

EATING DISORDERS



NEURODIVERSITY  
AUSTRALIA

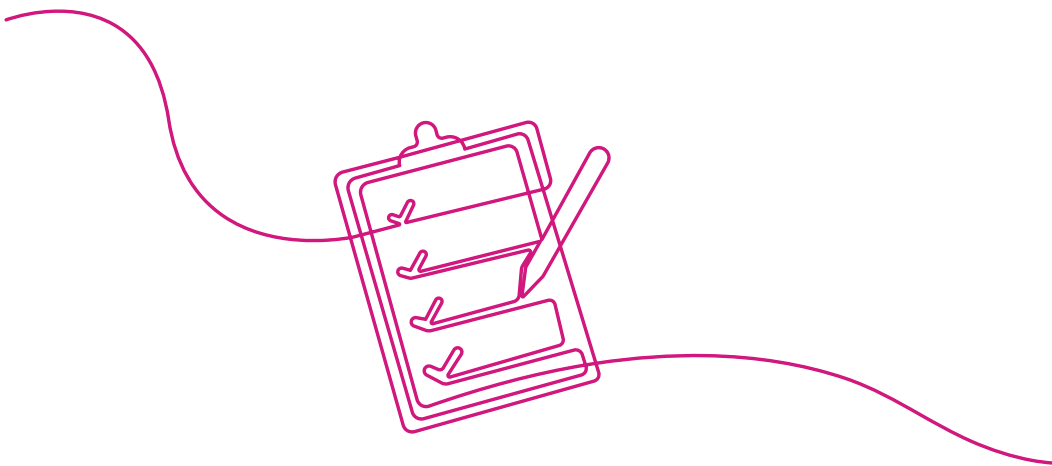
# NEURODIVERSITY- AFFIRMING TRAINING

## Clinician Checklist



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# 1 Context and Purpose

This checklist has been developed by neurodivergent clinicians with extensive experience in teaching and professional supervision. Its purpose is to provide a structured, neurodiversity-affirming framework for evaluating training programs – assessing both content and underlying assumptions to determine whether key principles are genuinely upheld.

While the checklist is designed for reviewing trainings rather than clinical practice, many of the principles – such as affirming language, embedded accessibility, clinical and cultural humility, and concrete adaptations – are consistent with neurodiversity-affirming therapeutic work more broadly.



## 1.1. Goals

- To offer a clear set of criteria for assessing whether a training meaningfully aligns with the neurodiversity-affirming paradigm in its values, goals, pedagogy, and clinical implications.
- To help distinguish genuinely neurodiversity-affirming training from programs that appear affirming at face value but remain assimilationist in practice.
- To support supervision, reflection, and advocacy by highlighting strengths and gaps in training programs.



## 1.2. Who this checklist is for

- Clinicians selecting professional development
- Managers or educators evaluating training for teams
- Organisations considering endorsing, commissioning, or partnering with training providers
- Supervisors guiding staff learning
- Anyone seeking clarity on whether a training aligns with neurodiversity-affirming principles



### 1.3. Core criteria for neurodiversity-affirming training

- **Neurodiversity paradigm:** Explicitly frames neurodivergence (ALL forms) as difference not deficit - operating from a place of neuroneutrality, not neuro-supremacy - and links this to clinical goals.
- **Lived-experience leadership & expertise:** Neurodivergent people shape content throughout in meaningful and substantive ways. This contribution is paid, credited, and not tokenistic.
- **Affirming stance & language:** Clear language policy that defaults to community-preferred identity-first terms, with flexibility to accommodate person-preferred terms and client agency.
- **Accessibility baked in:** Captions/transcripts and downloadable slides; flexible participation (online attendance options, camera off, chat use, questions-in-advance, breaks, session recordings, clear timelines, and recognition that there is no one "correct" of way of engaging).
- **Clinical humility & adaptations:** Acknowledges limits of screening tools/DSM criteria, addresses masking, sensory/interoceptive, and other neurotype-related differences and needs, and offers concrete adaptations for ED care.
- **Intersectional & ethical lens:** Considers culture, minority stress, consent, self-determination, and shared expertise (clinician + client).
- **Quality safeguards:** Trainer competence, evidence/lived-experience citations, and evaluation by neurodivergent participants.
- **Red flags (immediate stop):** Deficit-based framing, pathologising language and framing (e.g. use of DSM term or acronym for Autism), lack of or token lived-experience, coercive/'normalising' practices (e.g. uncritical ABA, goals to eliminate stimming, reference to "fixing" or "treating" neurodivergence), or lack of accessibility.

## 2 Essentials (must-have)

- **Clear framing from the start:** Training explicitly adopts a neurodiversity paradigm (recognising neurodivergence as differences, not deficits) and states how this shapes clinical goals.
- **Lived-experience leadership throughout:** People with lived neurodivergent experience are meaningfully involved in development of content and agenda, without tokenisation. They are appropriately compensated monetarily and acknowledged in authorship.
- **Speaker disclosures:** Presenters share their own neurotype (at least the ones relevant to the content of the training - if comfortable), pronouns (if safe and comfortable doing so), and relevant positionality/privilege statements.
- **Respectful language policy:** Uses identity-first and person-centred language intentionally, explains choices, models how to ask clients their preferences, and respects clients' language choices.
- **Focus on client experience & agency:** Emphasises that behaviours/communication have multiple meanings (which must be understood from an anti-pathologising, neuro-affirming, trauma-informed lens), and that clinicians should prioritise the person's reported experience, goals, and self-determination.

