This paper outlines clinical practice and training standards for mental health clinicians and dietitians in the field of eating disorders in Australia and New Zealand. It details the knowledge, skills and experience that mental health clinicians and dietitians require to competently manage and treat patients with an eating disorder. It also describes the criteria for assessing relevant training programs that provide education on the therapeutic knowledge and skills outlined in the practice standards.

ANZAED Mental Health and Dietetic Clinical Practice and Training Standards for the Treatment of Eating Disorders
Acknowledgements

Development of this paper has been based on evidence, national and international standards of practice, and the National Eating Disorder Collaboration (NEDC) eating disorder core competencies document. It has also been informed by expert clinical opinion.

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1. Executive summary

The Australia & New Zealand Academy for Eating Disorders (ANZAED) is the peak body for eating disorder (ED) professionals involved in research, prevention, treatment and advocacy in Australia and New Zealand. ANZAED fosters professional development and networking in the ED field and provides leadership and advocacy aimed at improving understanding, prevention and treatment of EDs.

EDs are expensive to manage and treat due to their psychiatric and medical complexity, with significant implications for policies, funding, management protocols, service planning and delivery. Effective treatment requires well-coordinated and skilled treatment teams involving mental health, dietetic and medical professionals.

Currently, there is no system in place to ensure that professionals providing treatment services to ED patients have adequate training and experience. To date, tertiary health education programs have provided limited training in EDs, and graduates do not enter the workforce with the skills needed to work in this field.

The National Eating Disorder Collaboration (NEDC) in Australia has developed a set of ED core competencies – https://www.nedc.com.au/assets/NEDC-Resources/national-practice-standards-for-eating-disorders.pdf – as a foundation for strengthening the workforce. They outline the values, attitudes, knowledge and skills required of individuals, services and systems to successfully respond to EDs and promote a coordinated and consistent approach to professional development and service improvement.

This paper builds on the NEDC competencies by outlining the clinical practice and training standards recommended for mental health clinicians and dietitians providing treatment in the field of EDs. It details the knowledge, skills and experience that mental health clinicians and dietitians require to competently manage and treat patients with an ED. It also describes the expectations and content required to be addressed in training programs that provide education on the therapeutic knowledge and skills outlined in these practice standards.
2. Principles

The patient journey across the developmental spectrum of EDs is complex, involving many different trajectories, from brief illnesses to recurring but different EDs with various comorbidities. No one service model can be specified, but there are general principles that should guide the development of any service provision.

1. Early intervention increases the likelihood of recovery. Shorter duration of illness at detection in primary care predicts recovery in both anorexia nervosa (AN) and bulimia nervosa (BN). Eligibility for services and treatments is not to be determined by the presence of an ED that meets strict diagnostic criteria.

2. Co-ordination of services is fundamental to all service models. Disruption to care, and subsequent deterioration, may occur when individuals transition between treatment settings, e.g. inpatient to outpatient-based treatment, between public and private settings, or between child and adolescent services to adult services. The co-ordination of ED services is key to effective service provision.

3. Provide evidence-based services (Appendix A). Where deviations are considered necessary, options should be evaluated, and expert supervision sought. Clinician anxiety can be high when treating EDs, resulting in deviations from evidence-based protocols. This typically results in avoidance of effective elements of therapy that are perceived by clinicians and dietitians as producing short-term distress for the patient. Inadequate treatment response to evidence-based ED treatment may indicate a need for more intense treatment options, e.g. more frequent sessions at an earlier stage, use of adjunct therapies, the inclusion of family as part of the treatment team, day- or inpatient treatment, or multi-family therapy.

4. Involvement of significant others in service provision is highly desirable. Utilising the resources of the family and significant others, with consent, is a key pillar in many ED treatments regardless of the age of the person and the type of ED. In addition, upskilling of significant others so they feel more confident and equipped to deal with an ED while attending to their own needs is important.

5. Personalised treatment approach, including cultural diversity. The treatment should be matched to the clinical presentation of the patient allowing for stepping up and down in intensity of care as needed, rather than automatically starting patients at the lowest intensity option. Firm empathy for the need for early change linked with a session by session evaluation collaboratively shared with the patient (and family as appropriate) is essential, not only for improving outcomes but also for detecting lack of early change as this predicts poorer outcome across EDs and modalities of treatment. Services are delivered in a culturally responsive manner, considering body size, age, sexuality and gender, with an awareness of working with First Nation people (Aboriginal Australians, Maori [tangata whenua] and Pacific peoples) and immigrant populations. It is important that clinicians adopt a strengths-focused approach, supporting recovery and/or quality of life, tailored to meet individual decision-making capacity and needs as they develop over the course of the illness.

6. Psychoeducation is included in all interventions. Communication and information for those with an ED, as well as families and significant others involved in supporting the person, is important, given the degree of misinformation widely available about ‘healthy’ eating, weight and the medical impact of disordered eating. Psychoeducation should also include the rationale for evidence-based treatment strategies, including an initial focus on restoring nutritional health.
7. **Multidisciplinary care is required.** EDs co-occur with a range of serious physical and psychological issues. Clinicians need to understand that a general practitioner/physician (adult or child) should be actively involved in patient care. Regular medical monitoring needs to be provided by the general practitioner/physician (adult or child) and linked with dietetic and psychological interventions. There must be access to tertiary-level expertise for consultation, supervision, guidance and referral, if required.

8. **A skilled workforce is necessary.** Evidence suggests that clinician expertise in EDs produces better outcomes. For example, in child and adolescent anorexia nervosa, specialist outpatient ED teams have been associated with faster recovery, higher patient satisfaction, lower costs, lower rates of inpatient admission and better case identification and access compared to care by generalist services.\(^9,10\) It is important to note that specialist supervision of novice therapists can produce similar outcomes to those of experienced therapists, so where clinician expertise does not exist, expert supervision is required.\(^11\)
3. General clinical practice standards

1. **Diagnosis and assessment.** Clinicians should be aware of and have a working knowledge of the diagnostic criteria for EDs (Appendix B), and clinical features of related appearance and eating conditions. They should conduct an assessment consistent with their understanding and scope of practice and arrive at a shared understanding of the illness with their patient and treatment team.

