National
Eating Disorders
Collaboration

Clarity in Complexity

Strategic Communication
to Support the Prevention and
Early Identification of Eating Disorders

National Eating Disorders Collaboration

March 2012

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Foreword

Eating disorders are serious mental illnesses that cause significant physical impairment. They are far more prevalent than many are aware, and they are too often fatal. As with all mental illnesses, the need for early identification and early intervention is paramount.

The urgent need to address the prevention and management of eating disorders must be included in the broader need for national mental health reform. Mental health concerns must be addressed as an integral component of Australia's health program, particularly within the envelope of Australia's innovative youth mental health reform agenda. Both incremental and radical changes are required to adequately address eating disorders and integration within stigma free 21st century models of primary and specialist youth mental health reform is a crucial next step.

The formation and work of the National Eating Disorders Collaboration has enabled the eating disorders sector to be included in this agenda. The next step is redesign and new investment to ensure that integration within innovative service frameworks actually occurs.

The National Eating Disorders Collaboration is an initiative funded by the Department of Health and Ageing to bring together those with expertise and interest in the prevention and management of eating disorders to develop a nationally consistent evidence based approach for Australia. With over 320 members, the NEDC draws from a broad base in collaboratively developing this approach.

Clarity in Complexity: Strategic Communication to Support the Prevention and Early Identification of Eating Disorders provides the evidence based approach for communicating about eating disorders, engagement in prevention programs and encouragement of help seeking.

Its counterpart, *An Integrated Response to Complexity: National Eating Disorders Framework 2012* is the first national schema for eating disorders in Australia.

The reports have been subjected to intensive scrutiny and review. They represent the collective view of those from across Australia who live with and fight eating disorders. As such, they represent a unique collaborative view.

I therefore strongly commend these reports to anyone who is seeking not only to increase their understanding of eating disorders, but how to address their prevention and management at a practical and effective level.

I would like to take this opportunity of thanking all those who have contributed to this framework including our Steering Committee, staff and members of the collaboration. Their ongoing input, feedback, enthusiasm and support have been essential ingredients for this project.

Professor Pat McGorry AO

Chair
National Eating Disorders Collaboration

Acknowledgements

The development of this Communication Strategy Report has been a collaborative effort involving many people from diverse sectors and organisations across Australia. The National Eating Disorders Collaboration (NEDC) gratefully acknowledges the time, effort and passion that people have brought to this process.

Particular thanks must go to the members of the Steering Committee who have made an extraordinary contribution through their leadership of the NEDC.

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Purpose

Clarity in Complexity: Strategic Communication is a report of the National Eating Disorders Collaboration. The report provides an evidence informed strategic framework and guidance for communication related to the prevention and early identification of eating disorders.

A consistent national approach to communication related to eating disorders will require collaboration and integration of activities across many sectors. The report is intended to inform on-going dialogue between professional sectors, governments and communities as a foundation for safe, effective communication that promotes general good health, supports prevention of eating disorders and enables early intervention when this is required.

Two areas of communication are considered in this report: communication about eating disorders to support treatment seeking and de-stigmatisation, and communication about risk factors for eating disorders to support prevention. The term 'communication' is used in this report to refer to all strategic approaches to disseminate messages to specific audiences in order to influence their voluntary behaviour.

In the opinion of the National Eating Disorders Collaboration, there is an urgent need to:

- Raise awareness of eating disorders
- Increase appropriate help-seeking in individuals at risk of or having eating disorders
- Address stigmatisation of weight and eating disorders
- Counteract the modifiable precursors of eating disorders (e.g. over-concern with weight, appearance concerns, dieting, unhealthy eating patterns, low self esteem)
- Increase professional engagement with the eating disorders sector to facilitate the development of a skilled workforce

Objectives for this report

The guidance included in this report will contribute to the implementation of consistent communication about eating disorders and associated risk factors that:

- Are safe and appropriate for intended audiences
- Are evidence based and evidence generating
- Support positive outcomes for prevention and early intervention
- Contribute to population health and wellbeing

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The National Eating Disorders Collaboration

The National Eating Disorder Collaboration (NEDC) is the second phase of a project initiated and funded by the Commonwealth Government Department of Health and Ageing (DoHA) in 2009. The primary purpose of the NEDC is to bring together Eating Disorder stakeholders and experts in mental health, public health, health promotion, education, research, and the media to help develop a nationally consistent approach to the prevention and management of Eating Disorders.

