National Eating Disorders Collaboration

Developing a Peer Workforce for Eating Disorders

Supporting Practice

Part C3

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 three 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 and evaluation of peer work initiatives. It may also provide useful content for training for peer workers and for clinicians.

C1. Codeveloping a Peer Workforce

C2. Robust Recruitment

C3. Supporting Practice This document

C4. Introductory Training Resource

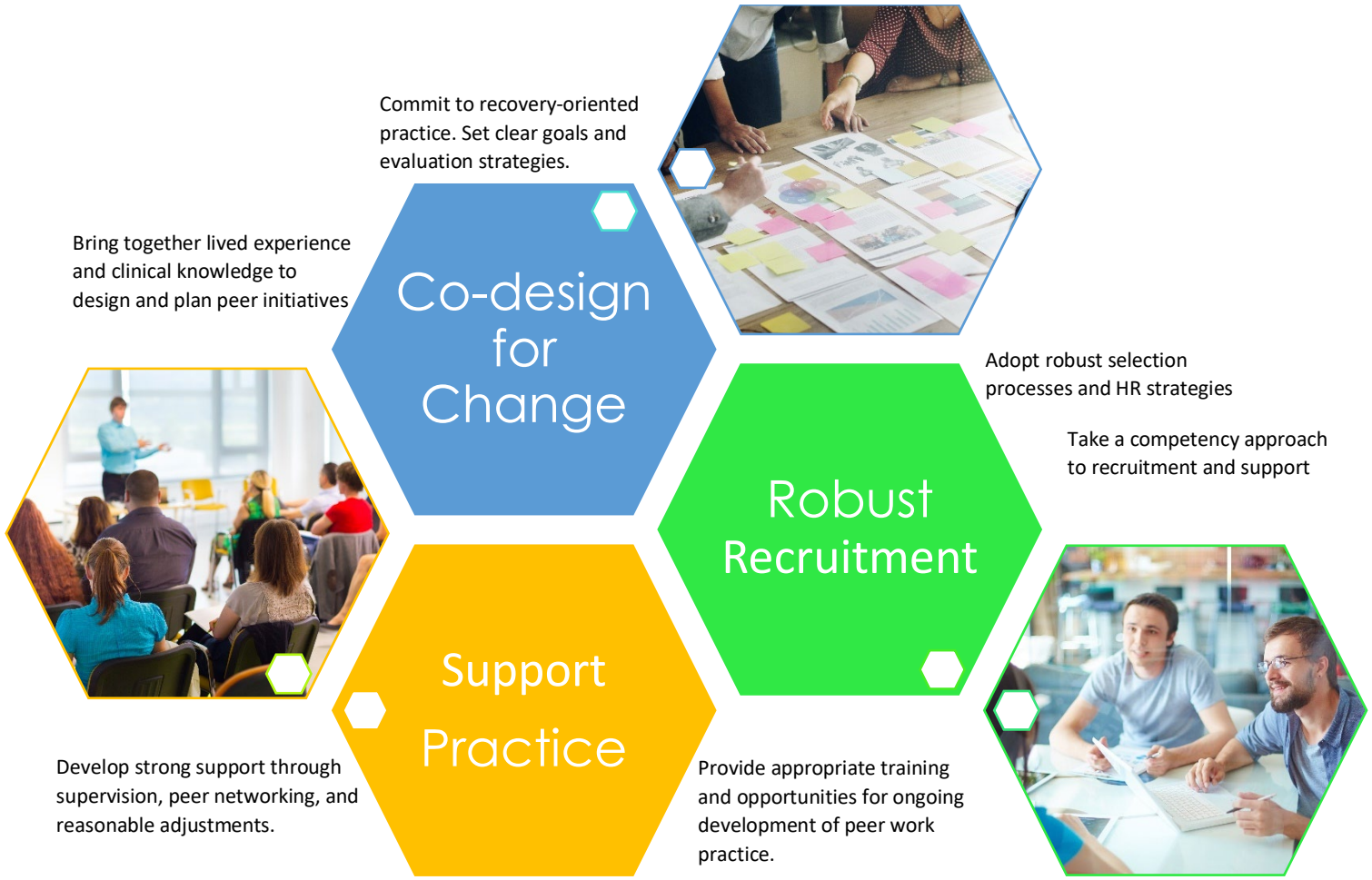

Figure 1: Organisational Steps Towards Safe Effective Peer Work

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Part C3. Supporting Practice

Training and professional development opportunities are an important part of the supportive environment for peer workers. This section explores the idea of competencies for peer work, focussing on the approaches that make peer work unique. Information is provided on the type of training that is used in practice to prepare people for peer to peer roles. Examples of learning content are provided at the end of the section.

