentation and evaluation.

- **Identify champions**
  Identify senior managers who are willing to share power with lived experience and actively advocate for recovery practices and lived experience roles.

- **Prioritise recovery focussed change**
  Peer work is most effective in settings that have a commitment to recovery-oriented practice or that are actively developing this as part of their strategic priorities. The peer workers will contribute to organisational change but it is safer and more effective if their work sits within a wider organisational commitment to change.

Smith, L. and Bradstreet, S. (2014). Experts by Experience: Guidelines to support the development of peer worker roles in the mental health sector, 2014, Scottish Recovery Network, Glasgow, Scotland.

Byrne, L., Roennfeldt, H. and O'Shea, P. (2017). Identifying barriers to change: The lived experience worker as a valued member of the mental health team. Report to the Mental Health Commission of Queensland, June 2017.

Peer Work and Recovery Oriented Culture

The general mental health literature indicates that employing peer workers increases commitment to recovery practices. Peer workers contribute to change by role modelling recovery and person-centred practices, and through formal and informal education and sharing of knowledge with their colleagues.

Review policies, procedures, practices and cultures through a recovery 'lens':

- **Person Centred**
  Are our services person-centred, tailoring care to meet the needs of the individual? Do we get to know people, focusing on their strengths to create plans that reflect who they are and their motivation for change?

- **Trauma Informed**
  Do we provide trauma-informed care? Are services and practices designed to avoid re-traumatising service users and staff?

- **A mentally healthy workplace**
  Is our workplace culture one that supports mental wellbeing for everyone? Do we have HR policies and procedures to support a mentally healthy workplace?

- **Family and carer inclusive**
  Are family members or carers engaged and supported to play an integral role in team care?

Taking it Further: Tools to Measure Recovery and Trauma Informed Work Environments

The National Framework for Recovery Oriented Mental Health Services (2014) is designed to provide guidance for all mental health professionals to support development of person-centred practices.
http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra

ROSSAT – a tool to help you to review the recovery orientated nature of the organisation. http://mhcc.learningcart.com/content/ROSSAT.aspx

TICPOT – a tool to help you review the trauma informed care nature of the organisation.
http://www.mhcc.org.au/resource/ticpot/

Repper, J. (2013). *Peer support workers: A practical guide to implementation*. London, UK: Centre for Mental Health and Mental Health Network, NHS Confederation.

Measuring Outcomes: Including Evaluation in the Design

Evaluation is important to demonstrate the outcomes of peer work. Clinical outcome measures provide an appropriate approach for measuring peer work outcomes that situate the peer workforce in a bigger picture of recovery practice development, enabling comparison between peer work and other initiatives. Measures of the effectiveness of peer work should include collection of narrative accounts from peer workers and peer service users. Peer work is based on dialogue and sharing stories, and qualitative measures provide a helpful framework for setting standards for peer work and for measuring outcomes (Mead and MacNeil, 2006). A reflective learning process and formal evaluation should be built into peer work. Feedback can shape the development of roles and services.

Peer work should be experienced as beneficial for the peer worker and make a positive contribution to the workplace culture (Byrne, Roennfeldt and O'Shea, 2017). Effective measures of peer work include process evaluation criteria with a focus on peer worker wellbeing and development of a mentally healthy workplace.

Measures used by existing peer programs in Australia include:

- Clinical assessment tools such as Eating Disorders Examination Questionnaire (EDE-Q) and Kessler Psychological Distress Scale (K10)
- Hope scale and quality of life scales
- Internal program measures of factors such as engagement and self-disclosure
- Measures of peer worker wellbeing and work satisfaction
- Self-reported measures of change in understanding and practice by clinicians.

"We probably need to do some work on defining hope and how it affects people with eating disorders in their journey through recovery. The real outcome of peer work is hope and we need to know how to help people find hope and how to measure the change this brings". (NEDC Peer Worker Interviewee)

A commitment to evaluation in the planning stages of a peer work initiative will help to clarify the outcomes and impact of this type of work and may generate improved tools for measuring recovery.

"What gets measured, gets done. People working in services, organisations and systems tend to do what they are rewarded for, and what their performance is assessed against – particularly where there is benchmarking and public reporting. The incentive to ensure effective and safe engagement and participation with people with lived experience would be significantly strengthened if commissioning and funding of services and organisations included performance reporting requirements and evidence of that engagement in co-design, monitoring and service improvement." (NMHC, 2018)

Planning for Individual Positions

The main challenge experienced by peer workers is a lack of understanding of the peer work role and its value in improving recovery outcomes (Kemp and Henderson, 2012). Poorly defined job roles make it difficult for peer support workers to be successful and hinder their integration into multi-disciplinary workplace teams (Jacobsen, Trojanowski and Dewa, 2012).