2. **Multidisciplinary care team (MDT).** Treatment of EDs should be multidisciplinary, including a medical practitioner, mental health clinician and a dietitian if accessible. Respective roles across the MDT should be clearly documented and understood. Processes of communication within the MDT need to be clearly outlined. All clinicians must practice within the scope of their profession and know when to refer to another clinician with focused ED skills. However, all clinicians will need to have an interdisciplinary working knowledge of medical, mental health, nutritional and psychiatric aspects of EDs, as indicated below:
   - **Medical:** All clinicians should understand the significant physical risks associated with ED behaviour, including the risk of death, and be aware of the parameters of physical stability, as outlined in the Royal Australian and New Zealand College of Psychiatry clinical practice guidelines for the treatment of eating disorders. There is a need for all patients to have a medical assessment, preferably by a medical practitioner who understands the risks associated with EDs. Ongoing medical review should be a non-negotiable element of treatment as required.
   - **Mental Health:** All clinicians should have an understanding of core psychological principles including behaviour change, behavioural experiments, core counselling micro-skills, modifying cognitions, managing affect and addressing underlying issues that may maintain the behavioural aspects of the ED. Referral to a mental health clinician is recommended for most patients to provide psychological support and evidence-based psychological interventions.
   - **Nutritional:** All clinicians should have a comprehensive knowledge of nutritional issues relevant to EDs (e.g. regular eating, the consequences of starvation or low energy availability, effects of binge eating and compensatory behaviours, body weight, paediatric growth charts, the importance of nutritional rehabilitation, the risk of refeeding syndrome, and an understanding of the importance of weight recovery). Referral to a dietitian experienced in ED management is recommended for patients finding it difficult to achieve nutritional, behavioural or physical goals, or with co-occurring medical conditions that may affect nutritional management (e.g. pregnancy, diabetes, polycystic ovarian syndrome, food allergy/intolerance, bowel disease)
   - **Psychiatric:** All clinicians should have an awareness of common co-occurring psychiatric presentations, and the ability to assess and respond to a risk of harm to self, and suicidal ideation. An assessment by a psychiatrist, preferably one experienced in EDs, is recommended where risk is identified, and/or when medication is required to support complexity and comorbidity.

3. **Establish a positive therapeutic alliance.** Many people with EDs find the process of change difficult. Clinicians should possess skills to develop a solid therapeutic alliance, address ambivalence about change and build up self-efficacy. They should also reach a collaborative agreement on the approach to, and goals and topics of therapy, while understanding the need for non-negotiables and assisting patients to achieve early symptom improvement, which enhances therapeutic alliance and treatment outcomes in EDs. The clinician should be competent in managing the challenges that arise within the therapist-patient relationship.

4. **Knowledge of evidence-based treatment.** Clinicians should be aware of clinical practice guidelines that summarise evidence-based approaches for the treatment of EDs (Appendix A). At a minimum, treatment should be specific to the patient’s age, diagnosis and stage of illness. All clinicians should understand the roles and importance of general psychoeducation for EDs, regular in-session weighing, and the establishment of regular eating; weight restoration and/or stability; self-
monitoring and behavioural strategies directed at addressing behaviours such as restriction, binge eating, and compensatory behaviours. Patients who are children or adolescents should be seen in the context of family therapy, and adult patients’ families and partners included in treatment whenever possible.

5. **Knowledge of levels of care.** Clinicians should be aware of the local treatment options that may be available to their patient (e.g., acute medical hospitalisation, admission to a specialist ED inpatient unit, a partial hospitalisation program or day program or intensive outpatient therapy). It may also include involuntary treatment and the use of a community treatment order. Clinicians should be aware of the guidelines for moving between levels of care. Constant assessment of patient status and progress is needed to inform changes in the level of care. Wherever possible these changes should be made collaboratively with the patient. It should be recognised that psychotherapy with a severely malnourished patient (noting this can present across the weight spectrum) is unlikely to be effective in obtaining behavioural change.\(^{12}\)

6. **Relapse prevention.** Every person treated for an ED requires a relapse management plan with monitoring for at least 12–18 months post-treatment.

7. **Professional responsibility.** Clinicians should be aware of and maintain important professional practices such as clinical supervision, professional development and their own wellbeing. Clinical supervision and ongoing professional development aim to upskill clinicians, support reflective practice, aid the provision of high-quality treatment and recognise the intensity and personal impact of treating complex mental health issues. For clinicians and dietitians treating patients with an ED, a significant component of these professional practices should be ED-specific, incorporating the implementation of non-negotiables to establish boundaries around treatment. Clinicians should also be aware of their own attitudes toward body shape and weight to avoid transmission of unhelpful messages or practices during therapy. It is expected that a clinician experiencing their own mental health difficulties while providing ED treatment would seek appropriate support and modify their work as needed to maintain their own and their patient’s wellbeing.
4. Mental health-specific clinical practice standards

4.1 Assessment
A thorough assessment should confirm or refute a diagnosis or diagnoses, explore elements of risk and develop a case formulation, which informs the treatment plan and priorities. As well as information from a general assessment, such as demographics, an ED Assessment\(^{16}\) should include (at a minimum):

- Bingeing, purging and compensatory behaviour
  - Type of compensatory behaviour (e.g. laxative use, excessive exercise, diet pills, steroid use)
  - Frequency
  - Amount
  - Types of food
  - Triggers to binge
- Height, weight and rate of any weight changes
- Core cognitive features
  - Over evaluation of weight and shape
  - Eating-related cognitions (e.g. guilt, control)
  - Body dissatisfaction
  - Body checking
  - Fear of fatness and weight gain
  - Perfectionism
- Eating behaviours (past and current; motivation to change each behaviour)
- Food rituals
- Avoided foods and food sensitivities
- Fluid intake
- Medical consequences of disordered eating behaviours\(^{12}\)
- Psychosexual and interpersonal functioning
- Treatment history
- Comorbidity (medical and psychological)
- Mental state assessment
- Mental health risk factors (e.g. suicidality)
- Family of origin and support system
- Trauma history
- Psychometric assessment – such as the Eating Disorder Examination-Questionnaire (EDE-Q)\(^{17}\) or the ED-15\(^{18}\) (Appendix C). The ED-15 and the 12-item EDE-Q\(^{19}\) (Appendix D) are suitable for a session by session assessment of progress, which is also shown to enhance the effectiveness of treatment\(^{18}\)

The case formulation should be based on the evidence-based treatment model being used by the clinician and include preliminary hypotheses about predisposing, precipitating and maintaining factors, as well as noting the individual’s strengths and protective factors. The formulation should be collaboratively co-authored with the patient and form the foundation of treatment.

A physical assessment (e.g. following RANZCP guidelines\(^{13}\)) is different from a mental health assessment, and while identifying ED signs and symptoms is expected, providing a medical assessment and diagnoses is not within the mental health clinician’s scope of practice.

4.2 Evidence-based intervention
Mental health clinicians should maintain an understanding of the current evidence-based treatments for EDs (Appendix A) and have appropriate training, as well as ongoing professional
development and supervision in the implementation of these treatments. Components of treatment may include:

- Collaboratively weighing the patient
- Reviewing eating and disordered behaviours
- Establishing regular eating
- Identifying antecedent variables (triggers) to ED behaviour
- Provision of alternative coping strategies to replace the ED. This is likely to involve seeking support and strategies to manage affect and relational triggers
- On an ongoing basis, addressing issues of motivation, body image and quality of life

4.3 Managing risk

Individuals with an ED present with elevated rates of death by suicide compared to other mental health disorders (e.g. depression and schizophrenia). Therefore, identifying and managing suicidality is imperative at all levels of care. Risk factors for suicide can include:

- Previous suicide attempts
- Substance abuse
- Comorbid depression
- Additional mental illness
- Social isolation
- Lack of fear of death
- Medication
- Increased family conflict
- Thinking that they are a burden
- Impulsive traits
- Experiences of trauma (including but not limited to post-traumatic stress disorder)
- Severity of ED
- Recent rapid weight loss

4.4 Managing comorbid mental health problems

Mental health clinicians treating patients with EDs need to also manage comorbid mental health diagnoses across the course of treatment.
5. Dietetic-specific clinical practice standards

5.1 Screening
Dietitians have an important role in early identification and screening of high-risk patients and should have the skills to implement screening and assessment consistent with evidence-based guidelines. This includes familiarity with screening tools (e.g. SCOFF\(^2\), BEDS-7\(^22\)) as well as knowing how and when to use each tool. For many individuals with an ED there are no, or few visible or obvious signs of ill-health. Without timely and appropriate screening and assessment, an opportunity for detection of symptoms may be missed.