Supportive Environment

Courageous vulnerability

The peer worker is required to draw on the insight they have gained from experience and also have enough capacity to hold another person's distress without being overwhelmed. In order to be able to do this, there needs to be support mechanisms and self-care strategies in place. Peer work is different to other types of work roles in mental health services and these differences must be managed appropriately for safe and effective peer work.

- Peer work involves emotional labour with inherent risks of burnout and vicarious trauma. Emotional labour involves drawing on and regulating personal feelings as an essential part of the work role and this describes the unique approach of peer workers (Mancini and Lawson, 2009).
- Experience of illness is an employment criterion and plans are required to avoid placing the peer worker's health at risk.
- Public disclosure of illness is a requirement of the work and this has implications for the peer worker's privacy, confidentiality and future career opportunities.

"Sharing from lived experience requires courage. We are sharing from the most vulnerable and often hidden parts of our lives to help others. Dipping into what is often some of our darkest experience and relating it to a new situation can take time, reflection and sheer hard work. The necessity to be courageously vulnerable is typical… but very often those sharing from lived experience do not get the support they need to keep on being courageous and can become worn out..." (Cook, 2016).

People whose work requires them to identify as having a lived experience of mental illness and to share personal stories may be exposed to greater risk than others. The peer worker needs to feel safe in their work environment and in their relationships with colleagues and supervisors.

"Safe engagement and participation means that people with lived experience feel comfortable being involved and speaking about their experience because the behaviours and actions of others demonstrate respect and a willingness to listen and learn." (NMHC, 2018)

Supporting Peer Worker Safety

"Peer work roles in eating disorder settings are not associated with physical risk. There may however be psychological risk to the worker and/or to the service user. Immediate access to a senior support person (e.g. supervisor or coordinator) is desirable to reduce any psychological distress. Mentors will have their own Wellness Plan that outlines their current supports and contact details in case of emergency. Mentors will also complete an online survey following each mentoring session and received a phone call from the EDV Coordinator to debrief. Mentors and mentees can also contact the project coordinator or psychologist any time for individual support, and they will attend three group debriefing sessions throughout the program. There are guidelines in place to manage self-reported increased eating disorder symptoms/ risk for mentees which include referring mentees back to their treating clinician for assessment and support." (Beveridge et al, 2018)

