# Holding Hope WORKBOOK

## For the Workforce Supporting People With a Longstanding Eating Disorder

**Shannon Calvert**
NATIONAL EATING DISORDERS
COLLABORATION | 2025

National
Eating Disorders
Collaboration

Evidence Experience Expertise

**NEDC acknowledges the traditional custodians of lands throughout Australia. We pay our respects to Aboriginal and Torres Strait Islander Elders, past and present, and recognise the important role of Aboriginal and Torres Strait Islander peoples, as well as their cultures and customs across Australia.**

## Recommended Citation

Calvert, S. (2025). *The Holding Hope Guide: A collaborative, ethical guide for supporting dignity, choice, and person-centred care in longstanding eating disorders.* National Eating Disorders Collaboration (NEDC).

## Acknowledgement of Origin

The Holding Hope Guide builds upon the foundational work of the Holding Hope Discussion Paper, which was funded by the Commonwealth Department of Health and Aged Care and released to the public in June 2024 via the NEDC website (nedc.com.au). The Discussion Paper initiated a national conversation about the complex intersection of longstanding eating disorders with palliative, person-led, and quality-of-life-oriented care. This Guide extends that work by offering practical tools, frameworks, and ethical prompts to support individuals, families, and professionals in navigating care with dignity, compassion, and clarity.

## The Holding Hope Guide Project Team

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https://su.vc/wzjrfwco

# Support Services

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| | |
|---|---|
| **Butterfly Foundation**<br>National Helpline | 1800 ED HOPE (1800 33 4673)<br>support@butterfly.org.au<br>Webchat |
| **Eating Disorders Victoria**<br>Helpline | 1300 550 236<br>hub@eatingdisorders.org.au<br>Webform |
| **Eating Disorders Families Australia**<br>Support for families and carers | 1300 195 626<br>admin@edfa.org.au<br>https://edfa.org.au/ |
| **Beyond Blue**<br>Mental health support | 1300 22 4636<br>Webchat |
| **Lifeline**<br>24/7 Crisis Support | 13 11 14<br>Webchat |
| **Kids Helpline**<br>24/7 Helpline and Webchat | 1800 55 1800<br>counsellor@kidshelpline.com.au<br>Webchat |
| **Suicide Call Back Service**<br>24/7 phone and online counselling for people affected by suicide | 1300 659 467 |
| **MensLine Australia**<br>24/7 phone counselling support for mental health, relationships, and family violence | 1300 78 99 78<br>Webchat |
| **13 YARN**<br>To talk with an Aboriginal or Torres Strait Islander Crisis Supporter | 13 92 76 |
| **Qlife**<br>LGBTIQ+ peer support | 1800 184 527<br>Webchat |

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# Before You Begin

This workbook was created with deep respect for the complex realities you navigate in your role. Whether you work within clinical teams, community organisations, as a peer worker, or care coordinator, you are often holding space for uncertainty, making difficult decisions, and walking alongside people whose needs do not always fit within conventional models of care.

We recognise that this kind of work is rarely straightforward. At times, it may challenge your usual frameworks or ask you to sit with discomfort, contradiction, or doubt. These moments can also be invitations towards courageous conversations, greater attunement, and care that is both principled and adaptive.

The tools offered here are not prescriptive. They are designed to assist you in reflecting on your role, navigating ethical tensions, and engaging in shared decision-making in ways that align with your values. You may also find prompts that support sustainable practice - because the wellbeing of those providing care is inseparable from the care itself.

At the heart of this resource is a commitment to what we call “holding hope” - not by insisting on a singular outcome, but by remaining present, relational, and responsive. This idea, drawn from the broader Holding Hope Guide, reminds us that even in times of complexity or constraint, it is possible to offer care that is grounded in dignity, humanity, and ethical intent.

Thank you for the work you do. We hope this workbook becomes a quiet companion in the moments when care feels most complex - and a reminder that reflection, respect, and presence are themselves powerful forms of support.

With appreciation,

Shannon, Sarah T, Amy and Sarah G

*Shannon Calvert and the NEDC Project Team*

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# How Can This Workbook Help?

I want to reflect on how my own values, biases, or experience may be shaping the way I support someone.

- Bias Reflection Tool
- Reflective Practice & Role Alignment Framework
- Values-in-Practice Check in Sheet

I need to make or support complex decisions in ethically challenging situations.

- Ethical Decision-Making & Dialogue Prompts
- Ethical Decision Reflection Aid
- Risk vs. Values Worksheet
- Scenario Walk Through Tool

I want to strengthen collaborative care with the person I support, their loved ones, and their broader treating team.

- Care Collaboration Summary Sheet
- Family Voice in Care Planning Template
- Language in Practice: A Prompt Sheet for Ethical and Relational Communication
- Care Coordination Toolkit & Planning Checklist

I'm feeling uncertain or overwhelmed and want to check in on my own sustainability and support needs.

- Co-Reflection & Ethical Debriefing Prompts
- Capacity & Voice Consideration Prompt Sheet
- Care History & Service Access Audit Tool

# Introduction

This workbook is a companion to The Holding Hope Guide: A collaborative, ethical guide for supporting dignity, choice, and person-centred care in longstanding eating disorders. It is part of the Holding Hope series, which offers practical, trauma-informed tools to support meaningful dialogue, values-led planning, and collaborative care.

This workbook focuses on members of the workforce who support people with longstanding eating disorders.

These tools support health professionals in facilitating safe, person-centred care. They acknowledge the unique and complex journey of those in supportive roles and honours the diversity of experiences that shapes each client's path.

Each tool is adaptable to the clinical context-whether used to guide therapeutic dialogue, enhance collaborative care planning, or reflect on the individual's needs and preferences in partnership with their family and broader support network.

Importantly, these resources are not diagnostic instruments or formal assessments. They are intended to be flexible, iterative, and revisited over time to meet the evolving needs of each client and their support system.

You are welcome to:

- Photocopy or print individual tools from the workbook
- Use guiding questions to stimulate conversation in clinical sessions, team meetings, or family consultations
- Integrate or adapt these templates into existing documentation or care planning resources

We encourage using this workbook in partnership whenever possible, whether with clients/patients, their support networks, or colleagues. These tools are most effective when they are part of a respectful and ongoing collaboration that values every voice and role in the care process.

**Access the Holding Hope Guide here**

# Values-in-Practice Check-In Sheet

**Purpose**

This tool helps clinicians, peer workers, care coordinators, and broader multidisciplinary teams reflect on whether their personal and collective values are being upheld in everyday practice.

It supports ethical sustainability, relational accountability, and the prevention of “ethical drift” - especially when navigating systemic barriers or complexity in care.

Use this sheet regularly in supervision, case reviews, or team meetings to strengthen alignment between actions, intentions, and principles.

**Values are not just aspirational - they are actionable.**

## 1. Grounding in Values

**What are my core personal values in this work?**

**What values do my team, service, or organisation name or strive to uphold in its work?**

**Which of these values feel most present or alive in my practice right now?**

**Which values feel at risk, diluted, or compromised?**

## 2. Real-Time Reflection

**Think about a recent case, decision, or interaction.**
**What value(s) guided my actions in that moment?**

**Did I feel aligned with those values - or was there conflict?**

**Was anything said, done, or implied that undermined the values I care about?**

## 3. Team Culture and Collective Practice

**Are values discussed regularly in my/our team or service?**

☐ Yes ☐ No ☐ Sometimes

**Are there moments where urgency, fear, or system pressure override our values?**

**How do we acknowledge and celebrate care that reflects dignity and connection, not just clinical outcomes?**

**How do we support one another with both accountability and compassion in upholding our shared values?**

## 4. Small Acts of Alignment

**One small act I have done recently that reflects my values:**

**One small act I want to commit to this week:**

**One value I want to stay anchored to, especially in times of complexity or pressure:**

## Closing Reflection

**Sustaining ethical care is not about perfection - it's about returning, again and again, to what matters most. This tool is most effective when used regu-larly, not only in times of ethical tension but as part of everyday team culture.**

# Reflective Practice & Role Alignment Framework

**Purpose**

This tool supports reflection on role clarity, emotional processing, and ethical sustainability in complex care settings.