Individuals who should be screened for an ED may present to a dietitian to discuss their dietary concerns without specifically seeking treatment or support for an ED.

Higher-risk individuals might be:
- Unusually thin, or have unexplained weight loss (across the weight spectrum)
- Following a self-imposed (e.g. gluten-free, food allergy-/intolerance-related, vegan) or medically prescribed restrictive diet (e.g. due to type 1 diabetes, coeliac disease)
- Presenting for weight management with concomitant significant concerns about appearance and/or repeated efforts to change body shape (pursuing weight loss, or gain)
- At a higher body weight
- Seeking bariatric surgery, and post-bariatric surgery
- Post-surgery or procedure which restricts eating adequately for a time e.g. removal of wisdom teeth
- Complaining of unspecified gastrointestinal symptoms such as constipation or abdominal pain, or have a diagnosis of IBS
- Presenting with unexplained symptoms that could be attributed to starvation/malnutrition
- Experiencing a concurrent mental or physical health concern
- Elite athletes or active people of all ages and body sizes. Those at highest risk may be those who participate in individual sports or that require meeting a weight criterion (e.g. lightweight rowers, jockeys, martial arts practitioners, boxers, dancers, gymnasts)
- Presenting with very selective eating habits (e.g. significant restriction in food variety and/or quantity) where there is nutritional deficiency/malnutrition or associated significant impairment of life functioning

5.2 Nutrition assessment and reassessment
When undertaking an assessment of an individual with an ED, dietitians need to consider factors across the assessment domains relevant to both physical and mental health. Particular attention should be given to the patient’s beliefs about food, dieting and weight, as well as the physical and psychological consequences of starvation, binge eating, compensatory behaviours and food avoidance. It is important that the person’s age, gender or body size does not distract from the assessment of the ED, and attention is given to the possible significance of all symptoms and presentations.

5.3 Nutrition diagnoses
Dietitians identify and manage specific nutrition problem(s) resulting from the psychological and physical complications associated with an ED. A nutrition diagnosis is different from a medical/psychiatric diagnosis, and while identifying ED signs and symptoms is expected, providing a medical or psychiatric diagnosis is not within the dietitian’s scope of practice.

5.4 Nutrition intervention
The role of the dietitian is to identify, plan and implement appropriate nutrition interventions with the purpose of modifying nutrition-related health status, behaviours, knowledge and attitudes with the goal
of physical, psychological and nutritional recovery, as well as supporting behaviours and attitudes which may best sustain wellbeing for each person.

**Food and Nutrient Delivery**
Food and nutrient delivery are tailored to the individual’s nutrition needs, but the individual’s stage of recovery will help to inform the treatment plan. The treatment plan considers evidence about specific foods and nutrients for weight restoration, appetite regulation, lifecycle nutrition, co-occurring psychiatric and medical conditions and stage of recovery. In an inpatient setting, dietitians may advise the MDT on the most appropriate method of nutrient delivery such as oral feeding, nutrition supplements and/or nasogastric feeding.

**Nutrition Education**
Nutrition support and education are provided throughout treatment and across all treatment settings. This includes information regarding the anticipated course of treatment, illness and recovery, energy and nutrient needs, the impact of food and nutrients on physical and psychological wellbeing, effects of nutritional deficiency or low energy availability, appetite cues and the relationship between dietary intake and exercise. Education serves to support the individual and/or family in considering the potential benefits of incorporating sustainable change in eating patterns and behaviours to promote the recovery process. The specific timing and topics of education should be patient-centred, varying according to the stage of change.

**Nutrition Counselling**
Nutrition counselling practice includes the use of principles from evidence-based psychological treatment models as applied to eating behaviour. These models include cognitive behaviour therapy, motivational interviewing, family-based therapy, acceptance and commitment therapy techniques and dialectical behaviour therapy. Nutrition counselling is applied to individuals and families as indicated by these treatments, and ideally complement the model used in therapy. Complementing a therapeutic model is different from implementing the model, and while understanding the model is expected, implementing a treatment model is not considered to be within the dietitian’s scope of practice without significant additional mental health training and supervision.

**5.5 Monitoring and evaluation**
Throughout treatment, ongoing nutritional monitoring is required to evaluate outcomes of treatment and particularly change in ED behaviour. It is important that treatment outcomes are evaluated both qualitatively and quantitatively. New and developing concerns need to be addressed with the patient and communicated to the rest of the treatment team as a lack of change in ED behaviour may indicate a need to review and change treatment.
6. Specific Training Standards

6.1 Mental health-specific clinical training standards

Mental health-specific clinical training should either partially or entirely address the mental health-specific clinical practice standards outlined on pages 31-35 (Appendix E), depending on the duration and intensity of the training course.

6.2 Dietetic-specific clinical training standards

Dietetic-specific clinical training should either partially or entirely address the dietetic-specific clinical practice standards outlined on pages 22-30 (Appendix F), depending on the duration and intensity of the training course.


### Appendix A: Guidelines for Treating Eating Disorders (ED) Across Different Treatment Guidelines

**General Principles**

<table>
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<tr>
<th>General Principles</th>
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<tbody>
<tr>
<td>Include psychoeducation; monitor weight, mental and physical health, and any self-harm; be multidisciplinary and coordinated between services; involve the person’s family members or carer where appropriate; be aware that people with an ED are vulnerable to stigma and shame; be sensitive when discussing a person’s weight and appearance; assess and, where possible modify, the impact of the environment (e.g. social media).</td>
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<table>
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<tr>
<th>ED</th>
<th>Principles specific to the ED</th>
<th>Specific therapies recommended across the guidelines</th>
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</thead>
<tbody>
<tr>
<td><strong>Anorexia nervosa</strong></td>
<td>(1) A key goal is to help people reach a healthy body weight for their age (2) Weight gain is key to supporting other changes needed for recovery (inpatient aim for 0.5–1.4 kg, outpatient aim for 0.2–0.5 kg per week) (3) When weighing consider sharing the results with the person and family (4) Only offer dietary counselling as part of a multidisciplinary approach (5) Do not offer medication as a sole approach (6) Have clear criteria for moving to more intensive treatment, e.g. admission to hospital</td>
<td><strong>Children and Adolescents:</strong> Anorexia nervosa-focused family therapy (parent-focused and multi-family group also acceptable); ED-focused CBT (CBT-ED) enhanced with family involvement; adolescent-focused psychotherapy <strong>Adult:</strong> Maudsley anorexia nervosa treatment for adults (MANTRA); Specialist supportive clinical management (SSCM); CBT-ED; ED-focused focal psychodynamic therapy</td>
</tr>
<tr>
<td><strong>Bulimia Nervosa</strong></td>
<td>(1) Explain that psychological treatments have limited effect on body weight (2) Do not offer medication as a sole approach; SSRIs are recommended as an adjunct treatment</td>
<td><strong>Children and Adolescents:</strong> Individual CBT-ED; bulimia nervosa-focused family therapy <strong>Adult:</strong> Guided self-help CBT-ED: if ineffective in the first four sessions offer more intensive CBT-ED; interpersonal psychotherapy</td>
</tr>
<tr>
<td><strong>Binge ED</strong></td>
<td>(1) Explain that psychological treatments have limited effect on body weight (2) For children and young people, offer the same treatments as adults (3) Do not offer medication as a sole approach; SSRIs are recommended as an adjunct treatment</td>
<td><strong>Adolescents and Adults:</strong> Guided self-help CBT-ED: if ineffective in the first four sessions offer more intensive CBT-ED; interpersonal psychotherapy</td>
</tr>
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**OSFED:** Offer the treatment for the ED it most closely resembles