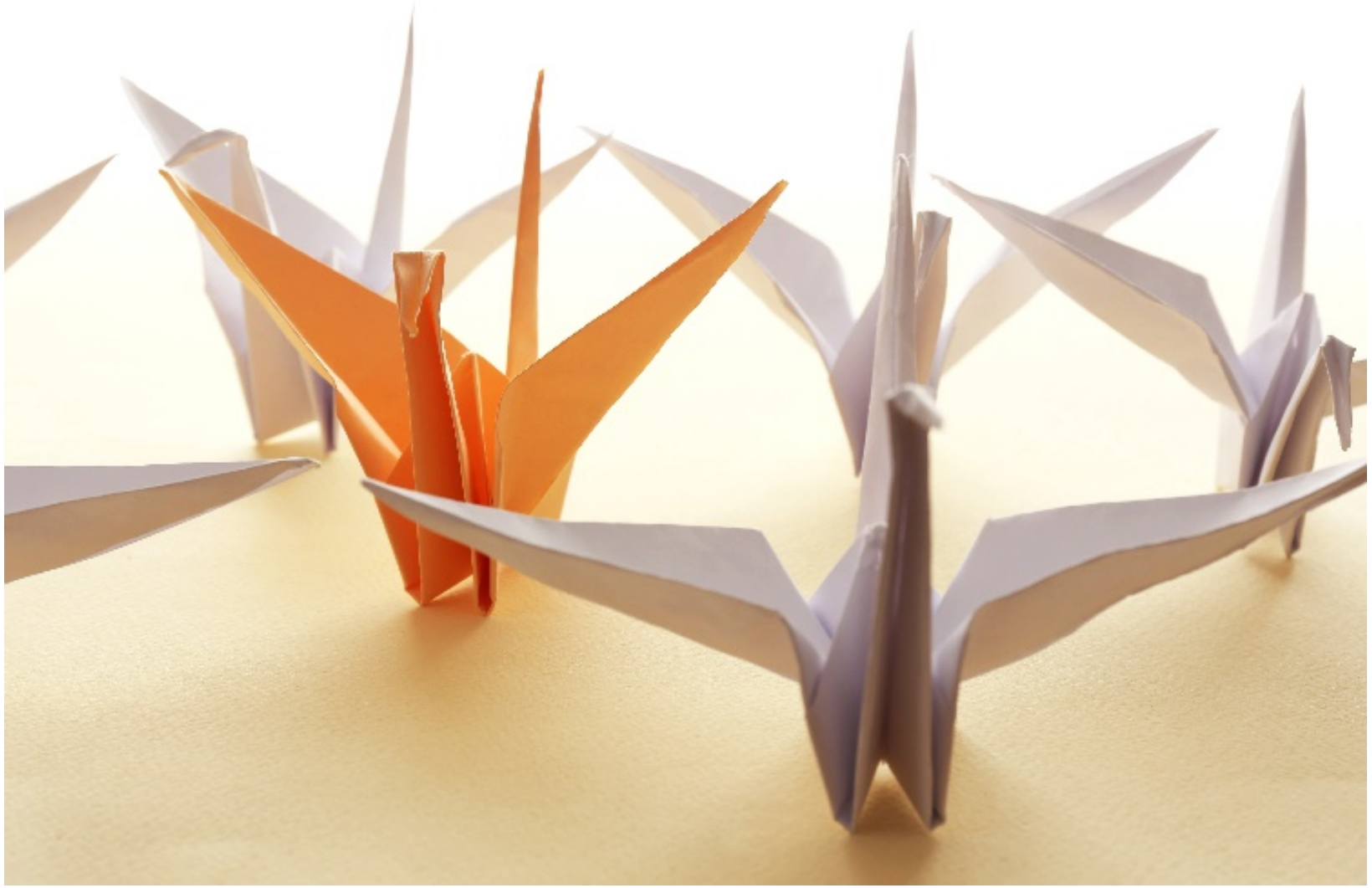
Taking it Further: Suggested Reading

Identifying barriers to change: The lived experience worker as a valued member of the mental health team. (Byrne, L., Roennfeldt, H. and O'Shea, P., 2017). https://www.qmhc.qld.gov.au/documents/identifyingbarrierstochangefinalreportpdf

Experiencing Co-Design: Lessons Learned from Participation in Co-Produced Projects. (Cook, L. , 2016 in Cassaniti, M, Robertson, S, Dunbar, L, Orr, F, Everett, M, Prowse, L, Farhall, J, Lloyd, C, Christensen, D, People: Authenticity starts in the heart, Contemporary TheMHS in Mental Health Services http://themhsdev.micko.fatbeehive.com/resources/1481/experiencing-co-design-lessons-learned-from-participation-in-co-produced-projects

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

"Make self-care and maintenance of own wellbeing a part of the role and hold people accountable for this. People who have to draw on their own lived experience of distress and trauma to support others experiencing similar difficulties carry a significant load of emotional labour. They need to have wellbeing strategies in place for self-care. This is part of trauma informed care. People who role model recovery need to prioritise their own recovery or they may cease to be effective in their role. If a peer worker is struggling with their health, work together to identify restorative strategies. It is vital that you do not isolate the worker who becomes unwell. They need to stay connected to their own peer support and to the work team."
(NEDC Interviewee, Lived Experience Consultant)



Supervision and Practice Development for Peer Workers

Compassionate support and supervision, delivered from a peer work perspective, improves the likelihood that the workplace will be experienced as safe and increases the effectiveness of peer work roles (Byrne, Roennfeldt and O'Shea, 2017).

1. Performance Supervision

Peer workers, like other employees, have a right to access guidance and professional support to enable them to achieve in their job roles and meet accountability standards. Every employee needs guidance to:

- know and understand what is expected of them in their job role
- have the opportunity to develop the skills and knowledge required to achieve the job role
- be given feedback and an opportunity to discuss their work performance
- be supported by the organisation to achieve their best performance in the role.

Performance supervision is based on the person's role within the work team and the organisation. The focus of supervision is on the job role, the person's job skills, and their performance and support needs. Performance supervision for peer workers should fit in with the general performance management system for all employees.

2. Practice Development

Support for practice development is vital for successful peer work.

Each peer worker brings their personal experience and knowledge to their role as a source of expertise. Job roles rely on more than knowledge; they require practical competency in the application of knowledge to new situations.

Developing competence increases confidence, broadens skills and knowledge, and contributes to job satisfaction and future employment opportunities.

The right kind of supervision for practice development is a critical factor in ensuring effective peer work practice (see for example: Daniel et al., 2015; Kemp and Henderson 2012; Swarbick & Nemec, 2010). Regular practice supervision contributes to quality and effectiveness of practice, role clarity, improved mental wellbeing, and a reduction in the risk of burnout and stress (see for example: Bell, Panther and Pollock 2014; Repper 2013).