It can be used individually, in supervision, or as part of multidisciplinary team reflection.

It is not an evaluation tool - it is a guide for reconnecting with our ethics, boundaries, humanity, and each other.

## 1. Grounding in Role and Values

**My role is:**

**What this role asks of me:**

**What this role means to me (ethically, relationally):**

**Values I want to bring into this work:**

## 2. Navigating Ethical Tensions and Emotional Load

**Situations that stretch me ethically or emotionally:**

**Times I felt uncertain, conflicted, or unheard:**

**How I tend to respond when I feel overwhelmed or unsure:**

**Words or reminders I need when I am carrying too much:**

## 3. Boundaries, Bias, and Assumptions

**Assumptions I may be holding about this person or situation:**

**Ways that bias, fear, or cultural context may be shaping my response:**

**Boundaries I need to uphold to remain safe and effective:**

**Where I feel pulled beyond my scope, role, or limits:**

## 4. Supervision and Support Needs

**Who helps me reflect clearly on complex or emotional cases?**

**Do I feel safe and supported in my supervision or support structures?**

☐ **Yes** ☐ **No** ☐ **Sometimes**

**What would make supervision more restorative or effective:**

**What support structures outside formal supervision help me sustain this work?**

## 5. Intention Setting and Next Steps

**One thing I want to continue doing well:**

**One thing I want to explore or strengthen:**

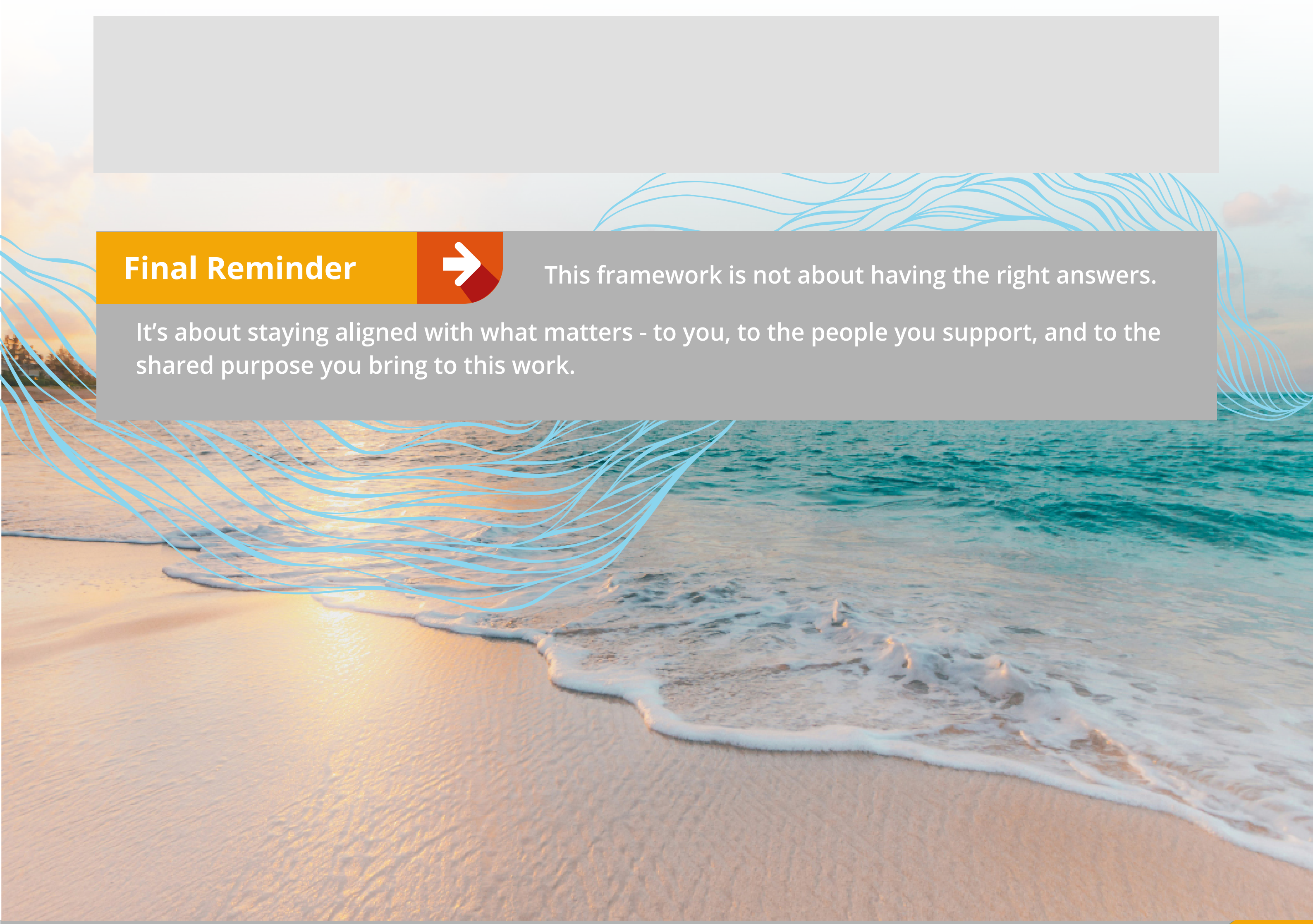
**A conversation or request I need to make:**

**What I want to remember about this work (even when it's hard):**

### Final Reminder

This framework is not about having the right answers.

It's about staying aligned with what matters - to you, to the people you support, and to the shared purpose you bring to this work.



# Care History & Service Access Audit Tool

**Purpose**

This tool supports ethical, transparent care planning by offering a structured way to map an individual's treatment history, experiences of disengagement, and system-related barriers. It is particularly useful when considering a shift in care goals (such as harm reduction, respite, or palliative care) or when advocating for alternatives to standard treatment pathways.

It honours the weight of a person's care journey - moving beyond assumptions toward informed, values-led decision-making.

This tool may be particularly useful when planning case reviews, shifting care goals, or preparing for multidisciplinary meetings where service decisions are being made.

## How to Use This Tool

This audit supports ethical, person-led care planning by documenting an individual's treatment history, barriers to care, and systemic experiences. It can be completed by clinicians, peer workers, care coordinators, or collaboratively with individuals and families.

**It is particularly useful when:**

- Shifting care approaches (e.g., exploring harm reduction, palliative pathways, or quality-of-life priorities)
- Supporting ethical decision-making and reflective practice
- Advocating for flexible, trauma-informed, or culturally safe alternatives
- Transparently acknowledging systemic gaps or limitations in care

**Important Reminders**

- Complete this tool respectfully and collaboratively wherever possible.
- Focus on lived experience - not assumptions, judgments, or deficits.
- Approach this tool as a way to understand the person's actual care journey in their own context
- Avoid framing disengagement as non-compliance, or long illness duration as failure. Instead, document what has been tried, what hasn't worked (and why), and what the person has experienced - including harm, help, or exclusion. This ensures future planning is grounded in truth, not in clinical expectations or systemic bias.
- This audit is a resource for understanding and advocacy. It should never be used to justify gatekeeping or the withdrawal of care.
- Revisit and update this document as care needs, engagement, and circumstances evolve.

