Guiding Principles

The thirteen Guiding Principles outline areas which guide and inform training. These Principles do not need to be covered through focused teaching content, for example, in a PowerPoint slide, but are underlying principles to be embedded throughout the development and delivery of training.

This checklist has been designed to support training providers, service leaders, and clinicians align workforce development initiatives with the Guiding Principles outlined in the National Framework for Eating Disorders Training – A guide for training providers.

Please see the Training Framework for a full reference list.

Principle	Description	Notes: Align Principle with training
1. Evidence-based and evidence-informed approaches	Research and evaluation are integral to prevention, early intervention, and treatment approaches for eating disorders. Training should incorporate the most recent evidence and be aligned to evidence-based and evidence-informed treatment guidelines.	
2. Training content tailored to match clinician knowledge and skillset	Training content should be appropriate for the audience. Where training content is appropriate for intermediate to advanced levels, this needs to be articulated in training promotional material and within the training itself. Training can be defined by the level of complexity and depth of learning and skill attainment, and the application of knowledge and skills. Where prior knowledge and skill in the specific topic is not required, the training should be described as appropriate for beginner levels. See the following resources for further information: • Australian Qualifications Framework	
3. Stepped system of care for eating disorders	A stepped system of care delivers evidence-based services that increase or decrease in intensity according to a person's psychological, physical, nutritional, and functional needs at any given time. People experiencing an eating disorder require access to a stepped system of services that matches their needs by delivering an appropriate intensity and focus of treatment and that allows healthcare providers to respond flexibly to changes in the person's needs. Training should equip clinicians with a sound understanding of the system of care at local, state, and national levels, and be able to support a person experiencing an eating disorder, and their family and supports to navigate and access the appropriate intensity and focus of treatment across mental health, medical, and psychosocial areas. For more information see: • NEDC's Stepped System of Care for Eating Disorders	

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4. Lived experience, family, and carer voice	The experience and insights of people living with or who have recovered from an eating disorder, and their families and supports should be embedded in training. This is in alignment with national mental health plans and agendas which emphasise consumer and carer participation in mental health system design and delivery. Training should involve meaningful input from people with lived experience, and their families, supports, and communities across planning, development, delivery, and evaluation. See the following resources for further information: • Consumer and Carer Engagement: A Practical Guide (National Mental Health Commission, 2018) • Lived Experience Framework (Mental Health Commission of NSW, 2018) • Insights into Recovery: A consumer-informed guide for health practitioners working with people with people with eating disorders (Butterfly Foundation, 2016) • Paid Participation Policy for people with a lived experience of mental health difficulties, their families and support people (National Mental Health Commission, 2019)	
5. Impact of stigma	Training should include information on the impact of mental health and eating disorder stigma and weight bias which may prevent people from accessing support. Clinicians need to understand the experience of stigma, feelings of fear and shame and fear of judgement regarding the experience of eating disorder symptoms and behaviours and the challenge this poses to help-seeking. Clinicians need to understand the impacts of weight bias on the person and its implications on healthcare and the importance of appropriate and inclusive language. See the following resources for further information: • The Management of Eating Disorders for People with Higher Weight: Clinical Practice Guideline • NEDC Weight Stigma factsheet	

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6. Recovery-oriented person and family-centred care	Care and treatment should sit within a recovery-oriented, person- and family- centred, and strengths-based approach. Recovery-oriented modes of treatment aim to support individuals in taking responsibility for their personal journey of recovery and offer a collaborative and holistic framework to work within. Services should be delivered with a strengths-based approach, building on the strengths and resources of the person, supporting long-term recovery, and tailored to meet individual decision-making capacity and needs as they develop over the course of the eating disorder. Training should refer to and embed principles of recovery-oriented person- and family-centred care to support clinicians to understand why and how this can be applied in clinical practice.	
7. Culturally safe, sensitive, and competence practice	Cultural safety is essential when working with diverse populations who experience mental health concerns. Cultural safety seeks to promote respect, social justice, and equity. Culturally safe practice requires that clinicians are equipped to identify, assess, and respond to important aspects of culture, identity, disability, neurology, and history when working with people who have an eating disorder. Clinicians should be aware of the impacts of intersectionality, that everyone has their own unique experiences of discrimination and oppression and how these may combine to create unique health and wellbeing disparities, risk and maintaining factors that interact with and influence the person's experience of an eating disorder. For example, client experience of racism, misogyny, homophobia, trans phobia, ableism, and stigma. Cultural safety requires a clinician to reflect on their own cultural identity, privilege and the power differential that may exist between a person and a healthcare provider. Evidence for the efficacy of evidence-based treatment models and evidence-informed dietetic practice that are helpful for people experiencing an eating disorder from specific cultural contexts is yet to be established. Training should be updated to include the latest evidence for culturally safe care for all people experiencing eating disorders as this arises. Until this occurs, training should be guided by and demonstrate application of principles of culturally safe practice, person-centred care, clinical judgement, and monitoring treatment efficacy. Training should support clinicians to think critically about the ways in which the aspects of a person's identify and experience of discrimination influences their eating disorder and equip them to transfer existing skills and knowledge regarding culturally safe practice within their work with people experiencing eating disorders. Clinicians who are not aware of culturally safe practice should be directed to resources to upskill in this area.	