Peer support supervision happens "when a peer support supervisor and peer support specialist supervisee(s) formally meet to discuss and review the work and experience of the peer provider, with the aim of supporting the peer in their professional role" (Daniel et al., 2015, p.7). Peer worker supervision should provide "a safe space where challenges and tensions can be identified… and the worker can experience empathy and validation" (VMAIC, 2018).

Professional supervision is the best practice standard for all workers in health care roles where the work context is complex. Access to supervision is associated with the peer worker's job satisfaction, emotional health and confidence to practice (SCIE). The objective of peer work supervision is to provide peer work staff with a safe, confidential and supportive space to reflect critically on professional practice (Chinman, 2015). Like clinical supervision, peer work supervision or mentoring is expected to 'foster resiliency and create space for doing the work necessary for replenishment and working on use of self' (Beddoe et.al., 2014, p.121).

"How you provide support for peer workers is the critical difference. Mentors need validation that they are doing a good job as there is a level of uncertainty around the role and what is expected. Supervision was a requirement for mentors with regular completion of questionnaires to monitor their wellbeing and monthly peer review plus clinical supervision. Supervision was used as a development opportunity and not as an authoritarian form of control. This was a very hands-on program in terms of availability of supervision and support and a lot of informal debriefing occurred.

Mentors filled in log books fortnightly to say what was happening, flagging issues they needed help with. Zoom check ins were available for peer mentors as a group. We also held more formal guest evenings where mentors and mentees could come together as a group and hear a guest speaker. The open workshop seemed effective for both groups".
(NEDC Interviewee, Instilling Hope)

Social Care Institute for Excellence (SCIE) UK www.scie.org.uk

Coaching or Supervision?

Several different terms are used in the literature to describe this collaborative and supportive approach, including professional supervision, coaching, mentoring and peer support. Each term means something different but in practice they are often treated as the same.

Coaching is task focused. It usually involves a time limited relationship to help someone achieve a specific professional or personal goal. This might include the development of a particular competence needed for the job.

Mentoring involves a partnership relationship in which a more experienced person helps someone with less experience to develop personally or professionally. Mentoring requires time so that both people can learn about one another and build a relationship of trust in which difficult issues can be safely raised.

Practice or professional supervision is a reflective process that provides a regular (often weekly or monthly) opportunity for a peer worker to meet with a more experienced peer worker in order to discuss the experience of practice and develop strategies for improvement together.

Each approach can contribute to the development of confident and competent practice. Practice supervision and mentoring approaches may be most appropriate to support peer workers as they allow for a longer-term relationship and rely on reflection and mutual learning rather than more specific goal focused change.

These approaches are all different to performance supervision which has a component of authority and 'power over' the employee. Practice supervision, coaching and mentoring are about voluntarily entering into a relationship with an open, flexible approach to explore issues and areas for development as the need arises.

Regardless of the title or approach used, all practice support strategies should be informed by a consumer perspective and model the practices expected of peer workers:

> "Consumer perspective supervision is founded on the same unique values and principles of consumer work. These include self-determination, connection, mutuality, lived experience as expertise, responsibility, authenticity, transparency, hope and curiosity" (VMIAC, 2018).

3. The Focus of Supervision

The purpose of supervision is to support workers to develop their knowledge and skills to work safely and effectively with and on behalf of service users. This proactive approach supports reflection and problem solving for workers who are faced with complex situations.

The approach makes a difference to supervision outcomes. A goal of the peer supervisor is to model the principles of recovery-oriented practice in the supervision context:

- a person-centred, strength-based approach
- an equal partnership between peer worker and supervisor sharing from each other's knowledge and experience
- collaborative coproduction approach

Practice supervision for peer work requires a commitment to mutual learning and development.

Peer work roles are different to clinical roles in their purpose and approach and peer workers require supervision that is specific to their unique role and expertise. Peer workers may have no prior experience of professional supervision.

In addition to any role- or organisation-specific issues, peer worker supervision should focus on the following areas:

- Reflective practice
- Identifying areas for professional growth and connecting the person with the resources they require for growth
- Boundaries, confidentiality and therapeutic relationship issues
- Maintaining the integrity of the peer work role, avoiding 'bracket creep' into more clinical or administrative roles
- Promoting personal growth and self-care
- Discussion of reasonable adjustments to the role or workplace when these are needed.

Outside the supervision session, the focus for the supervisor will also be on advocating for the individual and for peer workers more generally across the organisation. The supervisor's role in supporting the personal wellbeing of the peer worker extends to more general advocacy for mental wellbeing in the workplace. A mentally healthy workplace is of benefit to everyone.

4. Peer to Peer Supervision

Engage an experienced peer worker as supervisor.