## 1. Overview of Eating Disorder History

**Approximate duration of ED:**

**Diagnosis/es (if known):**

**Age of onset:**

**Has the diagnosis changed over time?**

☐ **Yes** ☐ **No**

## 2. Medical, Psychiatric, and Allied Health Care Received

**Include traditional, non-traditional, online, or overseas care if relevant**

| Type of Care | Accessed? | Approx. Years | Helpful? | Notes |
|---|---|---|---|---|
| GP/ Primary Care | **Yes**<br>**No** | | **Yes**<br>**No**<br>**Mixed** | |
| Dietitian | **Yes**<br>**No** | | **Yes**<br>**No**<br>**Mixed** | |
| Psychologist/ Therapist | **Yes**<br>**No** | | **Yes**<br>**No**<br>**Mixed** | |
| Psychiatrist | **Yes**<br>**No** | | **Yes**<br>**No**<br>**Mixed** | |
| Lived Experience support e.g.: peer worker, mentor, coach | **Yes**<br>**No** | | **Yes**<br>**No**<br>**Mixed** | |
| Social Worker /Case Manager | **Yes**<br>**No** | | **Yes**<br>**No**<br>**Mixed** | |
| Culturally-Specific Services | **Yes**<br>**No** | | **Yes**<br>**No**<br>**Mixed** | |

| Type of Care | Accessed? | Approx. Years | Helpful? | Notes |
|---|---|---|---|---|
| Gender-affirming or LGBTIQ+ service | Yes<br>No | | Yes<br>No<br>Mixed | |
| Other (please specify): | Yes<br>No | | Yes<br>No<br>Mixed | |

## 3. Intensive or Inpatient Treatments

| Service Type | Accessed? | Number of Admissions | Approx. Dates | Notes |
|---|---|---|---|---|
| Inpatient ED Program | Yes<br>No | | | |
| Day Program | Yes<br>No | | | |
| Medical Hospital Admission | Yes<br>No | | | |
| Mental Health Inpatient (general) | Yes<br>No | | | |
| Community or Outreach Team | Yes<br>No | | | |
| Other | Yes<br>No | | | |

## 4: Engagement and Disengagement

**Has the person ever chosen to disengage from services?**

☐ **Yes** ☐ **No**

**If yes, what were the reasons?**

**Have services withdrawn care or refused engagement or re-engagement?**

☐ **Yes** ☐ **No**

**If yes, under what circumstances?**

**Has the person ever experienced coercive treatment or medical trauma?**

☐ **Yes** ☐ **No**

**If yes, has this explored and acknowledged in future care planning?**

## 5: Barriers to Accessing Care

Tick all that apply

- ☐ Financial cost
- ☐ Wait times
- ☐ Geographic or rural isolation
- ☐ Co-occurring disability or neurodivergence
- ☐ Past trauma or mistrust of services
- ☐ Experiences of racism, ableism, transphobia, weight stigma, etc.
- ☐ Care options did not feel culturally safe or inclusive
- ☐ Services focused only on weight/BMI
- ☐ Services required weight restoration before offering support
- ☐ No peer-informed or trauma-informed options available
- ☐ Other:

## 6. Opportunities for Reconnection or Re-engagement

Are there approaches or supports the person may be open to, if adapted or offered differently?

What would increase the likelihood of engagement at this stage
(e.g., peer support, harm reduction, online options)?

## 7. Summary for Ethical Care Planning

**Have treating teams clearly documented the care options that have been explored and whether they were accessible, inclusive, or appropriate for the person?**

☐ **Yes** ☐ **No** ☐ **In Progress**

**If significant gaps exist, how will they be addressed or acknowledged?**

**If moving toward an alternative care approach (e.g., harm reduction, Advance Care Planning), is there a clear and respectful shared understanding of the reasons for this choice?**

## Final Reflection

This audit is not a scorecard.

It is a way to honour the person's history, ensuring that decisions moving forward are grounded in their lived reality, not assumptions.

# Language in Practice: A Prompt Sheet for Ethical and Relational Communication

**Purpose**

This tool supports teams and practitioners to reflect on the language they use in documentation, discussion, and care delivery. It encourages a shift toward words that uphold dignity, invite trust, and reflect a person-led approach.

**Why Language Matters**

The words we choose shape how people experience care - and how they experience themselves.

Language can either uphold dignity and autonomy or reinforce stigma and powerlessness.

Thoughtful communication is a core part of ethical, trauma-informed, and person-led practice.

## 1. Reframing Common Phrases

**These reframes aren't about sanitising language, but about ensuring our words reflect respect, shared meaning, and ethical awareness.**

| Instead of Saying... | Try Framing It As... |
|---|---|
| **Non-compliant** | The person is prioritising different needs or perspectives right now. |
| **Refusing treatment** | The person has chosen a different path or is declining this option at this time. |
| **Lacks insight** | The person holds a different understanding of their experience. |
| **Treatment-resistant** | The current approach may not align with the person's needs, values, or readiness. |
| **Failure to thrive** | The person is experiencing persistent challenges to health and wellbeing. |
| **Manipulative** | The person may be expressing distress or seeking connection, control, or safety in the only way they know how right now. |

## 2. Helpful Framing Starters

**Use these prompts to ground conversations in shared respect and curiosity:**

- “Can we slow down and check what matters most to the person right now?”
- What do we already know about what helps this person feel safe or heard?”
- Are we addressing actual risk - or responding to our own fear or sense of liability?”
- “What could we say that would make this conversation feel less threatening?”
- “How can we centre the person’s voice - even if they’re not present?”
- Is there language here that might feel stigmatising, clinical, or alienating?”
- “How can we acknowledge the perspectives of family, loved ones, or other supports while still centering the person’s voice?”
- “Are there ways to invite language from loved ones that reflects care and connection, not only concern?”

## 3. Notes for Practice

- Language matters - not to avoid discomfort, but to uphold dignity.
- There is no perfect phrase - just more intentional ones.
- Ask the person how they describe their experience. Mirror that language where appropriate.
- Encourage team reflection on default clinical terms and the values they reflect.
- When documenting, aim to write as if the person will read their own file - because they may.
- When appropriate, consider how families or supporters describe their experiences - and explore how this language aligns with or differs from the person’s own words.
- Use language that recognises the role of families and supporters, without overshadowing the person’s autonomy.
- Encourage reflection on whether clinical or system terms unintentionally exclude or silence the voices of loved ones.

## Final Reflection

Language evolves as our understanding deepens.

Stay open. Stay curious. Stay aligned with your values.

Small shifts in language can create powerful shifts in trust, connection, and care.

# Risks vs. Values Worksheet

**Purpose**

This worksheet supports reflective, relational con-versations about risk, value, and dignity in care.

It helps clarify competing concerns, surface hidden assumptions, and centre the person's values

- particularly when risk is present, but recovery is not the only or current goal. In longstanding eating disorders, risk is often present - but not all risk sig-nifies danger or hopelessness. This tool helps teams respond thoughtfully rather than reactively.

Use this tool for self-reflection, with your support network, or during times of uncertainty.

It helps you identify the risks a person may be fac-ing, the potential impact if those risks are not managed, and how significant that impact might be for them. This process may reveal differences be-tween what the care team prioritises and what the person with the eating disorder values.

For example, a care team might focus on achieving medical stability, even when the person has a his-tory of medical trauma. Meanwhile, the individual may feel that the emotional distress of a hospital admission outweighs the physical risks of not being admitted. It does not replace clinical or legal frameworks - but aims to strengthen ethical clarity and relational integrity.

## 1. Clarifying the Decision or Concern

**What decision, situation, or care pathway are we exploring?**

**Why does it feel difficult or ethically unclear?**

**Who is involved or affected by this decision?**

## 2. Mapping Risks and Harms

| Type of Risk or Harm | Examples or Concerns (e.g., low blood pressure) | Impacts if not addressed e.g., hospitalisation | Level of Concern (Low/Medium/High) |
|---|---|---|---|
| Physical Health | | | |
| Emotional Distress | | | |
| Therapeutic Relationship | | | |
| Autonomy / Rights | | | |
| Family / Carer Impacts | | | |
| Cultural / Identity Safety | | | |
| Other (e.g. spiritual distress, housing loss, stigma) | | | |

## 3. Exploring Value and Meaning

**What matters most to the person involved?**

**What relationships, values, or aspects of the person’s wellbeing might be harmed or overlooked if we apply a standard care approach without adapting to this context?**

**What could be protected, upheld, or honoured by adapting our approach?**

## 4. Context and Caution

**What past experiences - of the person, team, or family - might be shaping how risk is currently being perceived or responded to? Are any of these experiences unduly influencing the conversation?**

**Have we considered the relational impact of our decisions - not just clinical outcomes?**

☐ **Fully considered** ☐ **Partially considered** ☐ **Not yet considered**

**Are we responding from fear, bias, or procedural pressure more than from shared ethics and values?**

## 5. Shared Reflection and Next Steps

**Are there ways to meet safety needs while still honouring the person's voice and values?**

**Have we named and shared responsibility for the decision or plan?**

☐ **Yes** ☐ **No**

**What will be documented (e.g. care notes, handover summaries), and how will it be communicated with transparency and care?**

**Who will follow up - and when?**

**What supports are needed for the person, family, and team going forward?**

# Family Voice in Care Planning Template

**Purpose**

This tool supports ethical, transparent documentation when family members or loved ones contribute relevant insights into a person's care planning. It is especially useful when formal legal documents such as an Advance Health Directive (AHD) or Enduring Power of Guardianship (EPG) are not yet in place. This tool should be completed with sensitivity, respect for autonomy, and in line with trauma-informed care principles.