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Appendix B: DSM-5 Diagnostic criteria

Anorexia Nervosa (AN)

1. Restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

2. Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.

3. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Specify whether:

Restricting type: During the last three months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour (i.e. self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

Binge-eating/purging type: During the last three months, the individual has engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if:

In partial remission: After full criteria for anorexia nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behaviour that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.

In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria has been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild: BMI ≥ 17 kg/m²

Moderate: BMI 16–16.99 kg/m²

Severe: BMI 15–15.99 kg/m²

Extreme: BMI < 15 kg/m²

Bulimia Nervosa (BN)

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   a) Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
   b) A sense of lack of control of overeating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).

2. Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

3. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for 3 months.
4. Self-evaluation is unduly influenced by body shape and weight.
5. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify if:
In partial remission: After full criteria for bulimia nervosa were previously met, some, but not all, of the criteria have been met for a sustained period of time.
In full remission: After full criteria for bulimia nervosa were previously met, none of the criteria has been met for a sustained period of time.

Specify current severity:
The minimum level of severity is based on the frequency of inappropriate compensatory behaviours (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.
Mild: An average of 1–3 episodes of inappropriate compensatory behaviours per week.
Moderate: An average of 4–7 episodes of inappropriate compensatory behaviours per week. Severe: An average of 8–13 episodes of inappropriate compensatory behaviours per week. Extreme: An average of 14 or more episodes of inappropriate compensatory behaviours per week.

Binge eating disorder (BED)
1. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
   a) Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
   b) A sense of lack of control of over-eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
2. The binge-eating episodes are associated with three (or more) of the following:
   a) Eating much more rapidly than normal.
   b) Eating until feeling uncomfortably full.
   c) Eating large amounts of food when not feeling physically hungry.
   d) Eating alone because of feeling embarrassed by how much one is eating.
   e) Feeling disgusted with oneself, depressed, or very guilty afterwards.
3. Marked distress regarding binge eating is present.
4. The binge eating occurs, on average, at least once a week for three months.
5. The binge eating is not associated with the recurrent use of inappropriate compensatory behaviour as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Specify if:
In partial remission: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.
In full remission: After full criteria for binge-eating disorder were previously met, none of the criteria has been met for a sustained period of time.
Specify current severity:
The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.
Mild: 1–3 binge-eating episodes per week.
Moderate: 4–7 binge-eating episodes per week. Severe: 8–13 binge-eating episodes per week. Extreme: 14 or more binge-eating episodes per week.
Other specified feeding & eating disorder (OSFED)

This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. The other specified feeding or eating disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific feeding and eating disorder. This is done by recording ‘other specified feeding or eating disorder’ followed by the specific reason (e.g. ‘bulimia nervosa of low frequency’).

Examples of presentations that can be specified using the ‘other specified’ designation include the following:

1. **Atypical anorexia nervosa**: All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual’s weight is within or above the normal range.
2. **Bulimia nervosa (of low frequency and/or limited duration)**: All of the criteria for bulimia nervosa are met, except that the binge eating, and inappropriate compensatory behaviours occur, on average, less than once a week and/or for less than three months.
3. **Binge-eating disorder (of low frequency and/or limited duration)**: All of the criteria for binge-eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than three months.
4. **Purging disorder**: Recurrent purging behaviour to influence weight or shape (e.g. self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.
5. **Night eating syndrome**: Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual’s sleep-wake cycle or by local social norms. The disordered pattern of eating is not better explained by binge-eating disorder and or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.

**Avoidant/Restrictive Food Intake Disorder**

1. An eating or feeding disturbance (e.g. apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
   a) Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
   b) Significant nutritional deficiency.
   c) Dependence on enteral feeding or oral nutritional supplements.
   d) Marked interference with psychosocial functioning.
2. The disturbance is not better explained by a lack of available food or by an associated culturally sanctioned practice.
3. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one’s body weight or shape is experienced.
4. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.
Specify if:

**In remission:** After full criteria for avoidant/restrictive food intake disorder were previously met, the criteria have not been met for a sustained period of time.
Appendix C: ED-15

This questionnaire is designed to give a week-by-week picture of your eating disorder symptoms so that you and your therapist can keep track of changes. Please answer all the following questions just before your next session and hand the questionnaire to your therapist.

Your name: ___________________________ Date of completion: ___________________________

<table>
<thead>
<tr>
<th>Over the past week, how often have I:</th>
<th>Not at all</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Most of the time</th>
<th>All the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Worried about losing control over my eating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2 Avoided activities or people because of the way I look</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>3 Been preoccupied with thoughts of food and eating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4 Compared my body negatively with others’</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5 Avoided looking at my body (e.g. in mirrors; wearing baggy clothes) because of the way it makes me feel</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6 Felt distressed about my weight</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7 Checked my body to reassure myself about my appearance (e.g. weighing myself; using mirrors)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>8 Followed strict rules about my eating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>9 Felt distressed about my body shape</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>10 Worried that other people were judging me as a person because of my weight and appearance.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

If you have never used any of the following behaviours, please respond with N/A.

For those that you have used, over the past week, how many times have you:  

<table>
<thead>
<tr>
<th>Number of times</th>
</tr>
</thead>
<tbody>
<tr>
<td>a Binged (felt out of control of your eating, and eaten far more than a person normally would at one go)</td>
</tr>
<tr>
<td>b Vomited to control your weight (whether you had to make yourself sick or not) *</td>
</tr>
</tbody>
</table>

Finally, on how many days in the past week have you:  

<table>
<thead>
<tr>
<th>Number of days</th>
</tr>
</thead>
<tbody>
<tr>
<td>c Used laxatives to control your weight or shape</td>
</tr>
<tr>
<td>d Restricted or dieted in order to control your weight</td>
</tr>
<tr>
<td>e Exercised hard in order to control your weight</td>
</tr>
</tbody>
</table>

* i.e. Using your fingers or medicines to make yourself sick, or vomiting without such aids
### Appendix D: 12 item short form of the Eating Disorder Examination Questionnaire (EDE-QS)