Principle	Description	Notes: Align principle with training
8. Inclusive care	Inclusive care requires clinicians to consider the impact of lack of representation, microaggressions and unconscious bias on equality of access to health care, and client wellbeing. Training should equip clinicians to consider ways to practice inclusive care for people with eating disorders across the following areas: • Diverse age ranges and life stages • Neurodivergence (e.g., Autism, ADHD, learning disabilities), which is particularly underdiagnosed in women and girls • Diverse gender identity (e.g., Trans, non-binary, or other gender-diverse individuals) and cisgender men • Diverse sexual identity (e.g., Lesbian, Gay, Bisexual, or other sexually diverse individuals) • Intersex biological characteristics or other natural variations in sex characteristics • Diverse cultural identity, ethnicity, or language (e.g., Aboriginal and/or Torres Strait Islander people, other Culturally and/or Linguistically Diverse people) • Religion or spirituality • Physical, cognitive, intellectual, or sensory disability Training should use inclusive language and include research and lived experience examples that support awareness of the diversity of eating disorder lived experience. See the following resources for further information: • LGBTIQ Inclusive Language Guide (Victorian Department of Premier and Cabinet, 2022) • A guide to language about disability (People with Disability Australia, 2021)	
9. Working with Aboriginal and Torres Strait Islander people	Clinicians should understand Aboriginal and Torres Strait Islander peoples' holistic concepts of social and emotional wellbeing (SEWB), mental health and healing. This includes recognising that SEWB is affected by social, historical, and political determinants, including intergenerational and ongoing impacts of colonisation, trauma, grief, racism, social exclusion, and discrimination. In 2015, the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) released the Gayaa Dhuwi (Proud Spirit) Declaration, which aims to improve the mental health of Aboriginal and Torres Strait Islander peoples by supporting their leadership within the mental health system and promoting mental health system responses which appropriately balance clinical and cultural considerations. NATSILMH called for the Declaration to be adopted and implemented across the Australian mental health system. The Australian Government committed to supporting implementation of the Gayaa Dhuwi (Proud Spirit) Declaration in The Fifth National Mental Health and Suicide Prevention Plan.	

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	Evidence for the cultural appropriateness and efficacy of current evidence- based treatment models and dietetic practice has not yet been established for Aboriginal and Torres Strait Islander people experiencing an eating disorder. Clinicians should be guided by principles of cultural safety, trauma-informed care, person-centred care, as well as clinical judgement and treatment efficacy. See the following resources for further information: • Culturally safe health care for Indigenous Australians (Australian Government, 2020) • Aboriginal and Torres Strait Islander cultural safety (Australian Government, 2021) • Improving cultural competency (Australian Commission on Safety and Quality in Health Care, 2017) • LGBTIQ Inclusive Language Guide (Victorian Department of Premier and Cabinet, 2022) • A guide to language about disability (People with Disability Australia, 2021)	
10. Trauma-informed care	Care and treatment should be approached from a trauma-informed lens which recognises the high prevalence of trauma experiences and the impact that the trauma can have on the person and their recovery from an eating disorder. It adopts practices that promote a culture of safety, trust, choice, collaboration, empowerment, and respect for diversity. Providing treatment specifically focused on a person's personal experience of trauma is outside the scope of this document. Training should refer to and embed practices and principles of trauma- informed care.	
11. Working with families and supports	The active involvement of families, supports, and communities in the care team is a key principle of eating disorder treatment. Clinicians should strive to involve families and supports in all stages of treatment and recovery, ensuring families and supports receive their own care, skills and strategies, education, and information as needed to enable them to support the person experiencing an eating disorder and to maintain their own personal wellbeing. Training should incorporate information on the importance of involving family and supports across all stages of treatment and recovery and explore opportunities for meaningful family involvement and support.	

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12. Scope of practice	Understanding of, and commitment to, always working within one's scope of practice and recognising when to refer to another clinician/service is essential to a safe system of care. Completion of training in treatment provision for eating disorders provides basic skills in the specific model or dietetic practice but should always sit alongside professional development activities including supervision. Clinicians should be aware of and adhere to their own profession scope of practice guidelines. Training content should match the level of experience and skill of the target audience. Training should provide clinicians with a working understanding of scope of practice and a framework for understanding how training content fits within and changes a clinician's scope of practice, as well as implications for ongoing professional responsibility. Further information can be found on page 8 of the Training Framework. Clinicians should also refer to their professional Scope of Practice Guidelines, accessed through the relevant professional bodies.	
13. Professional responsibility	Clinicians should be aware of and maintain professional practices including clinical supervision and professional development to ensure safe and ethical practice and to manage their own health and mental health wellbeing. Clinicians need to engage in reflective practice, consistently evaluating and addressing challenges and limitations in knowledge and experience. Clinical supervision and continuing professional development (CPD) aim to upskill clinicians, support reflective practices, aid the provision of high-quality treatment, and supports clinicians to recognise and explore the complex interpersonal dynamics that can arise in the treatment of complex mental health issues. Training should emphasise the importance of reflective practice and activities which support and maintain professional, ethical, and legal responsibilities and support a clinician to work within their scope of practice as defined by their professional body.	

Building a safe, consistent and accessible system of care for people with eating disorders

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