## 1. Identifying the Supporter(s)

**Name(s) of family member(s) / supporter(s):**

**Relationship to the individual:**

**Contact details:**

## 2. Has the person consented to their involvement?

- ☐ **Yes**
- ☐ **No**
- ☐ **Partially (e.g. in some areas or at certain times)**
- ☐ **Unclear (e.g. consent not formally discussed or context is complex)**

## 3. Insights Shared by Loved Ones

**What do the loved ones understand to be the person's wishes, values, or care preferences?**

**How was this understanding reached (e.g. prior conversations, written statements, care history)?**

**Are there specific interventions or settings the person has expressed wanting or declining?**

**Have these preferences been shared with the broader care team?**

☐ **Yes** ☐ **No**

**If yes provide a brief overview:**

**In what ways do the perspectives of the loved ones align with - or differ from - the current care plan?**

**What ethical tensions or concerns are present?**

**Has an ethics review, supervision, or team dialogue occurred?**

☐ **Yes** ☐ **No**

## 5. Care Planning and Communication Steps

**How have the family's insights been documented and shared with the team?**

**Has a summary of this discussion been offered back to the person and/or family?**

☐ **Yes** ☐ **No**

**Are there follow-up steps to explore legal planning (e.g. AHD, EPG)?**

**Next review or check-in date:**

## 6. Final Reflections

**Do we believe the perspectives of those closest to the person have been heard, respected, and ethically considered?**

**Have we documented this process transparently and with accountability?**

# Scenario Walk-Through Tool

**Purpose**

This tool helps map the possible outcomes of a difficult decision, alongside emotional, relational, and ethical impacts. It supports clearer thinking and fosters shared accountability.

Use this tool in self-reflection, with your own supports.

This tool is not about finding a perfect or risk-free path - it is about navigating complexity with care, courage, and integrity.

## 1. Defining the Scenario

**What decision or situation are we currently facing?**

**Why does this feel difficult, risky, or ethically complex?**

**Who is involved - and who might be affected (including carers, community, or cultural supports)?**

## 2. Exploring Possible Pathways

**For each potential course of action, consider:**

| Option | Brief Description | Likely Outcomes | Emotional/ Relational Impacts | Ethical Considerations |
|---|---|---|---|---|
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Prompting Questions for Each Row:**

- **Option:** What are the possible actions or pathways?
- **Brief Description:** What does this option involve practically?
- **Likely Outcome:** What are the realistic clinical or care outcomes?
- **Emotional / Relational Impacts:** How might this affect trust, safety, grief, connection?
- **Ethical Considerations:** Which values (e.g., autonomy, dignity, justice) are being upheld or compromised?

## 3. What Are We Carrying?

**What personal fears, assumptions, hopes, or loyalties are shaping our thinking?**

**Are we reacting from urgency, fear, guilt, grief, or compassion?**

**Are we holding moral distress, responsibility, or unresolved past experiences that may be influencing this moment?**

## 4. Integrity and Intentions

**What would it mean to act with integrity here - even if the outcome remains uncertain?**

**What do we want to be true about how we show up - regardless of which pathway is chosen?**

**What individual or collective supports might help us move forward with clarity and care?**

## Closing Reflection

Decisions in complex care often evolve. This tool can be revisited as situations shift, or new information emerges.

Acting with care is not about finding certainty - it is about staying aligned with values, humanity, and relational trust at every step.

# Bias Reflection Tool

**Purpose**

This bias reflection tool is crafted to assist clinicians, peer workers, and multidisciplinary teams in uncovering underlying beliefs, assumptions, and systemic factors that may impact care decisions. This is particularly important when working with individuals whose treatment histories are long, complex, or characterised by disengagement, deterioration, or resistance to traditional care models.

Designed for non-judgmental use - whether individually, in supervision, or within multidisciplinary teams. This tool promotes ethical reflection, shared accountability, and person-led decision making.

This tool is not about assigning blame. Instead, it aims to cultivate space for courage, compassion, and the complexity of care. Utilise it to remain open, humble, and focused on the individual, prioritising their needs over merely adhering to the plan.

Use this tool alongside:

- Ethical Decision-Making & Dialogue Prompts (page 39)
- Advance Care Planning Workbook (page 25 Con-sumer workbook)
- Capacity & Voice Consideration Prompt Sheet (page 49)
- Bias Reflection Tool (page 33)
- Advance Care Planning Workbook (page 25 Con-sumer Workbook)
- Capacity & Voice Consideration Prompt Sheet (page 49)

## 1. Clinical Assumptions and the Recovery Lens

**Am I assuming that full recovery must remain the primary goal, regardless of this person's history or stated preferences?**

**Do I equate refusal of treatments (e.g., refeeding, hospitalisation) with "lack of insight" or "non-compliance"?**

**Have I acknowledged that this person may have engaged fully with available treatments - and yet remains unwell?**

**Am I open to recognising that hope can include stability, safety, dignity, and relational trust - not just symptom reduction?**

## 2. Misconceptions about Harm Reduction and Palliative Principles

**Do I fear that discussing harm reduction or palliative care might be perceived as unethical, negligent, or giving up?**

**Am I confident in applying harm reduction principles in eating disorder contexts, or do I need more support or training?**

**Have I explored how palliative principles (e.g., comfort, meaning, quality of life) can serve this person, even if they are not imminently dying?**

## 3. Ethical Risk, Fear of Failure, and System Accountability

**Am I experiencing moral distress or anxiety about “doing enough”?**

**Is fear of litigation, scrutiny, or systemic risk influencing my recommendations in ways I haven’t acknowledged?**

**Do I feel that taking a harm reduction or adaptive approach means failing the person - or failing professional expectations?**

**Have I considered whether service limitations - not the individual’s motivation - are contributing to unmet needs?**

## 4. Service History and the Weight of Accumulated Harm

**Have I truly considered the cumulative toll of repeated admissions, failed interventions, and systemic trauma?**

**Am I unintentionally minimising this person’s experiences because their story feels “familiar” or “typical”?**

**Have I created an open genuine space for the person to share how services have helped, harmed, or shaped their journey?**

**Am I remembering that longstanding illness is not synonymous with hopelessness?**

## 5. Language, Tone, and Assumptions

**Am I using language that upholds dignity (e.g., “supporting autonomy”) instead of framing through pathology (e.g., “refusing care”)?**

**Am I recognising choices as valid adaptations to trauma and experience, not simply resistance?**

**Have I questioned assumptions based on body size, facial expression, communication style, or cultural background?**

**Would I respond differently if this person reminded me of someone I personally care about?**

## 6. Person-Centred vs Patient-Centred Practice

**Have I adapted care planning around the person's life, values, and context - not just their clinical diagnosis?**

**Am I respecting their right to make decisions, even when those decisions carry risk or sorrow?**

**Have I allowed the person to shape care goals, or are we only offering pre-set clinical endpoints?**

**Have I confused protocol-driven practice with truly ethical, relational care?**

## 7. Relational and Team Reflection

**Have I brought these tensions into supervision, team reflection, or ethical review processes?**

**Is our service or team environment enabling ethical care - or are we constrained by pressures that misalign with our values?**

**Does our team culture support emotional honesty and critical reflection - or do we prioritise quick solutions?**

**Are we willing to sit with discomfort, or do we over function to soothe our own fears?**

**Have we asked: "What would care look like if this person's life - as it is - mattered as much as their diagnosis?"**

## Closing Reflection

These questions are not a one-time exercise - they can be revisited throughout care, especially during uncertainty or systemic pressure.