<table>
<thead>
<tr>
<th>On how many of the past 7 days</th>
<th>0 days</th>
<th>1–2 days</th>
<th>3–5 days</th>
<th>6–7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Have you gone for long periods of time (8 waking hours or more) without eating anything in order to influence your weight or shape (whether or not you have succeeded)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Has thinking about food, eating or calories made it very difficult to concentrate on things you are interested in (such as working, following a conversation or reading)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Has thinking about weight or shape made it very difficult to concentrate on things you are interested in (such as working, following a conversation or reading)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Have you had a definite fear that you might gain weight?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Have you had a strong desire to lose weight?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Have you tried to control your weight or shape by making yourself sick (vomiting) or taking laxatives?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Have you exercised in a driven or compulsive way as a means of controlling your weight, shape or body fat, or to burn off calories?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Have you had a sense of having lost control over your eating (at the time that you were eating)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 On how many of these days (i.e., days on which you had a sense of having lost control over your eating) did you eat what other people would regard as an unusually large amount of food in one go?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the past 7 days</td>
<td>Not at all</td>
<td>Slightly</td>
<td>Moderately</td>
<td>Markedly</td>
</tr>
<tr>
<td>11 Has your weight or shape influenced how you think about (judge) yourself as a person?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 How dissatisfied have you been with your weight or shape?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix E: Mental health-specific clinical practice and training standards

1. Eating disorder treatment foundations

All mental health clinicians seeking to assess and treat ED patients should have a well-developed foundational knowledge that allows more specific evidence-based treatment model training to occur within a context of already well-developed and developing skills. Key points from the NEDC workforce core competencies are outlined below. It is expected that clinicians will be trained in and achieve these practice standards via multiple pathways that include formal and informal learning opportunities.

<table>
<thead>
<tr>
<th>1. General eating disorder knowledge</th>
<th>In training</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Understand the diagnostic criteria for ED, how they overlap and how atypical presentations differ from typical presentations</td>
<td></td>
</tr>
<tr>
<td>1.2. Understand the risk factors that contribute to the development of ED and have knowledge of populations at high risk for developing at ED</td>
<td></td>
</tr>
<tr>
<td>1.3. Understand the signs of an ED at different stages of development and have an awareness of the way in which the seriousness of ED symptoms can be minimised when clinicians are poorly informed</td>
<td></td>
</tr>
<tr>
<td>1.4. Understand the typical illness progression and the psychological, social and quality of life impacts</td>
<td></td>
</tr>
<tr>
<td>1.5. Understand the short- and longer-term physical impacts of an ED including the need for urgent assessment and intervention if there is a risk of medical instability</td>
<td></td>
</tr>
<tr>
<td>1.6. Understand the common medical and psychiatric comorbidities that are typical for people with an ED and high prevalence of psychiatric risk in this group</td>
<td></td>
</tr>
<tr>
<td>1.7. Understand the role of families and carers in assessment, engagement, treatment and recovery support for children, young people and adults</td>
<td></td>
</tr>
<tr>
<td>1.8. Understand the need for a developmentally sensitive family and person-centred approach to setting up and implementing treatment</td>
<td></td>
</tr>
<tr>
<td>1.9. Understand the impact of culture, mental health stigma, weight bias and stigma that can prevent people from accessing support</td>
<td></td>
</tr>
<tr>
<td>1.10. Understand how to organise further information, assessment and treatment for people with ED</td>
<td></td>
</tr>
</tbody>
</table>

2. Eating disorder mental health essential skills

Engagement

2.1. Understand how to join with the patient and family in a supportive way that promotes discussion about the key issues and concerns

2.2. Understand how to implement treatment boundaries such as confidentiality and treatment non-negotiables

2.3. Understand the need for culturally appropriate practice in the engagement process

Assessment

2.4. Understand how to complete a biopsychosocial assessment that integrates assessment of ED symptoms, being aware that symptoms may be minimised by the person with an ED

2.5. Understand how to complete a family or significant other assessment that engages key parents, carers or partners

2.6. Understand how to complete an assessment of comorbid psychiatric issues including risk of suicide and self-harm
2.7. Understand the need to identify and support the recognition of strengths and resources for the person with an ED

2.8. Understand the use of and implementation of age-appropriate validated ED assessment tools and psychometric tests

2.9. Encourage patients to allow their family to share information with the treatment team

2.10. Understand how to identify when a person requires urgent medical assessment or psychiatric assessment and when they should be referred to a hospital emergency department

2.11. Understand how to refer on for further assessments to address physical, psychiatric or nutritional needs

2.12. Understand the when and how involuntary treatment is implemented for person with an ED

**Intervention**

2.13. Understand how to support a person and family with an ED while awaiting specialist care or evidence-based treatment to commence including:

2.13.1 Understand the need to help the family and person feel contained, and to appreciate the impact of the problem on everyone and that the person with an ED is not intending to harm themselves or their loved ones

2.13.2 Understand how to put risk management plans in place for self-harm and suicidal ideation

2.13.3 Understand what effective medical management should involve and ensure that regular medical review is occurring

2.13.4 Understand and be able to advise the person and family about basic immediate steps and their benefits such as regular eating, supervision and support, the need for weight gain

2.14. Understand developmentally appropriate basic nutritional and healthy eating principles

2.15. Understand how to support the person and family to manage any distress that may be occurring

2.16. Understand the need to provide a follow-up schedule that matches the severity of the ED and the treatment model being implemented

**Referral**

2.17. Understand the services that are available at different care levels locally

2.18. Understand when to escalate care to a more specialised level

3. **Knowledge of eating disorder psychological symptoms and motivations**

3.1 Understand how an ED mindset can impact engagement with and adherence to treatment and the importance of having clear treatment outcomes mitigate against missing instances of poor progress that require further intervention

3.2 Understand complex relationships between motivation and behavioural change for people with EDs and that ambivalence is common in ED presentations, despite a strong underlying need to feel better

3.3 Understand the nature and role of distress for people with EDs and how distress needs to be managed so that important behavioural changes, such as weight gain, are still a focus of treatment

3.4 Understand the importance of interest in the patient’s values, goals and hopes for the future, as well as their fears about weight gain and other changes needed

4. **Knowledge of Care Levels**

4.1 Understand the importance of the treatment context and how this should be matched to symptom severity
4.2 Understand the indicators for referral to a higher level of care (e.g. as an inpatient or day patient) and the aim of each care level. Factors like patient age and illness severity and duration as well as available access to higher levels of care will impact on decision making.