Supervision needs to be tailored to the peer work role and the needs of the peer worker. Generally, peer workers prefer supervision from someone who has been a peer worker.

> "Peer support workers want more frequent supervision and feedback in order to understand their performance. In addition, they need more interpersonal, emotional support that is best provided by a peer." (Newberry & Strong, 2015, p. 22)

Alternatives that should be considered when there is no experienced peer worker available to provide supervision include:

- a clinical supervisor with a commitment to recovery-oriented practice and a good understanding of peer work
- external supervision sourced through a consumer and agency
- connecting the peer worker to a peer worker support network for peer to peer supervision
- external supervision from a peer worker may also be helpful for the clinical (non-peer) supervisor

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.

"Our approach to supervision is peer led. You need someone with more experience as a peer worker to act as a sounding board. In addition to formal one-to-one supervision, we use phone catch-ups after each mentoring session, and provide online feedback forms to keep supervisors informed and connected. There is an open-door approach. Group supervision sessions allow mentors to share their experiences and resources and provide mutual support. We have found one key question to be important in terms of risk identification: 'Did this session make you think about your recovery – if so, in what way?' " (NEDC Interviewee, EDV)

5. Planning professional supervision for peer workers

Supervision goals are developed collaboratively to reflect the role of the peer worker, their skills, experience and competencies and the areas in which they would like to develop their practice. Negotiation of goals should take into consideration:

1. Scope and level of responsibility of the role
2. Professional development needs
3. Support requirements
4. Individual preferences
5. Clinical supervision requirements, for peer workers who are also registered clinicians
6. The knowledge and experience of available supervisors

The focus of supervision is on the job role and the person's job skills, performance and support needs and not on the person's health status. Professional development needs may focus on the key areas for professional practice identified in the core competencies for peer work:

- Ability to role model recovery including self-care strategies to manage own wellbeing
- Purposefully apply lived experience to promote and support recovery; selecting and using experience-based knowledge for the benefit of others
- Establishing relationships of mutual trust and respect, creating a safe and supportive environment for service users

Peer Networking

Best practice makes sure that peer workers are connected with others in similar roles. This can be achieved by:

- Providing a lived experience supervisor or enabling the use of a peer mentor
- Recruiting more than one peer worker enabling them to work together as a team and access group supervision
- Including attendance at external peer networking meetings or events in the job role

7. Peer Work Supervision Challenges

Peer work supervision extends into organisation-wide advocacy, education and promoting wellbeing for everyone.

Managing change – supervision is often a challenge when the peer work role is new to an organisation or team. Organisational change is rarely experienced as a smooth and trouble-free transition. As problems arise, it is important to distinguish between problems that directly relate to the peer work role and problems that are really about the tensions caused by change. It takes time to understand and embed new roles in practice. Shared learning activities between peer workers and others may be the best approach to overcome misunderstandings.

Recovery oriented practice – a key to appropriate supervision is an organisation wide commitment to the principles of personal recovery. If this commitment is not in place there will be increased tension between the demands of the organisation and other team members and the peer worker. The role of the supervisor is to advocate for recovery-oriented practice and to promote understanding of the role of peer work.

A therapeutic perspective – when the supervisor is not a peer worker it is easy to fall back on the familiar role of therapist. Effective peer supervision is based on recognition of the value of the knowledge derived from lived experience and the motivating relationships that peer workers are able to form with service users. The focus of supervision needs to be on work performance and not on the person's health status. Many peer workers feel powerless and lose confidence when supervisors attempt to monitor or micromanage their recovery.

Relationships with non-peer colleagues – a lack of understanding of the peer work role or negative attitudes about the safety or ability of people with a history of mental illness will lead to a lack of integration of the peer worker into the team, increased stress and potentially to interpersonal conflict. The supervisor has a bridging role, helping the peer worker to understand what is happening without internalising the negativity, and helping other workers to understand the value of the peer work role.

Role strain – when peer workers become part of a clinical team there is often pressure for them to adopt the same working practices as health professionals or to take on tasks that would otherwise be done by someone else on the team. Supervision can help the peer worker to sustain the integrity of the peer role.

Boundaries and balance – the approach to relationship building with the service user, boundaries, and personal sharing are usually different to those of clinical staff. Boundaries may be more permeable because of the mutuality and sharing that happens in the role and it is easy for peer workers to over-identify with service users, or over-commit to providing support. Some peer workers may over-rely on sharing their own story of recovery at the expense of learning about other people's experiences. Supervision is the place to help the peer worker identify and address these issues.

Navigating Boundaries

Peer work roles blur the distinctions between staff and service users; between professional and personal. They rely on mutuality and reciprocity, developing equal relationships rather than hierarchical relationships of power. Peer workers are facilitators of change for the service user and for the organisation, rather than being service providers (Boyd, Slay and Stephens, 2010).