Bias is not personal failure. It is a human tendency shaped by training, experience, systems, and emotion. Ethical care asks not for perfection, but for reflection, humility, and ongoing recalibration.

# Ethical Decision-Making & Dialogue Prompts

**Purpose**

This tool supports ethical, person-led, and reflective decision-making in complex or evolving care.

In this workbook, it is intended to guide multidisciplinary supervision, co-reflection, and care alignment - especially when decisions involve uncertainty, shared responsibility, or long-term planning.

It is designed for use collaboratively, with space for honest discussion, discomfort, disagreement, and shared responsibility.

This tool is not about delivering certainty.

It is about creating clarity, compassion, and collaboration - even in complexity.

Let the guiding question be:

*"What does it mean to care - ethically, relationally, and realistically - for this person, in this moment?"*

**Use this tool alongside:**

- Bias Reflection Tool (page 33)
- Advance Care Planning Workbook (Page 25 Consumer Workbook)
- Capacity & Voice Consideration Prompt Sheet (page 49)

## 1. Clarifying the Context

**What decisions or directions are we being asked to make or revisit?**

**What has brought us to this point (e.g., disengagement, medical risk, refusal of treatment)?**

**What is the individual communicating about their needs, values, or boundaries - explicitly or implicitly?**

## 2. Principles Before Protocols

**Which of our service, team, or organisational values are being tested or upheld?**

**Are we grounding our approach in safety, dignity, autonomy, or protection - and how are we balancing these?**

**Are we prioritising ethical fidelity (doing what's right for the person) over procedural fidelity (doing what's standard)?**

## 3. Voices in the Room - and Those Missing

**Who is included in this discussion - and who isn't, but should be?**

**Has the individual had a genuine, supported opportunity to participate, even if they are distressed, exhausted, or ambivalent?**

**Have carers, peer workers, cultural leaders, or other trusted supports been invited to share perspectives if appropriate?**

## 4. Exploring the Emotional Layer

**What feelings are present in the room? (e.g., fear, grief, moral fatigue, helplessness)**

**Are any of us carrying the emotional or legal burden of risk alone?**

**Are we reacting primarily from fear of failure, scrutiny, or litigation - and how might this be influencing our approach?**

## 5. Exploring Bias and Power

**Are we unconsciously equating a person's refusal or resistance with them giving up?**

**Are different standards being applied because of age, body size, diagnosis, cultural background, or perceived prognosis?**

**Who holds power in this decision - and are we using it to include, or unintentionally to exclude, the person's voice?**

## 6. Exploring Possible Pathways and Trade-Offs

**What are the potential care pathways - including supportive, harm reduction, comfort-focused, or minimally invasive options?**

**For each option, what might be gained - and what might be compromised - ethically or relationally?**

| Option | Likely Outcomes | Ethical Benefit | Ethical Risk |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Is there a pathway that supports continued engagement, trust, or dignity - even without pursuing traditional recovery?**

## 7. Accountability, Adaptability, and Communication

**How will we document this discussion transparently and ethically?**

**How will we communicate the plan clearly - to the individual, family/carers, and other involved teams?**

**How will the plan be reviewed, adapted, and updated over time?**

**Who is responsible for follow-up and relational continuity?**

**Have we offered a summary of this discussion back to the individual (and supporters) in a way that is clear and respectful?**

## 8. Reflective Closing Prompts

**Have we acted in alignment with our values - not just out of fear or protocol?**

**Have we respected this individual as a whole human being, not just a clinical diagnosis?**

**How can we distribute responsibility for ongoing care - so no one is left holding complexity alone?**

**What will help us stay grounded in humility, courage, and connection moving forward?**

# Ethical Decision Reflection Aid

**Purpose**

This tool is designed for use during supervision, team reflection, or case review to help unpack ethical tensions when facing complex, high-stakes, or uncertain scenarios.

It supports inclusive dialogue across disciplines and centres relational, person-led, and values-driven care.

It complements, but does not replace, formal clinical, legal, or organisational decision-making frameworks. This aid can be used proactively (during planning), or reflectively (after a challenging event), to support clarity, courage, and care across teams.

## 1. Clarifying the Context

**What decisions or directions are we currently facing?**

**What has brought us to this point (e.g., deterioration, refusal, risk escalation)?**

**What is the individual asking for - directly, indirectly, or through their actions?**

## 2. Naming the Ethical Tension

**What is the core dilemma or point of uncertainty?**

**Which values or principles are in tension (e.g., autonomy vs. safety, choice vs. duty of care)?**

**Are we privileging policy over person-centred practice - and what is influencing that?**

## 3. Considering Impact and Meaning

**What will this decision mean for the person - emotionally, practically, relationally?**

**What would the person likely say about this decision?**

**Are we considering quality of life, dignity, and trust - or only clinical metrics?**

## 4. Exploring Assumptions and Bias

**What assumptions are being made about motivation, capacity, prognosis, or insight?**

**Are there risks of bias based on identity, history, appearance, communication style, or perceived 'compliance'?**

**Are we allowing space for different forms of hope, engagement, or success?**

## 5. Inclusive and Person-Led Practice

**Has the person had meaningful, supported input into this decision?**

**Are peer workers, carers, cultural liaisons, or other trusted supports being included where appropriate?**

**How have we operationalised shared decision-making - not just conceptually, but practically?**

## 6. Responsibility and Follow-Up

**Who is responsible for documenting, communicating, and holding relational continuity for this plan?**

**What are the agreed next steps - and how will they be reviewed?**

**How will we adapt or revisit the decision if new information, needs, or changes arise?**

## 7. Final Reflection

**Have we acted in alignment with the person's values, rights, and humanity - not only our protocols or fears?**

**Are we holding this decision with shared accountability, humility, and care?**

**What supervision, peer support, or reflection will help us continue this work sustainably and ethically?**

# Capacity & Voice Consideration Prompt Sheet

**Purpose**

This tool supports respectful, nuanced exploration of how decision-making capacity, communication, and voice are understood and upheld.

It does not replace formal legal assessments of capacity - it complements them. It invites care teams to think relationally, ethically, and flexibly about how capacity and insight show up in real-world care.

This tool is designed to support ethical reflection and planning by multidisciplinary teams. It should be completed collaboratively - ideally in supervision, team meetings, or shared care planning sessions where diverse perspectives can be included.

**Use this tool alongside:**

- Bias Reflection Tool (page 33)
- Ethical Decision-Making & Dialogue Prompts (page 39)
- Advance Care Planning Workbook (page 25 Consumer Workbook))

## 1. Clarifying Capacity

**Has a formal capacity assessment been conducted?**

☐ **Yes** ☐ **No** ☐ **Not Sure**

**If yes, who conducted it and under what circumstances?**

**Was the person offered time, support, and safety in the process?**

☐ **Yes** ☐ **No** ☐ **Unsure**

**Does the team understand how capacity may fluctuate with stress, environment, or relational dynamics?**

☐ **Yes** ☐ **No** ☐ **Needs discussion**

**Has the person had opportunities to express their views outside of formal assessment settings?**

☐ **Yes** ☐ **No**

**Have we documented or shared our reflections with the broader care team?**

☐ **Yes** ☐ **No**

## 2. Understanding Communication and Voice

**How does the person typically communicate what they want, need, or fear?**

**Are we attuned to non-verbal or relational expressions of voice?**

☐ **Yes** ☐ **No**

**Are we interpreting overwhelm or withdrawal as incapacity?**

**Have we asked how the person would prefer to communicate difficult decisions?**

## 3. Cultural, Neurodivergent, and Trauma-Informed Considerations

**Are we aware of how trauma history may influence decision-making or engagement?**

☐ **Yes** ☐ **No** ☐ **Needs reflection**

**Are we relying on a Western, clinical model of communication and consent that may not reflect the person's values?**

☐ **Yes** ☐ **No**

**Have we considered cultural or spiritual frameworks that shape the person’s relationship with care?**

☐ Yes ☐ No

**Are communication needs related to neurodivergence (e.g. sensory, executive functioning, processing time) being accommodated?**