5. Knowledge of evidence-based treatments

5.1 Understand, describe and have a working knowledge of the current evidence base for ED treatments and how they are implemented for each diagnosis

5.2 Understand the need for speciality training and supervision to learn and implement a treatment model competently and with fidelity

5.3 Understand how the treatment context will impact the implementation of an evidence-based model

6. Working in a multidisciplinary team

6.1 Understand the role and significance of a multidisciplinary team in treatment

6.2 Understand the role of each team member and how to set up a multidisciplinary team consistent with the treatment model being delivered

6.3 Participate in implementing treatment recommendations consistent with their professional background and work collaboratively with other team members both within and external to their organisation

6.4 Understand the impact ED pathology can have on the functioning of the multidisciplinary team

6.5 Be aware of commonly utilised communication methods, such as formal letters, care conferencing and personal communication, to ensure consistent, collaborative care

7. Professional practices

7.1 Consistently reflect on and judge knowledge and experience limitations so that safe care is consistently provided

7.2 Understand the importance of clinical supervision as required by their professional body

7.3 Understand that clinical supervision on ED cases should be undertaken with a clinician with experience in ED and that regular ED focused clinical supervision is an essential professional requirement to enable effective reflective practice, as well as to support treatment planning and therapy model implementation. In addition, clinical supervision supports clinicians to know the limits of their expertise and when to seek advice or refer on

7.4 Understand the importance of continuing professional development as required by their professional body with the aim to develop the knowledge, skills and attitudes required to provide and manage mental health care for people experiencing ED

7.5 Understand the importance of measuring treatment adherence and outcomes using methods that are standardised or of an accepted standard in the field such as monitoring weight, binge-purge frequency, or ED psychopathology with psychometric measures

2. Training components for evidence-based psychotherapy practice

It is essential that clinicians seeking training in a specific evidence-based model receive training at a level that meets the following content and quality standards. Training in evidence-based models should extend on the foundational training outlined above

Workshop content

Workshops on a specific evidence-based model should contain the following:
• An up-to-date research review for the model’s inclusion as an evidence-based model in the relevant clinical practice guidelines
• The core concepts of the model and its underlying theory
• The structure and phases or stages of the treatment
• Information consistent with the published manual if manualised and address issues of model efficacy
• Recommendations on the implementation and application of the model in different practice settings and within a multidisciplinary team
• A reflective component for clinicians to appreciate how they may need to change their practices to reflect the model being taught
• A significant practice component in the form of video demonstration, role play, case scenarios or similar, to enable the translation of theory to practice

Training program standards
Training programs and workshops should have clear learning goals and should be of a suitable length to meet the stated aims of the training. Additionally, the capacity of the training to provide the skills to use the model in practice after the training event should be clearly stated. Benchmarking training in specific models against equivalent training internationally provides a good guideline for locally provided training. Institutions, training organisations and individuals providing training in specific models should be suitably qualified, recognised for their expertise in the model and have significant experience implementing the treatment in different practice settings. Where training in a specific model is being implemented in a specific context, the institutions, training organisation or individual should have appropriate experience providing treatment to meet the needs of the context such as community, private practice or tertiary settings.

Translating training into practice
It is recognised that attending training does not automatically translate to a suitable level of capacity to implement a model at the required level to provide treatment efficacy that will result in acceptable patient outcomes. Clinicians should recognise the need for post-training model-specific clinical supervision and additional professional development to develop the expertise to implement the model for individual patients and families. This could include but is not limited to advanced practice workshops, observing more experienced clinicians, professional reading programs, and conference workshops. This need should be integrated into their existing professional organisation CPD requirements.

Consideration should also be given by a clinician to their previous experience to determine what additional training is needed. New clinicians should proceed cautiously, recognising their need to develop both foundational as well as specific model related skills.

Model-specific supervision differs from general clinical supervision in that it should consider the developmental stage of the clinician in the model and thus provide a high ratio of teaching and instruction which will become more reflective over time. Supervision at the highest standard will involve the review of audio or video to support the clinician develop appropriate micro-skills in the model. Clinicians learning a new model will generally need 1–2 years of supervised/supported practice (depending on their practice context) to become competent in a new model.
**Appendix F: Dietetic-specific clinical practice and training standards**

In addition to having competency in the standards outlined in the General Clinical Practice Standards (p.6), it is recommended that dietitians working with patients with EDs are competent in the dietetic-specific clinical practice standards detailed below. It is expected that training programs that educate dietitians working with patients with EDs should identify which of the standards they address in the right-hand column.

<table>
<thead>
<tr>
<th>1. Screening</th>
<th>In training</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Utilises appropriate screening tools such as SCOFF and skills to implement screening consistent with evidence-based guidelines</td>
<td></td>
</tr>
<tr>
<td>b. Demonstrates an awareness that individuals may deny the seriousness of illness or mask symptoms due to previous stigmatising experiences, shame or embarrassment</td>
<td></td>
</tr>
<tr>
<td>c. Demonstrates an awareness of individuals at high-risk of an ED who should be screened</td>
<td></td>
</tr>
<tr>
<td>d. Understands when and where patients should be referred on due to their severity of illness (and beyond dietitians’ competence of practice). This includes referral pathways for patients who are suicidal, or who require urgent hospital admission for medical instability</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Communication</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1. Communication within the multidisciplinary care team</td>
<td></td>
</tr>
<tr>
<td>a. Collaborates with the multidisciplinary care team and patient to develop shared treatment* and safety plan (i.e. addressing medical and psychiatric risk)</td>
<td></td>
</tr>
<tr>
<td>b. Ensures processes and systems are set up for effective communication including:</td>
<td></td>
</tr>
<tr>
<td>- Communication during periods of non-attendance</td>
<td></td>
</tr>
<tr>
<td>- Communication of upcoming leave</td>
<td></td>
</tr>
<tr>
<td>- Discussion of communication outside of formal clinical reviews (e.g. who facilitates communication, in what format, how often)</td>
<td></td>
</tr>
<tr>
<td>- Communication of risk</td>
<td></td>
</tr>
<tr>
<td>c. Understands the local systems to escalate care where necessary (e.g. inpatient admission pathways, specialist ED services)</td>
<td></td>
</tr>
<tr>
<td>d. Demonstrates ability to discuss splitting / other issues of potential contention around treatment and recognises the potential of this in an ED context</td>
<td></td>
</tr>
</tbody>
</table>

| 2.2. Communication with patients | |
| a. Demonstrates ability to compassionately discuss the medical risks associated with EDs with patients and direct to appropriate professional / service for follow up where necessary |
| b. Understands psychological risks associated with EDs with ability to directly undertake risk assessment or direct to the appropriate |
c. Ensure processes / systems are set up for effective communication including determining with the client
   - The patient’s main supports and the patient’s preference for the extent and timing of their involvement in treatment (particularly for adults)
   - Consent to communicate/share notes within the treating team, as well as for the purpose of clinical supervision
   - Confidentiality and duty of care (adults and adolescents)

d. Able to enhance patient autonomy and choice, while balancing the clinician’s duty of care

e. Able to utilise counselling skills, e.g. motivational interviewing skills

f. Understands that the physical environment forms a basis of communication

g. Ensure the clinic environment is not triggering or stigmatising

h. Identify practices that promote inclusion for people from a range of backgrounds, cultures and marginalised communities