"There was some confusion between the role of friend and the role of mentor." (Instilling Hope)

The peer to peer approach involves translating the benefits of informal relationships into the service context without losing the essential equality in the relationship. The peer worker is likely to be expected to share information about themselves that in other circumstances would be private. Blurred boundaries between personal and professional may be difficult to navigate.

In the programs reviewed for this Guide, the process of defining how the mentoring relationship would end was important and needed to be defined at the beginning of the program. Programs insisted on clear boundaries between the mentor and mentee in terms of communication, where they met, the amount and type of contact. All programs were seen as an adjunct to treatment and mentees were required to be in treatment and have a psychologist and GP as a minimum.

Most peer programs expect peer workers to limit their contact with the people they work with to their regular work hours. This minimises liability issues for the organisation and the risk of emotional burnout for the peer worker. Clearly specifying the time and contact boundaries before the working relationship starts can avoid distress for both parties later on.

"The challenge for me in this consult, and I suspect future consultations, is the strong desire to continue communications beyond the scope of the role/project. Clearly, the professional nature of carer consulting needs to have boundaries which often do not exist in voluntary parent support, however the flipside is that it feels much more controlled and less demanding. Future roles like this need to have clear guidelines and expectations as regards the level, if any, of ongoing contact." (CEED, 2014)

Navigating Boundaries in Practice: Body Esteem Program

"We found the main boundary issues were time of contact and response boundaries. The mentor was not an emergency service provider and strict boundaries were maintained around availability. If the mentor had concerns about someone's well-being they were expected to pass the information on to their supervisor or to a health service provider.

The non-negotiables of the program were:
- Program length
- Crisis responses: Actions to take in cases of risk or self-harm
- Participation in training
- Minimum contact between mentor and mentee of one hour per week."

(Instilling Hope)

"The prerequisite of 'lived experience' means that facilitators are required to share personal information to an extent that would not be expected within other professional positions. Due to this, personal and professional boundaries need to be extremely clear and addressed within peer review and clinical supervision.

The main boundary issue is no contact outside of group sessions. The facilitator is not an emergency contact. Each facilitator is provided with a phone so that group members can ring with essential messages (e.g. not coming to group today) but these phones are only turned on in the hours immediately before and after a workshop."

(NEDC Interviewee)

Induction and Training

Most people come to peer work roles without specific qualifications for that role. Some will have qualifications in other areas, including health professions. These qualifications may be desirable for some peer work roles but they do not prepare the person to apply their lived experience in the workplace.

Some peer workers will have a qualification in peer work, such as the Certificate IV in Mental Health Peer Work. While this is a good general qualification it is not specific to eating disorders. If the person has not worked in an eating disorder health service setting before or shared from their experience of an eating disorder, they will probably need some additional training.

Developing a strong induction training program for peer workers helps to overcome some of the challenges for peer work, including clarifying the role, demonstrating how the role fits into the organisation and team, and establishing appropriate boundaries for the work. Providing induction training enables people who have not done this work before to apply for positions. For some people, peer work is a useful first step into the workforce after illness and certificated training helps people to take this step.

"If we did this again, I would like to offer more formal training for mentors to increase their confidence. For the second intake a guide to the mentor role was made available online to support the training and this helped" (NEDC Interviewee, Instilling Hope)

Growing in Confidence and Applied Practice Skills

People thinking about becoming peer workers are often uncertain about the role and their ability to be helpful to others. Training, especially group training with other peer workers, can help people develop confidence in the value of their experience and insight.

"The best piece of advice to someone who is thinking about mentoring or peer work would be 'buckle your seat belt you are in for a bumpy ride'. No matter what you think it will be like, the reality will be different to your expectations. When I started mentoring, I felt a lot of self-doubt and fear. I didn't really believe I could do this. I have learned that as a peer worker you don't have to be the expert; you don't have to have the answers. You just have to be there and work on problems together with the person you are supporting. This is about being messy humans together. It sits right outside clinical order and linear progression. When we were ill, we didn't feel like we fitted in. As peer workers, we still don't fit in in a sense, but this is how we are learning to confidently be ourselves. (NEDC Interviewee, Peer Mentor)

The general mental health literature discusses concerns that professional training may inadvertently shape the peer worker into the familiar practices of health professionals rather than enable them to provide a unique peer approach. Providing training that is specifically for peer workers, designed by peer workers based on the principles of peer work is one way to make sure that training enhances the peer work role (Byrne, Roennfeldt and O'Shea, 2017).