☐ Yes ☐ No

**Has the person been offered tools like visual aids, peer support, or written options for care planning?**

☐ Yes ☐ No

## 4. Supporting Voice and Relational Autonomy

**What matters most to this person - regardless of clinical goals?**

**Has the person named others they trust to support them in decision-making?**

☐ Yes ☐ No

**Are lived experience or peer workers involved meaningfully in this planning process?**

☐ Yes ☐ No

**Are refusals or hesitations being interpreted as protective insight, not resistance?**

☐ Yes ☐ No

## 5. Reflective Prompts for Teams

**Are we confusing capacity with compliance?**

**Are we allowing space for autonomy, without con-fusing it with risk or non-compliance?**

**Have we acknowledged how our own fears or biases may be shaping our interpretation of this person's insight?**

**Are we open to insight showing up in non-traditional ways?**

## 6. Final Reflections

**Have we paused long enough to hear the person beyond the pressure of the moment?**

**Are we willing to really hear a person's voice in their resistance – and see their capacity within the complexity?**

**What would shift if we prioritised connection and trust - even in moments of uncertainty?**

# Co-Reflection & Ethical Debriefing Prompts

**Purpose**

This tool supports shared ethical reflection, emotional processing, and relational recalibration following complex or distressing care events. It can be used after crises, critical incidents, difficult transitions, or emotionally heavy decisions. Use it flexibly - moving sequentially or focusing only where it feels most needed - in one-on-one or group settings.

## 1. Naming the Experience

**What happened that felt significant, distressing, or ethically complex?**

**Who was involved, and how did it affect them?**

**What was most difficult or painful about this experience?**

## 2. Emotional Debrief

**What am I feeling right now (e.g., guilt, grief, fear, helplessness, confusion)?**

**What aspects of this experience am I still carrying emotionally?**

**Did I feel supported, isolated, silenced, or overwhelmed?**

## 3. Ethical Reflection

**Were there moments where I felt our care aligned or misaligned with the person's values?**

**Were there risks, harms, or tensions that were left unspoken or unaddressed?**

**Were there any assumptions, biases, or power dynamics that may have influenced what happened - even unintentionally?**

**What might we do differently next time - and what did we do with care and integrity?**

## 4. Team and System Reflection

**Were roles and responsibilities clear, shared, or confused?**

**What systemic barriers made this harder than it needed to be?**

**What support structures (e.g., supervision, peer support, cultural input) would have made this experience more manageable or supported better outcomes?**

## 5. Integration and Intention

**What are we still holding - and what needs to be processed further?**

**What do we want to carry forward into future care or collaboration?**

**What support, supervision, or collective care might help us stay grounded?**

**Final Reflection**
This tool is not about blame or perfection.
It offers space for shared meaning, emotional truth, and ethical care.
Use it to hold complexity with compassion - and to remain in respectful, ongoing conversation with each other.

# Team Reflection & System Learning Prompts

**Purpose**

This tool is designed to support structured team reflection following challenging cases, ethical dilemmas, or service disruptions. It promotes shared insight, reduces blame, and fosters transparent system learning. Use it in multidisciplinary team meetings, reflective practice sessions, or supervision settings - particularly when care has felt fragmented, high-stakes, or emotionally complex.

Ethical care is a team responsibility. Reflection makes learning visible - and makes care safer.

**Use this tool alongside:**

- Ethical Decision-Making & Dialogue Prompts (page 39)
- Co-Reflection & Ethical Debriefing Tool (page 53)
- Care Coordination Toolkit (page 63)
- Values-in-Practice Check-In Sheet (page 8)

## 1. Looking Back: What Happened?

**What was the situation or turning point that challenged our team?**

**What actions were taken - and how were those decisions made?**

**What emotions were present within the team, and how were they acknowledged or managed?**

## 2. Voices and Values

**Whose voices were centred in the decision-making process?**

**Were the person's values, context, or stated goals clearly heard and honoured?**

**Did any values (e.g. safety, autonomy, dignity) come into tension - and how were they navigated?**

**Were any voices missing from the conversation that should be included in future planning?**

**(especially where cultural liaison, peer input, or family voice might have been overlooked)**

## 3. What Worked and What Didn't?

**What aspects of our response aligned well with our ethical and clinical goals?**

**Where did we see gaps - in communication, planning, trust, or follow-through?**

**Were there points of friction or confusion about team roles or responsibilities?**

**What do we wish we'd done differently - and what stopped us at the time?**

## 5. Learning and Accountability

**What are we taking forward from this experience - personally and as a team?**

**What actions (e.g. policy changes, training, process improvements) could strengthen our practice?**

**How can we ensure this reflection feeds into service development - not just individual learning?**

**Who is responsible for taking any recommended next steps or sharing learnings beyond this team?**

## 6. Staying Connected

**How do we support one another after ethically or emotionally heavy cases?**

**Are there team members who need follow-up, debriefing, or supervision?**

**What would help us stay grounded, clear, and aligned when we meet complexity again?**

**What would help us stay grounded, clear, and aligned as a team?**

This tool is best used alongside the Reflective Practice Framework, Co-Reflection Prompts, and Values-in-Practice Check-In. It is designed to strengthen team accountability, reduce moral distress, and support service learning in ethically complex care.

# Care Collaboration Summary Sheet

**Purpose**

This summary sheet helps document:

- Who is currently involved in the person's care
- What agreements have been made
- What the next steps are
- It supports clarity, transparency, and continuity - especially during transitions, care planning reviews, or shared decision-making processes.

This sheet is a working document. It can (and should) be updated as care evolves.

## 1. Who Is Involved?

**Name of person receiving care:**

**Carer or family member(s) (if involved):**

**GP or primary medical contact:**

**Psychiatrist:**

**Dietitian:**

**OT, or allied health professional:**

**Peer Worker or other community support**

**Other key supports or services (e.g., housing, community, NDIS, advocacy):**

## 2. What Has Been Agreed?

**Current goals or focus of care (in the person’s own words where possible):**

**Key harm reduction, Advance Care Plans, or comfort-focused decisions made:**

**Priorities for what the person - and the team - want to avoid
(e.g., coercion, re-traumatisation, loss of trust):**

**Shared language or relational approaches agreed to
(e.g., “supporting safety” instead of “enforcing compliance”):**

## 3. What Happens Next?

**Date of next check-in, care review, or team meeting:**

**Person(s) responsible for checking in and following up:**

**Any outstanding referrals, documents, or coordination actions (e.g., ACP updates, medical reviews, peer support connection):**

**Plan if care becomes uncertain or distress increases:**

## Final Reflection

This summary can be shared - with the person's consent - across their care team, supporters, and relevant services.

It is not a contract. It is a living tool designed to support shared understanding and accountability.

Revisit and update regularly to ensure it remains aligned with the person's evolving needs, preferences, and circumstances.

## Using This Summary Sheet Well

| | |
|---|---|
| **Lead With Relationships** | This summary is a guide for conversation, not a checklist. Begin with genuine connection and shared purpose. |
| **Centre the Person's Voice** | Use their own words wherever possible. If quoting a care goal or value, honour its meaning - even if it doesn't match clinical language. |
| **Review Together, Not in Isolation** | Whenever possible, review the completed summary with the person (and their chosen supporters), ensuring they feel ownership and understanding. |
| **Update Transparently** | Care goals, team roles, and agreements can and will shift. Invite updates openly rather than treating the document as final or fixed. |
| **Use for Connection, Not Compliance** | This tool is about keeping care aligned and person-led - not about rigidly enforcing expectations. |
| **Reflect on Gaps** | If coordination breaks down, name it. Use those moments to guide improvement and collaboration, not just individual response. |

# Care Coordination Toolkit & Planning Checklist

**Purpose**

This toolkit supports ethical, person-led care coordination - especially during transitions, changes in care goals, or multidisciplinary planning. It can be used by a care coordinator, clinician, peer worker, or service lead, ideally in collaboration with the individual and their chosen supports.