### 2.3. Communication with family and carers

a. Understands that family/significant others can play an important role in the recovery process

b. Determines when family involvement may or may not be indicated

c. Communicates nutritional risks to family members in a timely manner

d. Understands the stress that EDs place on families and carers, particularly at mealtimes

e. Has awareness of family support services and resources and can provide this information

f. Has knowledge of and can provide credible ED nutritional/meal support resources

g. Understands other systems that may require involvement in the communication process (e.g. school principal, sports coaches)

h. Able to create boundaries for provision of information to carers or significant others when necessary

i. Understands duty of care and times where confidentiality may be broken

### 3. Ethical and sensitive practice

#### 3.1. Commitment to ethical care

a. Understands varying roles of dietitians in ED care

b. Identify EDs, assist with early intervention, and refer to GP for further mental health assessment

c. Provide nutrition advice regarding maintaining medical/nutritional safety in the community

d. Participate in shared care team role at the request of mental health care leader (mental health clinician or GP)

e. Provide dietetic consultation to mental health and medical team

f. Actively engages in a reflective practice model, demonstrating a commitment to and use of clinical supervision to improve outcomes, ensure safety in practice and maintain clinician resilience

g. Understands the importance of maintaining professional boundaries with patients
3.2. Commitment to sensitive practice with diverse presentations
   a. Awareness of trauma-informed care and working with people with complex trauma backgrounds, whilst staying within the scope of practice
   b. Understands challenges in mental health literacy
   c. Understands how to work with diversity in sexuality, gender, religion and culture
   d. Utilises a stages-of-change framework – enabling rather than reducing the chance of change

4. Assessment
   4.1. Food and nutrition-related history
      a. Food and nutrient intake
         a. Assesses usual and current dietary intake, considering macro and micronutrients, fluid, caffeine and alcohol intake and dietary patterns
         b. Assesses the risk of refeeding syndrome
      b. Food and nutrient administration
         a. Evaluates previously prescribed diets, self-selected diets and dieting attempts, considering their purpose and intention
         b. Analyses any history of vegetarianism or other sociocultural dietary modification, identifying the timing of onset in relation to the ED commencement and motivations for the dietary modification
         c. Identifies who undertakes food shopping and meal preparation, and with whom meals are consumed
         d. Evaluates how meals are prepared, considering planning, flexibility, timing and routines
         e. Assesses eating environment, observing location and atmosphere
      c. Medication and complementary/alternative medicine use
         a. Assesses medications or nutritional supplements used or needed for psychiatric or co-occurring medical conditions, and evaluates their impact on nutritional management of the ED
         b. Assesses use of medications or supplements used for weight loss/weight control e.g. laxatives, diuretics, diet pills, insulin omission
      d. Knowledge/beliefs/attitudes
         a. Assesses motivation and confidence to change, alongside potential barriers to change
         b. Determines when and how worry and concern about weight/appearance began
         c. Understands the patient’s satisfaction/dissatisfaction with their appearance/shape
         d. Assesses occurrence and frequency of body checking, measuring and weighing behaviours
         e. Recognises familial patterns of body image concerns
         f. Understands specific food-related anxieties and reasons for these
         g. Evaluates attitudes and beliefs about food and dieting in the family, including relationships with food and ED behaviour
      e. Behaviour
         a. Identifies the type, frequency, duration and triggers of ED-related behaviours (e.g. binge eating, restriction, vomiting, hiding food, chewing gum, chewing and spitting)
f. **Factors affecting access to food and food/nutrition-related supplies**
   - a. Assesses availability of and accessibility to food shopping facilities and safe food and water
   - b. Identifies current participation in programs providing food/nutrition, such as home enteral nutrition programs, day programs and residential programs

g. **Physical activity and function**
   - a. Analyses physical activity levels, including frequency, duration, type and motivation
   - b. Understands premorbid physical activity levels
   - c. Recognises any sport-specific nutrition needs for competitive athletes
   - d. Recognises familial patterns of exercise and physical activity

h. **Nutrition-related patient-centred measures**
   - a. Understands the patient’s perception of the nutrition intervention and the impact on the patient’s quality of life
   - b. Identifies patient’s aims of nutrition intervention

4.2. **Anthropometric measurements**
   - a. Determines weight history, including highest and lowest weights reached, as well as weight fluctuations
   - b. Assesses body weight and shape patterns in the family
   - c. Assesses current weight, height and body mass index, and age-related indices (i.e. relevant percentiles and z-scores)
   - d. Understands patient’s desired weight

4.3. **Biochemical data, medical tests and procedures**
   - a. Reviews biochemistry results in relation to nutritional status
   - b. Understands the impact of diagnostic test results (e.g. bone densitometry, electrocardiogram) on ED
   - c. Assesses need for additional tests based on clinical presentation

4.4. **Nutrition-focused physical findings**
   - a. Assess actual or potential physical and psychiatric complications of ED behaviours, including consequences of under-nutrition, starvation and compensatory behaviours
   - b. Assess gastrointestinal function
   - c. Reviews past and current menstrual function in anyone who identifies as female or is expected to menstruate (including transgender males and non-binary individuals who were born as female)
   - d. Evaluates appetite awareness including hunger, fullness and satiety cues

4.5. **Patient history**
   - a. **Personal history and experiences**
     - a. Considers relationship with body and food prior to the development of the ED
     - b. Identifies current and past life stressors that may have contributed to the development of body image concerns, relationship with food and ED behaviours
     - c. Recognises when and how the ED started and progressed
     - d. Seeks to understand lived experience with any weight-based stigmatisation, including within the health care system
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<td><strong>e.</strong> Seeks to understand previous experiences with nutrition professionals</td>
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<td>b. Determines relevant medical comorbidities and their impact of managing the ED (e.g. diabetes, allergies, gastrointestinal disorders, etc.)</td>
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<td>b. Estimates fluid requirements</td>
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<td>c. Determines estimated body weight range, considering age and growth, life history, genetics and relevant medical conditions</td>
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<tr>
<td>5. <strong>Nutrition</strong></td>
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<tr>
<td>5.1. <strong>Identifies and labels nutrition problems</strong></td>
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<tr>
<td>a. Identifies nutrition problems considering all relevant assessment data, including weight and medical stability parameters, nutrition-focused physical findings, food, nutrient and bioactive substance intake, compensatory behaviours and impact of current behaviour on psychological/social functioning</td>
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<tr>
<td>b. Differentiates between disordered eating patterns (typically present in anorexia nervosa, bulimia nervosa and binge-eating disorder) and limited food acceptance (typically present in avoidant restrictive food intake disorder)</td>
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<tr>
<td>c. Informs multidisciplinary treatment team members of nutrition problems whose interventions influence the nutritional care of the patient</td>
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<tr>
<td>5.2. <strong>Determines aetiology (cause/contributing risk factors)</strong></td>
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<tr>
<td>a. Demonstrates understanding and identification of risk factors associated with developing disordered eating patterns and limited food acceptance</td>
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<tr>
<td>b. Differentiates between nutrition problems with an aetiology of psychopathology or medical complications of ED behaviour and ‘normal’ nutrition problems influenced by the environment, society and culture</td>
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<td>c. Identifies when a patient’s presentation may meet DSM-5 diagnostic criteria for an ED and presents relevant aetiology e.g. fear of weight gain, history of dieting, or family history of an ED</td>
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<tr>
<td>d. Determines an aetiology that adequately informs multidisciplinary treatment team members whose interventions influence the nutrition care of the patient</td>
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<tr>
<td>5.3. <strong>Clusters signs and symptoms (defining characteristics)</strong></td>
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<tr>
<td>a. Identifies when a patient’s presentation may meet DSM-5 diagnostic criteria for an ED and presents relevant signs and symptoms e.g. frequency of binge eating or purging</td>
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<td>b. Clusters signs and symptoms to adequately inform multidisciplinary</td>
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treatment team members whose interventions influence the nutrition care of the patient