Objectives for the second phase of the NEDC project include:

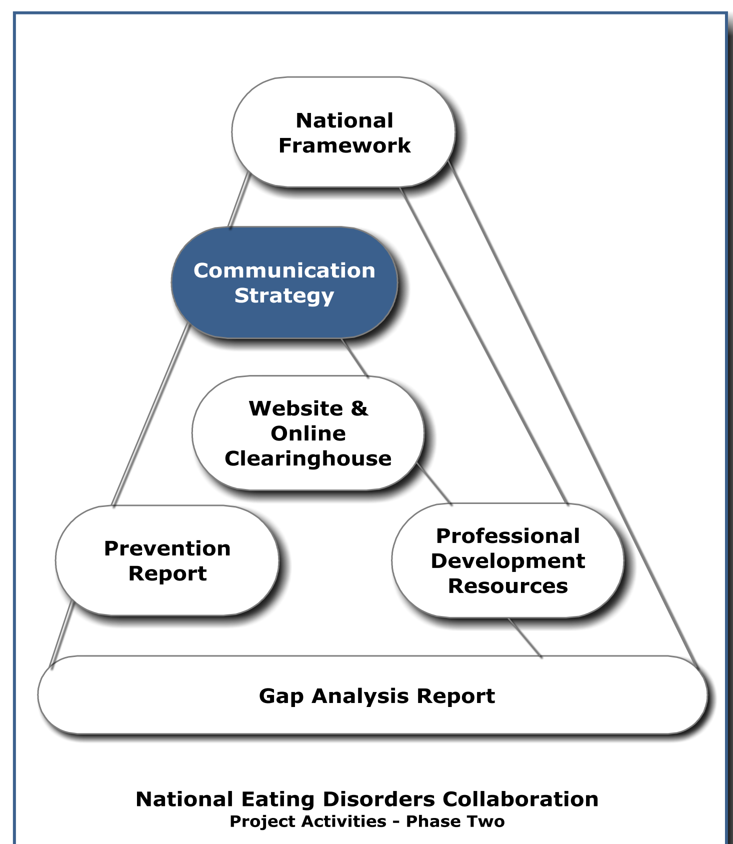
- Provide or facilitate access to helpful, evidence based information to young people and their families on the prevention and management of eating disorders and healthy eating;
- Promote a consistent evidence based national approach to eating disorders
- Develop and assist in implementing a comprehensive national strategy to communicate appropriate evidence based messages to schools, the media and health service providers.

In working towards these objectives, the NEDC is actively pursuing the vision and goals outlined in the first phase of the project:

1. Eating disorders are a priority mainstream health issue in Australia
2. A healthy, diverse and inclusive Australian society acts to prevent eating disorders
3. Every Australian at risk has access to an effective continuum of eating disorders prevention, care and ongoing recovery support.

In addition to developing an inclusive national collaboration, NEDC activities in the second phase include the development of an integrated suite of reports and resources which includes:

- A National Framework and national standards schema
- Prevention and Early Intervention Report
- Gap Analysis Report
- Professional Development activities and resources
- Website and online clearinghouse



The NEDC National Framework (Eating Disorders: The Way Forward, 2010) concluded that a comprehensive communication strategy, integrated with the development of other eating disorder initiatives, is required to achieve

the vision and objectives for addressing eating disorders.

Introduction: Communicating about Eating Disorders

Eating Disorders: A Serious Health Problem for Australia

Eating disorders are serious mental illnesses that do not self-limit and can have potential consequences for the whole of a person's life. Without early intervention, eating disorders may result in significant physical complications, functional disability and an increased risk of mortality.