Use it to clarify roles, identify care gaps, and ensure shared understanding across the team. It is most helpful when used proactively, and revisited regularly to support continuity, connection, and responsiveness in care.

## 1. Care Team Mapping

**Who is currently involved in this person's care?**

☐ **GP / Primary care:**

☐ **Peer worker / Lived experience support:**

☐ **Psychiatrist:**

☐ **Psychologist:**

☐ **Dietitian:**

☐ **OT / Allied health professional:**

☐ **NDIS or Support Coordinator (if relevant):**

☐ **Carers / Family / Chosen supports (if involved):**

☐ **Other key services (e.g. housing, palliative care):**

☐ **Any roles the person would like involved but currently aren't?**

## 2. Transition Planning

**Is the person currently transitioning into, within, or out of a service?**

**This transition involves:**

☐ **Discharge or exit from service**

☐ **New service engagement**

☐ **Change in primary contact**

☐ **Shift in care goals (e.g. palliative focus)**

**Have we agreed what needs to be in place before, during, and after transition?**

**Lead contact responsible for coordinating the transition:**

**Name:**

**Role:**

**What does the person want or need to remain stable or consistent?**

**What risks (physical, emotional, relational) are we monitoring or preparing for?**

**Have cultural, spiritual, or neurodivergent preferences been considered?**

## 3. Shared Care Plan Essentials

**Has a clear, shared care plan been developed and circulated?**

☐ **Yes** ☐ **No**

**Has the person reviewed and contributed to this plan?**

☐ **Yes** ☐ **No**

**Does the care plan include:**

- ☐ **Key contacts and team roles**
- ☐ **Support goals and preferences**
- ☐ **Stated non-negotiables and boundaries**
- ☐ **Crisis response and safety plans**
- ☐ **Review timelines**

**Does the plan include any notes from the individual in their own words?**

☐ **Yes** ☐ **No**

**Where is the care plan stored/shared?**

## 4. Responsibility and Follow-Up

**Who is maintaining regular contact with the person (how often, and by what method)?**

**Who is responsible for updating care documentation and informing the team?**

**Who is responsible for relational continuity and emotional check-ins (not just clinical updates)?**

**Is a follow-up check-in date already scheduled?**

**Are all team members aware of their current responsibilities and boundaries?**

☐ **Yes** ☐ **No**

**Are escalation pathways clearly defined and understood if issues arise?**

☐ **Yes** ☐ **No**

## Final Reflection

Effective care coordination isn't just about logistics - it's about relationships, trust, and shared clarity. Return to this plan regularly, especially when care feels unclear, fragmented, or at risk of disconnection.

# Care Coordination Service Self-Assessment

**Purpose**

This tool helps assess an organisation's readiness and capacity to deliver coordinated, person-centred care for individuals with longstanding eating disorders. It highlights areas of strength, identifies implementation gaps, and supports sustainable improvements across roles, services, and systems.

## 1. Foundations and Commitment

- ☐ **Our service has a clear definition of care coordination.**
- ☐ **We understand how coordination supports individuals with complex or longstanding needs.**
- ☐ **Person-centred, trauma-informed, and culturally safe care are embedded in coordination policies.**
- ☐ **Peer or lived experience voices are included in service design, training, or planning.**

## 2. Team Structure and Roles

- ☐ **There is a designated care coordinator (or role with similar responsibilities) for each client.**
- ☐ **Role boundaries are clearly defined and communicated across the team.**
- ☐ **Staff know who is responsible for key follow-up and care planning tasks.**
- ☐ **Diverse disciplinary roles (peer workers, social workers, GPs, dietitians) are acknowledged and integrated.**

## 3. Communication and Documentation

- ☐ **Teams have shared access to up-to-date care plans, goals, and contact details.**
- ☐ **There is a process for ensuring documentation is collaborative and accessible.**
- ☐ **Transition plans and crisis protocols are written down/documented, not just verbal.**
- ☐ **Families, peer workers, and community partners are engaged in communication (with consent).**

## 4. Transitions and Continuity

- ☐ Our service actively plans for transitions between settings (e.g. inpatient to community).
- ☐ We coordinate handovers with clarity - including roles, preferences, and review points.
- ☐ We consider the emotional and relational impacts of care transitions.
- ☐ People are not discharged into gaps - supports are mapped before services step back.

## 5. Review and Accountability

- ☐ Coordination roles and plans are reviewed regularly.
- ☐ Feedback from service users and carers informs how coordination is working.
- ☐ There are processes to notice and record care breakdowns, missed follow-ups, or disengagement and to guide timely improvements in response
- ☐ We invest in staff training and supervision related to care coordination.

Use this checklist in service audits, implementation planning, or team reflection.

Scoring high on paper is not the goal - building meaningful, sustainable systems of care is.

# Glossary

These definitions reflect the context of eating disorder care and advance care planning, including person-led, trauma-informed, and dignity-based approaches. Some terms have been drawn from the National Eating Disorder Strategy 2023 - 2033 and the National Palliative Care Strategy 2018 with adaptation to support practical, values-led use.

| Term | Description |
|---|---|
| **Advance care planning** | Advance care planning is care planning that prepares for future healthcare needs by identifying and articulating the person's personal values, beliefs, and healthcare preferences. It enables individuals to make decisions about the health care they would or would not like to receive in the future if they became seriously ill and were unable to communicate preferences or make treatment decisions (Advance Care Planning Australia, 2024). |
| **Advance care directive** | An advance care directive documents a person's preferences for future healthcare and may include a record of their values, life goals, preferred outcomes and directions for future care and treatments. |
| **Autonomy** | Autonomy refers to a person's right and capacity to make informed, uncoerced decisions about their own life and care. In healthcare, respecting autonomy means acknowledging the individual's values, preferences, and choices - even when these differ from clinical recommendations - provided they have the capacity to decide (Beauchamp & Childress, 2019). |
| **Capacity** | Capacity refers to a person's ability to make informed decisions about their own care. While legal definitions vary across Australian states and territories, capacity is generally understood as the ability to understand relevant information, appreciate the consequences of a decision, and communicate a choice. In the context of mental health and eating disorders, assessing capacity should include consideration of trauma, relational context, and fluctuating cognitive or emotional states - and must not be conflated with agreement to treatment.<br>*Note: For jurisdiction-specific details, refer to local mental health laws. This Guide includes Victorian principles as one case study* |
| **Compassionate Communities Frameworks** | A framework which extends care beyond clinical settings and promotes shared responsibility, relational support, and community connection, especially in contexts of complexity, loss, or life-limiting illness (Dumont et al., 2022; Bakelants et al., 2023). |

|  |  |
|---|---|
| **Complex** | In a trauma-informed context, “complex” refers to circumstances, needs, or presentations that involve multiple, intersecting factors - such as trauma history, co-occurring conditions, systemic disadvantage, and relational or psychosocial distress. Complexity is not simply about diagnostic difficulty or service fragmentation; it recognises the impact of structural and relational adversity, and the need for care that is flexible, nuanced, and person-led (Sweeney et al., 2016). |
| **Co-occurring/ Co-existing conditions** | Refers to the presence of two or more conditions or experiences at the same time. In the context of eating disorders, this often includes co-occurring or co-existing mental health challenges such as anxiety, depression, trauma-related disorders, or substance use. These conditions may interact in complex and compounding ways, affecting care needs and recovery pathways (SAMHSA, 2016). |
| **Dignity of Risk** | People have the right to make informed choices, even when those choices involve uncertainty or perceived risk *(Mental Health and Wellbeing Act, 2022)*. An understanding that autonomy, growth and development often require an element of risk, and that allowing some level of risk shifts the focus to collaborative support, rather than coercive (Marsh & Kelly, 2018). |
| **Disordered Eating** | Disordered eating encompasses eating behaviours and patterns that fall between ‘normal’ eating and an eating disorder, generally including symptoms and behaviours of eating disorders at a lower frequency or level of severity. Restrictive, compulsive, irregular and/or inflexible eating behaviours and patterns may be considered disordered eating and are a risk factor for the development of an eating disorder. |
| **End of Life** | End of life refers to the stage in a person’s life when they are living with an advanced, progressive, and life-limiting condition, and where death is likely within a period of months, weeks, or days. It may be brief or prolonged and includes the physical, emotional, social, and spiritual support needed during this time. |
| **Enduring Power of Guardianship** | An Enduring Power of Guardianship is a legal document that allows a person to appoint someone they trust to make personal, lifestyle, and health-related decisions on their behalf, if they lose decision-making capacity in the future. The appointed guardian may be authorised to make decisions about medical care, living arrangements, and other non-financial matters, depending on the powers granted (ALRC, 2014).<br>In Australia, the scope and legal process for EPGs vary by state and territory. In Western Australia, for example, EPGs are governed by the *Guardianship and Administration Act 1990 (Wa)* and must be made while the person has full capacity. |
| **Evidence-based practice** | An approach to practice and decision-making that relies on the best available evidence. Evidence-based practice involves the integration of research evidence, clinical expertise, and person values and perspectives, to inform care. |