6. Nutrition Intervention

6.1. Plans nutrition intervention

a. Plans the nutrition intervention using nutritional diagnosis with consideration for the severity of the problem(s) and identifying medical risk and safety e.g. risk of refeeding, gastrointestinal concerns, and malnutrition

b. Plans nutrition intervention identifying the patient’s readiness for change, stage in the treatment process, individual needs, available patient supports and resources, recognition of patient mental health concerns e.g. psychiatric status and personality traits such as perfectionism, obsessive-compulsive traits

c. Plans with an emphasis on selecting a wide variety of foods including intake of energy-dense foods throughout the course of treatment. Planning addresses common disruptions in eating patterns, such as inclusion of ‘feared’ foods, (in particular dietary fat and carbohydrate), inclusion of calcium-rich foods and minimising intake of low energy and ‘diet’ foods

d. Planning emphasises increased flexibility of food choice, eating out socially and eating for enjoyment rather than to influence weight or shape

e. A nutrition plan describes the appropriate level of prescriptiveness, it considers strengths and risks of different nutrition support models such as sample meal plans, dietary portions, plate models, mindful or intuitive eating practices

6.2. Food and nutrient delivery

a. Prescribes energy and nutritional support via oral nutrition with three balanced ‘non-diet’ meals and 2–3 snacks, and in anorexia nervosa treatment, considers enteral feeding and high energy supplements if medically at risk or unable to meet adequate oral intake needs

b. Determines the appropriate rate of weight restoration, and in anorexia nervosa treatment, adjusts intake gradually beyond homeostasis to achieve regular weight increments, depending on the risk of refeeding syndrome

c. Prescribes regular and adequate carbohydrate intake to prevent hypoglycaemia during refeeding in anorexia nervosa

d. If refeeding risk is present at low body weight, administers prophylactic phosphate before refeeding and thiamine supplementation

e. If underweight, considers calcium and vitamin D supplementation based on the duration of low body weight

f. Manages gastrointestinal discomfort such as constipation and manages laxative cessation

g. Manages exercise during treatment based on medical risk and weight progress

6.3. Nutrition education

a. Provides nutrition education to patients across all stages of ED presentation and treatment settings

b. Includes education topics such as gut function, consequences of
**ANZAED Mental Health and Dietetic Clinical Practice and Training Standards for the Treatment of Eating Disorders**

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<tr>
<td><strong>6.4. Nutrition counselling</strong></td>
<td><strong>6.5. Coordination of nutrition care</strong></td>
</tr>
<tr>
<td>a. Understands principles of evidence-based treatments (e.g. CBT-E and FBT) and applies these principles in eating behaviour counselling</td>
<td>a. Collaborates with members of the multidisciplinary team</td>
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<td>b. Uses therapeutic skills including active listening, non-verbal attending skills, emotional intelligence and consistency</td>
<td>b. Seeks regular consultation and supervision with more senior colleagues</td>
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<td>c. Shows care, compassion and appropriate use of self-disclosure in counselling</td>
<td>c. Coordinates and recommends referrals to higher levels of care</td>
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<td>d. Expresses empathy, acknowledges barriers to change and supports self-efficacy</td>
<td>d. Communicates nutrition intervention with the multidisciplinary team, patient and supports</td>
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<tr>
<td>e. Determines the level of patient motivation, cognitive flexibility and developmental expectations and limitations of the patient to participate in nutrition counselling</td>
<td>e. Liaises with food delivery services and communicates nutrition plan for food delivery</td>
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<td>f. Is familiar with specific strategies that may be used in nutrition counselling such as motivational interviewing, goal setting, cognitive restructuring, self-monitoring, graded exposure, behavioural experiments, structured problem solving and relapse prevention</td>
<td>f. Acts as a nutrition consultant for the management of nutrition support and eating behaviours across all treatment settings</td>
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<td>g. Has knowledge of body image work and mindfulness in relation to eating behaviour and ED recovery</td>
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<td>h. Can adapt counselling dependent on what psychological treatments the patient is engaged in</td>
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<tr>
<td>i. Acknowledges any co-occurring psychiatric conditions in the use of counselling strategies</td>
<td><strong>7. Monitoring and evaluation</strong></td>
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**Restriction/starvation, compensatory behaviours and risks, weight stigma, non-diet nutrition, appetite regulation, weight and body changes, the role of nutrients, achieving an adequate energy intake, social eating and incorporating exercise or additional needs**

c. Incorporates information regarding course of treatment, illness and recovery into nutrition education
d. Tailors education to the appropriate developmental stage of the patient (e.g. growth needs of adolescents)
e. Integrates nutrition education to support specific psychological treatment principles (e.g. cognitive-behavioural therapy for EDs [CBT-E] or family-based therapy for EDs [FBT])
f. Addresses concerns relating to weight or body changes and food choices and the influence of genetics
g. Provides nutrition and meal support education to those providing meal support appropriate for the treatment context, including family, carers and treatment facility food service and meal support staff
### 7.1. Food and nutrition-related history

#### a. Food and nutrient intake
- Assesses current dietary intake, considering macro and micronutrients, fluid, caffeine and alcohol intake and dietary patterns
- Assesses the risk of refeeding syndrome

#### b. Food and nutrient administration
- Identifies who undertakes food shopping and meal preparation, and with whom meals are consumed
- Evaluates how meals are prepared, considering planning, flexibility, timing and routines
- Assesses eating environment, including location and atmosphere

#### c. Medication and complementary/alternative medicine use
- Assesses changes in medications or nutritional supplements used or needed for psychiatric or medical comorbidities, and evaluates their impact on nutritional management of the ED

#### d. Knowledge/beliefs/attitudes
- Assesses motivations to change, alongside potential barriers to change
- Understands the person’s satisfaction with their appearance/shape
- Assess the occurrence and frequency of body checking and weighing behaviours
- Assesses changes in specific food-related anxieties
- Evaluates changes in attitudes and beliefs about food and dieting

#### e. Behaviour
- Identifies the current type, frequency, duration and triggers of ED-related behaviours (e.g. binge eating, restriction, vomiting, laxative use, hiding food and chewing gum)

#### f. Factors affecting access to food and food/nutrition-related supplies
- Assesses availability of and accessibility to food shopping facilities and safe food and water
- Recognises current participation in programs providing food/nutrition, such as home enteral nutrition programs, day programs and residential programs

#### g. Physical activity and function
- Analyses active and incidental physical activity levels, including frequency, duration, type and motivation

#### h. Nutrition-related patient-centred measures
- Understands the patient’s current perception of the nutrition intervention and the impact on the patient’s quality of life

### 7.2. Anthropometric measurements

- Assesses changes in body weight, height and body mass index, as well as age-related indices

### 7.3. Biochemical data, medical tests and procedures

- Reviews biochemistry results in relation to nutritional status
- Evaluates the impact of diagnostic test results (e.g. bone densitometry and electrocardiograms on ED)
- Assesses need for additional tests based on clinical presentation

### 7.4. Nutrition-focused physical findings

- Assesses changes in current physical and psychiatric complications of
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