Position descriptions for the peer workforce should follow the same principles as those for any other employee but they also need to reflect the unique qualities of peer work:

- Focus on the purpose and scope of work rather than on a detailed set of tasks. Peer work roles need to be flexible to respond to the needs of service users and to make the best use of the unique contribution of each peer worker.
- Clearly specify the competencies required for the position.
- Choose language that reflects a commitment to lived experience participation and recovery-oriented practice.
- Compare the draft position description with the principles of peer work.

A good way to make sure that the position description is appropriate for a peer worker is to co-produce the description. Engage experienced peer workers, in your organisation or as external consultants, to draft or review the position description.

Peer Work Hub Employer's Guide to Implementing a Peer Workforce
http://peerworkhub.com.au/resources/downloads/

BEING Mental Health and Consumer Advisory Group
http://being.org.au/resources/

Foundations for a Peer Work Job Description

The uniqueness of peer worker practice needs to be preserved when you define your peer worker roles. Clear job descriptions are not the same thing as prescriptive task lists. The role of peer mentor is very variable depending on the need of the mentee including their diagnosis, stage of treatment and recovery, personal goals and the person's other sources of support. A position description is important but it needs to be flexible and person centred, allowing peer mentors and mentees to develop their own agreements about the scope of their work together.

"The flexibility of the first programs was good and should not be lost. The program helped people to put in place their own ways of working. It accommodated real-world issues and people's availability" (NEDC Interviewee, Program Organiser, Instilling Hope).

The following description is based on research by Jacobsen, Trojanowski and Dewa (2012).

Peer Work Job Description

This is a non-clinical role.

The peer worker will:

- Work collaboratively with clients, co-workers and the community
- Advocate on behalf of clients and help clients to navigate the health and social service systems
- Work closely with clients to address problems and answer questions
- Gather and provide information and advice
- Initiate, establish and maintain relationships with clients, developing trust and rapport
- Act as a mentor to help clients to set goals and work toward developing skills
- Share and discuss common experiences with clients
- Be responsible for planning, organising, developing, leading and facilitating group activities
- Complete administrative duties as required to support work with the client
- Complete any training required for the position
- Communicate with team members, attend team meetings and meet with supervisors

Creating a Peer Work Role

Co-design	Engage lived experience workers and other stakeholders to design the position description
Purpose	Define the expectations of the role. How will this achieve your purpose and objectives? Identify key performance measures.
Relationships	Identify who the position will relate to and what their needs are.
Competency	Identify the essential competencies needed for the peer role. Are other non-peer specific skills required for this position?
Integration	What features does the role need to integrate into the work team and be a catalyst for change?
Support	How will you support the person to achieve in this role?

Jacobsen, N., Trojanowski, L. and Dewa, C.S. (2012). What do peer support workers do? A job description. BMC Health Services Research, 12: 205.

Centre of Excellence in Peer Support (CEPS). position descriptions. http://www.peersupportvic.org/

Preparing for Change: Integrating new roles in the clinical team

The best practice is to fully integrate the peer worker into the workplace and the specific work team, as a valued member of the team.

One integration strategy that is supported by evidence from the general mental health field is the provision of education on peer work, lived experience expertise and recovery practice for the whole workforce. Improve staff understanding and acceptance of peer work by providing co-delivered training.

"Best outcomes are achieved when all members of staff understand the purpose of having peer workers on the team and design collaborative ways to best utilise the lived experience expertise. An organisation planning to include peer support must embody a non-stigmatising attitude to mental illness and a belief that personal recovery, as defined by the individual, is a goal of treatment, regardless of diagnosis". (Reaching Out for Hope)

Suggestions for workforce training include:

- Definitions of peer work and the scope of peer work roles
- Principles and values of peer work
- The purpose and benefits of peer work
- Peer perspectives on practice, including on mutuality and the management of boundaries
- Applying a recovery and consumer perspective lens to service delivery

(Adapted from: Te Pou, 2014)

Te Pou, Service user, consumer and peer workforce: A guide for managers and employers

www.tepou.co.nz/uploads/files/resourceassets/service-user-consumer-and-peer-support-workforce-a-guide-for-managers-and-employers.pdf

References

This document is a part of the **Developing a Peer Workforce in Eating Disorder Service Settings** suite of resources. A full list of references for this document may be found in Part A: Exploring the Evidence.

National Eating Disorders Collaboration

The National Eating Disorders Collaboration

Email: info@nedc.com.au

For a downloadable copy of this resource visit: www.nedc.com.au

The National Eating Disorders Collaboration (NEDC) is an initiative of the Australian Government Department of Health.