| | |
|---|---|
| **Family/supports and community** | An individual who provides care, support, or advocacy for someone experiencing an eating disorder. This may include family members (e.g., parent, child, partner, grandparent), friends, or members of the broader community. It is important to recognise that cultural and relational contexts vary and that extended family, chosen family, and community networks often play vital roles, particularly within Aboriginal and Torres Strait Islander communities and other cultures. |
| **Grief** | Grief is a natural response to loss, encompassing emotional, cognitive, social, and physical reactions. While traditional models - such as the five stages of grief - may describe common themes (e.g., denial, anger, bargaining, depression, acceptance), grief does not follow a fixed path or timeline. Each person's experience is unique, shaped by their relationship to the loss, cultural context, personality, and available support. |
| **Harm Reduction** | Harm reduction is a pragmatic, person-centred approach that seeks to minimise risk and support safety, dignity, and engagement - especially when treatment is declined, not accessible, or no longer effective. In the context of longstanding eating disorders, harm reduction can include medical monitoring, flexible therapeutic goals, and relational support, without requiring recovery as a precondition for care.<br>(Birch, Downs & Ayton, 2024). |
| **Life-limiting Illness** | A life-limiting illness, also known as a terminal illness, is a condition or disease that has little or no prospect of cure and is likely to cause death at some point in the future. |
| **Lived Experience of an Eating Disorder or Disordered Eating or Body Image Concerns** | An individual who has previously or is presently experiencing an eating disorder (whether diagnosed or undiagnosed), disordered eating or body image concerns. |
| **Longstanding Eating Disorder** | A descriptive term used to refer to individuals who have been living with an eating disorder for a prolonged period - often alongside significant health, social, or treatment-related challenges. This term acknowledges the ongoing nature of the experience without implying hopelessness or permanence. |
| **Mental Health Law** | A framework of legislation that governs the assessment, treatment, and rights of individuals experiencing mental illness. These laws differ across Australian states and territories, with each jurisdiction having its own Mental Health Laws outlining legal criteria for involuntary treatment, decision-making capacity, and safeguards. In this Guide, mental health law is referenced in the context of ethical care, capacity, and systemic obligations. |
| **National Safety and Quality Health Service Standards (2021)** | The National Safety and Quality Health Service Standards aim to protect the public from harm and to improve the quality of health service provision. The Standards provide guidance as to the level of care consumers can expect from health services (Australian Commission on Safety and Quality in Health Care, 2021). |

| | |
|---|---|
| **Palliative Care Principles** | Palliative care principles refer to a holistic approach to care that prioritises quality of life, dignity, and relief of suffering for individuals living with serious or life-limiting conditions. These principles include person-centred care, respect for autonomy, comfort, open communication, and support for emotional, spiritual, and psychosocial needs. They are relevant across the care continuum - not only at end of life - and can be applied alongside therapeutic, harm reduction, or community-based approaches (Palliative Care Australia, 2018; World Health Organization, 2020) |
| **Person-centred Care** | Person-centred care is an approach that respects, acknowledges and responds to a person's preferences, needs, and values. It treats individuals as human beings rather than conditions to be treated or cured, and it includes the person - along with their families, carers, and supports - in all care and decision-making processes (Australian Commission on Safety and Quality in Health Care, 2021). |
| **Person-led Care** | Person-led care builds on person-centred principles by placing the individual in a leading role - actively guiding the direction, pace, and priorities of their care journey. This approach is especially important when navigating trauma, complexity, or longstanding health conditions. Person-led care honours autonomy and seeks to rebalance traditional power dynamics in healthcare and support systems (Sweeney et al., 2016). |
| **Recovery** | A subjective state defined by an individual that reflects personal goals and perspectives. For some people experiencing eating disorders, recovery may signify overcoming the thoughts, feelings, beliefs and behaviours associated with the eating disorder, resulting in improved physical and psychological wellbeing. For others, recovery may reflect a dynamic process of moving towards or maintaining a subjective state of wellbeing or quality of life. |
| **Relational Authority** | Relational authority refers to the influence, insight, and trust that emerge through sustained, authentic relationships - particularly when legal documents (such as an Advance Health Directive or Enduring Power of Guardianship) are absent or limited. In the context of care, it recognises the knowledge held by those who have walked closely alongside a person - such as family, peer workers, or long-term supporters - whose relational understanding can guide values-aligned decisions.<br>This concept is grounded in relational ethics, which values interdependence, trust, and the situated knowledge that emerges through meaningful human connection (Hirsch, 2023). |
| **Relational Ethics** | Ethical decisions are grounded in the quality of the relationships involved. It involves deep listening, being present and responsive, collaborative decision making and building authentic connections (Pollard, 2015). |
| **Severe and enduring eating disorder** | A 'severe and enduring eating disorder' may refer to an eating disorder that exhibits prolonged duration, however this is not a diagnostic term and there is currently no consensus definition. Further research into criteria and preferred terminology is needed. |

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| **Shared Decision-Making** | Shared decision-making is a transparent, collaborative process that includes the person receiving care, their family or carers (if appropriate), and health professionals. It respects the individual's values and preferences while integrating clinical knowledge and cultural or lived experience expertise (Advance Care Planning Australia, 2022). |
| **Specialist Palliative Care Services** | Services provided by a multidisciplinary team of clinicians who have specialist skills, competencies, experience and training in palliative care. These services may provide direct care to patients with complex palliative care needs, and/or provide consultation services to support non-specialist clinicians to provide palliative care. |
| **Spiritual Care** | Spiritual care involves recognising and responding to the needs of the human spirit when people are facing trauma, illness, or grief. This may include the need for meaning, connection, faith, hope, or a sense of peace. Spiritual care can be religious or non-religious and is shaped by the person's own beliefs, values, and culture. It may be provided by a chaplain, spiritual adviser, cultural healer, or by trusted people within the person's community or care team (Royal College of Psychiatrists, 2020). |
| **Stepped System of Care for Eating Disorders** | The stepped system of care for eating disorders depicts the full continuum of coordinated, evidence-based services that should be available and increase or decrease in intensity according to a person's changing needs (NEDC, 2023). |
| **Substitute Decision-maker** | Someone that an individual trusts to make healthcare decisions on their behalf if they become unable to do so. They may be appointed as part of an advance care planning directive. |
| **Terminal Illness** | A condition that is expected to lead to death, typically within a relatively short time frame. In palliative care, "terminal" often refers to the final stage of a life-limiting illness, where curative treatment is no longer effective or appropriate, and the focus shifts to comfort and quality of life (Australian Commission on Safety and Quality in Health Care, 2021). |
| **Trauma-Informed Practice** | An approach to care that recognises the widespread impact of trauma, prioritises emotional and psychological safety, and avoids re-traumatisation. It emphasises choice, trust, collaboration, and cultural humility in every aspect of support (Blue Knot Foundation, n.d.). |

Note: References for tools and frameworks are included in The Holding Hope Guide.