Training for peer workers should build on the person's existing capabilities. The objective is not to turn the worker into a 'standardised' peer worker but rather to enable them to make the most effective use of what they have. Approaches to training are participatory and reflective, focussing on the application of lived experience in different contexts.

This model for translating everyday life skills into competencies for action was developed for general education settings but is useful for understanding how the training provided by the employer adds to and enhances the knowledge and skill the peer worker already had to empower appropriate action.

This model is adapted from Kwauk and Braga, 2017, Translating competencies for empowered action https://www.qfcc.qld.gov.au/knowledge-and-resource-hub/translating-competencies-empowered-action-framework-linking-girls'-life .

Developing an Induction Program

Practice in Australian peer work programs suggests that an induction program of between two and five days is desirable, with access to the following types of learning content:

Core Training	Possible Topics and Sources of Training
Orientation to the Organisation	Internally developed and delivered training covering topics such as: – organisational policies and procedures – introductions and meetings with co-workers – working in a multidisciplinary team – line management and supervision procedures – relevant policies and codes of conduct including ethics, privacy and confidentiality.
Peer Work Approaches	This could be an external course such as **Intentional Peer Support** or the **MIND Mental Health Support** course, or internally developed training on the specific peer work role or peer work program including consideration of: – the purpose and scope of the peer work role – applying lived experience knowledge – self-care and wellness planning – role specific protocols – negotiating boundaries.
Safe Story Sharing	This could be an external course or an internally developed training. The extent of training will vary depending on the way in which the peer worker is expected to share their story (e.g. public speaking, sharing personal information with a mentee, or drawing on personal knowledge without disclosure). The NEDC provides resources to support safe story sharing.
Eating Disorders Information	If the peer worker will be working with people who are using different treatment approaches, it can be helpful to provide a brief introduction to the types of treatment and the roles in a multi-disciplinary team. People may also benefit from the opportunity to reflect on the similarities between different eating disorders diagnoses. The NEDC provides a five module Introductory Professional Development video series and a range of factsheets available on the NEDC website.
Suicide Prevention and Trauma Informed Care	Peer workers may be the first people to notice that someone is struggling with thoughts of suicide or with past trauma. Introductory level training in suicide prevention and trauma informed care is desirable for all peer workers. Some of the programs reviewed in the development of the Guide used **SafeTalk** for suicide prevention training or **Mental Health First Aid**.

Peer Mentor Training in Practice

The following examples describe peer training provided by two peer mentor programs in Australia.

Peer Mentoring Training Program – Eating Disorders Victoria

"Mentors will attend a 3-day training and induction program prior to the program rollout to ensure that mentors are prepared in their role. The training starts with inducting them as employees and going through the procedures and policies outlined for all EDV staff members.

"An overview of the Intentional Peer Support (IPS) model is given to all mentors as a framework to base all interactions. The four core elements of IPS are connection—between the mentor and mentee, holding a worldview and understanding how we have come to know what we know and mutuality—learning and growing together and moving towards identified goals (recorded in the mentee's Wellness Plans).

"Information about the program's aims and objectives are made clear so the mentors know what they are working towards. As there is a high possibility of self-harm and thoughts of suicide, all mentors complete an internationally recognised safeTALK suicide alertness workshop which covers hands-on skills to be able to respond to someone who has the thoughts of suicide. During training, our psychologists facilitate role-plays with mentors which raise common." (Beveridge et al., 2018)

"We provide training on safe sharing of personal stories. Facilitators only disclose what they feel comfortable with and what is relevant to the group. This is not about sharing a personal story but about using experience to help others." (NEDC Interviewee, Body Esteem Program)

"You need good supervision as it can be intense and draining. The training needs to be rigorous. Carolyn Costin trains her coaches with the same material as she trains therapists but makes sure they know the difference between therapy and peer or coach support. It's very important to know how to use your empathy without crossing the boundary into a friendship. So important to know how to be strong to help sufferers challenge their eating disordered thoughts, behaviours and beliefs." (NEDC Survey Feedback)

Reaching Out for Hope – Western Australia

Reaching Out for Hope provides training that:

- Highlights insights, strengths and coping strategies
- Supports a process of reflection and integration in order to deal with any residual trauma
- Skills to confidently carry out their role in a clearly defined, structured and manageable fashion.
- Provides orientation to the workplace
- Develops eating disorder knowledge and skill
- Builds skill and confidence in how to tell the 'story' in a way that helps others

Trauma Informed Care Training

To deliver effective care and improve treatment outcomes, care needs to be based on an understanding of the person's life experience, including their exposure to trauma (Menscher & Maul, 2016). Trauma informed care is a key component of recovery-oriented practice.