The risk of premature death is increased for people with all types of eating disorders. The risk of premature death for women with anorexia nervosa is well documented, with estimates of risk at 6-12 times higher than the general population and "much higher" than other psychiatric disorders. Suicide is a major cause of death as well as medical complications.

Eating disorders are estimated to affect approximately 9% of the total population (males and females of all ages) although these estimates do not take into consideration the frequent under-reporting and under-treatment of eating disorders. Estimates of sub-clinical eating disorders suggest that up to 20% of females may be affected. For young females, eating disorders represent the third most common chronic illness and the second leading cause of mental disorder disability.

Research indicates that the prevalence of eating disorder behaviour in Australia is increasing in parallel with the increase in obesity. It is probable that there is a relationship between the increase in concerns about obesity and an increase in extreme weight loss behaviours and body dissatisfaction.

While moderate changes in diet and exercise are safe, extreme dieting practices are associated with significant mental and physical consequences. Dieting and disordered eating are proximal risk factors for the development of eating disorders. They are also associated with other health problems including malnutrition, depression and weight gain. Dieting is common in Australian society in all age groups. Amongst adolescents, half to three quarters of young people express body dissatisfaction and attempt to lose weight, with a high level of engagement in extreme weight loss behaviours such as self induced vomiting.

Eating disorders have traditionally been regarded as illnesses which primarily affect female adolescents. Adolescence is the peak period for onset of eating disorders and the majority of people receiving treatment for eating disorders are girls or women, however, there is evidence which indicates that anyone of any age, cultural background or gender, may experience an eating disorder.

Some of the groups of people at risk in Australian society include:

- **Older women**: eating disorders and disordered eating are emerging as issues for older women, with stressful life changes such as marriage, pregnancy, menopause, and divorce as potential triggers. As many as 25% of people seeking treatment for eating disorders are

women over the age of 30 and eating disorder behaviours have been identified in women in their seventies and eighties.

- **Men**: studies have shown that males may make up approximately 25% of people with anorexia or bulimia and 40% of people with binge eating disorder
- **Athletes**: people engaged in competitive physical activities, including sports, fitness and dance, are at risk of developing body dissatisfaction, disordered eating and eating disorders
- **Young children**: children as young as 6 have been identified as having eating disorders, body dissatisfaction or dietary restraint
- **Pregnant women**: pregnancy can exacerbate eating disorders with unfavourable consequences for the child including a risk of premature birth, growth retardation, congenital abnormalities and higher peri-natal mortality.
- **Migrants**: the stress of migration together with social pressures to conform may contribute to the development of eating disorders in migrant populations

The cost of care is substantial both for individuals and for the community. Early intervention to reduce the duration or severity of illness, associated disability and economic burden is worthwhile.

In practice people with eating disorders often do not seek help, or only seek help after a long period of illness. Analysis of the duration of treatment delay has identified a median of 10 years delay for those with bulimia nervosa and 15 years for those meeting criteria for anorexia. Factors which inhibit help-seeking include the ego-centric nature of the illness, social stigma and difficulties accessing informed professional support.

A whole of community issue

The development of an eating disorder requires a complex interplay of biological, personality and environmental factors. The modifiable risk factors are identified as: body dissatisfaction, extreme weight loss behaviours, low self-esteem, adoption of the socially endorsed thin body ideal as a personal standard, and placement of an undue emphasis on weight and shape in the evaluation of the self and others.

The risk factors for eating disorders intersect with other health issues including obesity, diabetes and depression and are influenced by the same social environments and lifestyle issues. Integrated, coordinated messages targeting both obesity and eating disorders are possible.

The environmental risk factors for eating disorders are endemic to Western culture. It has been suggested that "it is a Western cultural pastime to talk about, think about, and obsess about how our bodies look and what we can do to change them". Mass media play an influential role in promoting these risk factors. Media messages, appearance teasing and conversation ('fat talk'), pressures to achieve, or to compare oneself with, unrealistic body ideals have all been implicated as contributors to the developmental pathway into disordered eating.