# 3 Practical Accessibility and Pedagogy

(strongly encouraged)

- **Multiple modes of access:** Online attendance always an option; captions/subtitles on videos; access to image descriptions, transcripts, recordings, and downloadable slides.
- **Options for participation:** Permission to have camera off, step away/ take breaks, stand/sit/lay down, move during sessions, eat/hydrate during sessions; multiple ways to contribute (chat, typed Qs, polls, anonymous questions, question sent in advance); flexibility for engagement in any group activities/discussions.
- **Sensory & pacing considerations:** Breaks scheduled, predictable and proactively communicated agenda, warnings for sensory content (sound, flashing), unnecessary slide animations removed, accessible colour schemes, warnings for trauma.
- **Accessible materials design:** Dyslexia, colour-blindless, and sensory friendly fonts and contrast, use of visuals to explain steps, no reliance on long paragraphs or on purely verbal instructions or information. Allowing slides to be downloaded in advance so participants can adjust brightness, zoom, or use colour filters/dark mode, or provide alternative-contrast slides on request. Providing plain-text AAC-compatible version of slides (with image descriptions also included). Communicating numerical information in terms of their implications as well as their values or graphs, to accommodate for dyscalculic or dysgraphic attendees.
- **Assessment of comprehension:** Alternative ways to check learning (e.g. options of oral and written Q&A) and allow asynchronous completion.

# 4

## Clinical Practice and Formulation

(core clinical content that must be present)

- **Diagnostic humility & nuance:** Acknowledges limitations of screening and diagnostic tools (including but not limited to validity and accessibility), and the risk of false negatives/positives (diagnostic overshadowing, risk of misdiagnosis/misidentification).
- **Trauma-informed stance:** Understands that many neurodivergent people have experienced trauma and minority stress (historically and ongoing), and prioritises safety, responsivity, informed consent, and choice.
- **Masking/camouflaging awareness:** Describes camouflaging, its mental and physical health costs (e.g. fatigue, allostatic load, self-esteem, delayed diagnosis), how to sensitively enquire about it, and how to create a sense of felt safety so the person can show up as their authentic self. Does not pressure people into unmasking without feeling comfortable to do so, particularly if the training is provided in a group setting with work colleagues.
- **Sensory & interoceptive differences:** Practical strategies for assessment and ED interventions that accommodate sensory preferences and needs, and interoceptive differences.
- **Individualised formulations:** Therapists co-create formulations that centre neurotype strengths, interests, and challenges (avoiding “one size fits all” formulaic or behaviour change approaches).
- **Client-centred goals over “normalisation”:** Clinical success metrics focus on quality of life, safety, and capacity-aligned functioning (not forcing neurotypical norms or reducing stimming).
- **Harm minimisation & consent in medical care:** Clear guidance on consent for examinations and respecting autonomy (including around masking or compliance).

- **Risk assessment nuance:** Discuss how suicidality, self-harm, or restrictive behaviours may present differently; include practical safety planning adapted for communication differences and integrating neurodivergent values and strengths.

## 5 Intersectional and Systemic Considerations

- **Intersectionality & minority stress:** Content examines the intersections of race, gender, sexuality, socioeconomic status, migration, language, disability, and other forms of marginalisation, and how these intersections shape access, experiences, needs, and risk.
- **Cultural humility:** Training explores cultural meanings of neurodivergence and eating/body practices and avoids applying a single cultural lens.
- **Weight stigma, bias, and discrimination:** Training acknowledges how weight-related stigma and broader biases can impact neurodivergent individuals' experiences, engagement with healthcare, and clinical outcomes. Training does not uphold Body Mass Index (BMI) or other weight-centric frameworks.
- **Clinician posture:** Models curiosity, collaboration, and shared expertise – clinician brings clinical skills, client brings lived expertise.
- **Family and carer involvement:** Guidance for involving families sensitively (respecting neurodivergent adult/autistic parent rights, when relevant) and supporting carers without erasing client agency.
- **Systemic barriers & advocacy:** Discusses how services, referral pathways, and measurement tools can exclude neurodivergent people and includes strategies to advocate for reasonable adjustments.

## 6 Workforce and Quality Assurance

- **Trainer competence & diversity:** Presenters include clinicians with demonstrated competence in neurodiversity-affirming care and a range of lived experiences.
- **Ongoing supervision & reflective practice:** Training encourages clinicians to seek neurodivergent-informed supervision and includes prompts for reflective practice.
- **References & evidence transparency:** Cites contemporary and critically examined literature, cites lived-experience sources, and explicitly names limitations or debates.
- **Evaluation by neurodivergent people:** Course evaluation must include comprehensive feedback from both clinician and non-clinician neurodivergent individuals, not just satisfaction scores from clinicians. Neurodivergent individuals are appropriately compensated for this feedback.
- **Actionable resources:** Provides lists of reputable neurodivergent-led organisations, advocates, clinical tools, and accessible client resources.



# 7 Red Flags

(reason to withhold endorsement or require major revision)

- Deficit-focused language that focuses on and frames neurodivergence pathologically.
- Tokenistic lived-experience inclusion (e.g. small section labelled “lived experience” with no substantive contribution/integration or remuneration), or absence of lived-experience inclusion.
- Endorsement of coercive or conversion-style interventions (e.g. behavioural approaches that aim to “fix” or “normalise” differences).
- Uses “neurodivergence” as a synonym or euphemism for Autism and/or ADHD.
- Interventions encouraging masking or explicit goals to eliminate stimming.
- Heavy reliance on DSM as the only framework without discussion of neurodiversity paradigm, functional, or dimensional frameworks.
- No discussion of sensory/interoceptive differences in ED contexts.
- No discussion of other neurotype-related differences in ED contexts.
- No accessibility features (e.g. captions, transcripts, participation options).
- Claims of being “the definitive” or “complete” training
- No evaluation by individuals with lived experience.
- Little or no reference/discussion of intersectionality or positionality.