Exposure to trauma is a significant public health issue with traumatic experiences in childhood found to be key risk factors for poor health in adulthood (Beckett et al, 2017). Overcoming trauma can be painful and difficult but with appropriate ongoing support most people recover quickly and are able to gradually resume normal life.

People with eating disorders may experience trauma at any stage in their illness; for some, eating disorder behaviours develop as a means of coping with trauma; for others the experience of treatment is traumatic. Developing awareness of how the steps in treatment may be experienced as traumatizing, and how family and supporters may be traumatized by their exposure to illness and treatment, is important for understanding how to support the person.

Examples of External Training Resources

Intentional Peer Support (IPS)

IPS training is based on Shery Mead's book, *Intentional Peer Support: An Alternative Approach*. The five-day introductory training explores new ways of relating, learning and creating together. Topics include listening differently, ways of relating, co-reflection, the impact of trauma, and negotiating boundaries and limits. This training is available internationally and has been adopted as recommended training for peer workers in the Queensland Government's Community Care Unit.

Intentional peer support [http://www.intentionalpeersupport.org].

safeTalk

"safeTALK is a half-day workshop that prepares people over the age of 15 to become aware of suicide risk. Most people with thoughts of suicide don't truly want to die; through their words and actions, they invite help to stay alive. safeTALK-trained helpers can recognize these invitations and take action by connecting them with life-saving intervention resources, such as caregivers trained in ASIST". Workshops feature the simple yet effective TALK steps: Tell, Ask, Listen, and KeepSafe."

safeTALK http://www.livingworks.com.au/programs/safetalk/

Mental Health First Aid

Mental Health First Aid (MHFA) provides a 12 hour course for adults who want to develop the skills to help someone who they're concerned about. Participants learn how to assist an adult who may be experiencing a mental health problem or mental health crisis until appropriate professional help is received using a practical, evidence-based action plan. Specific guidelines are available from MHFA on eating disorders. If possible, make sure that these guidelines are included in the training provided.

Mental Health First Aid Australia https://mhfa.com.au/

Certificate IV in Mental Health Peer Work

The Community Services and Health Industry Skills Council conducted an extensive consultation process to develop the core competencies for peer work that are the foundation of the Certificate IV in Mental Health Peer Work. The qualification was endorsed in 2012 and revised in 2015.

The nationally accredited Certificate IV in Mental Health Peer Work provides core content that has been designed by people with a lived experience of a mental illness.

The six core units of the Certificate IV in Mental Health Peer Work cover:

- Applying peer work practices in the mental health sector
- Contributing to continuous improvement of mental health services
- Applying lived experience in mental health peer work
- Working effectively in trauma informed care
- Promoting and facilitating self-advocacy
- Contributing to work health and safety processes.

MIND Mental Health Peer Support

The MIND mental health peer support course is a five-day training program for people who are thinking about becoming peer workers. The course covers nine areas:

1. Peer support mental health recovery principles
2. Effective listening
3. Searching for the flame
4. Moving forward in the journey
5. Ethics, values and boundaries
6. Cultural competency
7. Medication and treatment
8. Structuring the environment for recovery
9. Sharing and networking.

MIND professional training https://www.mindaustralia.org.au/about-mind/professional-training

The Carolyn Costin Institute Mentor Training

The Carolyn Costin Institute is based in the USA. Its training program for peer mentors prepares them to meet individually with mentees and to facilitate support groups, hosting a community of like-minded individuals who come together to help each other recover. Similar to sponsors in 12-step programs, mentors make themselves available to mentees for ongoing support and guidance.

It is expected that mentors offer their services for free. Mentors are not trained to have meals with clients or to serve in the detailed capacity reserved for Certified Eating Disorder Coaches, who charge a fee.

Carolyn Costin Institute Mentor Training https://www.carolyn-costin.com/mentoring

Introductory Learning Resources

Part C4 of this Guide provides introductory level resources which may be useful for self-directed learning or internal induction training to be delivered before peer workers start longer courses of study.

The Introductory Learning Resources include topic units on:

1. **The Peer Work Approach** – an introduction to peer work and the way it contributes to recovery from an eating disorder.

2. **Sharing from Experience** – an introduction to safe story sharing for peer support and advocacy.

3. **Thinking about Eating Disorders** – an introduction to eating disorders and the most common treatment approaches to assist learners to be aware of the different experiences that other people may have.

4. **Staying Safe** – an introduction to self-care and wellness planning including thinking about boundaries as an essential factor in everyone's wellbeing.

5. **Trauma Informed Care** – an introduction to the principles of trauma informed approaches.

6. **Suicide Prevention** – an introduction to strategies to help someone feel calm and seek professional help when they are at risk of suicide or self-harm.

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.