When a large population is exposed to a risk factor, preventing exposure to the risk can result in valuable reductions in the burden of associated disease. Small net effects have been identified in eating disorder behaviours and attitudes across a range of different prevention strategies. These

effects may be increased and become more sustainable when prevention is delivered in a context of environmental and social support.

Early intervention is dependent on the capacity of community members, both professionals and lay people, people with symptoms of eating disorders and their supporters, to recognise and act on the health problem.

Prevention requires support for the implementation of evidence based prevention programs at all levels. The long term impact of prevention messages may be strongly influenced by the social environment, therefore to be effective prevention programs should be delivered within a broader context of cultural change. Cultural change requires consistent responses across a wide range of communication channels.

To change risk behaviours and patterns of help-seeking will require:

- A trained and resourced professional workforce, including health professionals and professionals in gatekeeper roles such as teachers, school counsellors and physical activity instructors, who are able to identify and respond to people at risk

- Widespread implementation of evidence based prevention programs

- Extensive community education to develop mental health literacy about eating disorders

- A paradigm shift in the cultural norms that support dieting, appearance comparison and unhealthy weight loss

There is an urgent need to develop integrated prevention initiatives which encourage body esteem, healthy eating and lifestyle behaviours without prompting engagement in fad diets, weight loss attempts and the diet-binge cycle.

Achieving a cultural change of this magnitude will take time. It will also require a committed collaboration across many sectors to ensure consistency of messaging.

This report outlines the basic principles and key messages for safe and effective communication about eating disorders as a framework for future communication action. Implicit within this framework is an invitation to other sectors and organisations to work collaboratively towards integrated communication that supports health and wellbeing for all Australians.

Note: A more detailed discussion of the complexity of eating disorders with references appears in Part B of this report

A Communication Framework for Eating Disorders

This section provides guidance on the objectives, key messages, principles, audiences and channels of communication identified as most appropriate for communication to support eating disorders prevention and early intervention.

Community Awareness of Eating Disorders | 1

Eating Disorders are often poorly understood and underestimated in contemporary society. There are mistaken beliefs that eating disorders are about vanity, a dieting attempt gone wrong, an illness of choice, attention seeking, or a person "going through a phase". Beliefs about eating disorders frequently lead to attitudes of blame. Stewart, Keel and Shiavo (2006) found that people have more negative views of people with anorexia nervosa than of people with schizophrenia, including beliefs that the person with anorexia nervosa is to blame for their condition. Eating disorders are also frequently believed to affect only adolescent girls (NEDC, 2010). These attitudes may contribute to reluctance to seek treatment (Stewart et al, 2006).

While there may be strong dissonance between the community's understanding of eating disorder and that of mental health professionals (Hart et al, 2009) frontline health professionals frequently reflect the dominant ideas of their society. These types of misconceptions affect the responses and explanations sufferers receive when they present for help from frontline health professionals. This may lead to a failure to diagnose or delays in diagnosis. It may also contribute to feelings of shame and reluctance to seek further help (NEDC, 20101).

Consultation with young people (Inspire Digital, 2010) indicated that young people are confused about eating disorder behaviours, recognising the potential for people to be at risk whilst simultaneously accepting body 'obsession' and dieting as normal parts of growing up.

Research indicates that there is a generally low level of mental health literacy in the community (Hart et al, 2009) and general beliefs about mental health will inform community responses to eating disorders.

Extensive community education would be required to develop an appropriate level of understanding of eating disorders, including identification of symptoms, to support prevention and early help-seeking.

Eating Disorders in a Community Context

A person's body image, self esteem and sense of self-worth, is affected by many different aspects of their community environment including school curricula, peer and family relationships (e.g. teasing) (Hart et al, 2009) workplace expectations, sports involvement, and adult attitudes, especially as modelled by family, teachers, sports coaches and youth leaders. It is also affected by wider social factors such as media reporting, entertainment and advertising and cultural stereotypes and stigma (O'Dea, 2005).

People at risk need support from their community and personal network of friends and family in order to engage with prevention strategies prior to the onset of illness and treatment and recovery options and support when illness has occurred. The sphere of influence for each person may include

relatives, friends and frontline professionals such as teachers, sport and fitness coaches and youth workers. Families, carers and supporters need to be educated, supported and included as part of the treatment team.

Individual experience, beliefs and personality are developed and informed by the environmental context of community knowledge and cultural norms. To develop new behaviours that are sustainable in the environmental context, the environment must change before or at the same time as the individual.

A greater level of community education is required to raise the level and accuracy of knowledge and beliefs about eating disorders in order to support prevention, early identification and help seeking (Hart et al, 2009).

Cultural Norms

Western society holds a very thin ideal of beauty for women (Paxton et al 2002) and a highly muscular ideal for men (Russell-Mayhew, 2007; Weltzin et al, 2005). Choate (2005, cited Russell-Mayhew, 2007) suggests that "it is a Western cultural pastime to talk about, think about, and obsess about how our bodies look and what we can do to change them". Most people in Western society are exposed to a culture of dieting, poor nutrition and social comparison with body ideals providing an environment conducive to the development of eating disorders, disordered eating and body dissatisfaction, all of which have negative implications for individual health including weight gain (AED) and depression (Durkin, Paxton & Wertheim, 2005).

Concern over rising weights has seen the introduction of a range of social marketing and school-based interventions (AED) as well as generating a level of popular concern expressed as an interest in issues related to diet and dieting.

The safety and efficacy of interventions to prevent or reduce the incidence of obesity has been questioned. There is a "substantial body of evidence from the eating disorder literature" demonstrating a connection between an emphasis on appearance and weight control and the development of eating disordered behaviours (AED).

In this context, dieting is encouraged and modelled in families, peer groups and the media (Paxton et al 2002). Attitudes and behaviours which are risk factors for the development of eating disorders are now common in society (Russell-Mayhew, 2007).

Media messages, appearance teasing and appearance conversation ('fat talk') are all variables that contribute to body dissatisfaction (Neumark-Sztainer et al., 2006; Richardson & Paxton, 2010). Comparison with images and standards projected by the media have been found to mediate low self esteem and body dissatisfaction for females ((van den Berg, Paxton, Keery, Wall, Guo & Neumark-Sztainer, 2007).Pressures to achieve, or to compare oneself with, unrealistic body ideals have been implicated as one developmental pathway into disordered eating (Becker, 2003).

A Population Health Issue

When a large population is exposed to a risk factor, preventing exposure to the risk factor can result in valuable reductions in the burden of associated disease (Commonwealth Department Health and Aged Care, 2000). Small net effects have been identified in eating disorder behaviours and attitudes across a range of different prevention strategies. Two independent meta-analysis studies, found prevention initiatives to be effective in influencing eating disorder related knowledge, attitudes and behaviours (Fingeret et al, 2006). These effects may be increased and become more sustainable when prevention is delivered in a context of environmental and social support.

Eating disorders are associated with some of the highest rates of mortality of any psychological disorder and, once established, will have long term impacts on a person's physical, mental and social wellbeing. For adolescents and young adults at risk, they represent a significant threat to physical and mental development. Consequently, even quantitatively small preventative effects could be important (Fingeret et al, 2006).

Eating disorders are the result of a complex interplay of biological, psychological, social, and environmental factors at both individual and community levels and prevention approaches must therefore address all modifiable risk factors across this spectrum. This is consistent with the assumptions underpinning a population health promotion approach (Commonwealth Department Health and Aged Care, 2000).

Health promotion combines actions which strengthen individuals and actions which change social environments (Keleher & Armstrong, 2005). Fostering a positive environment is as important to the prevention or amelioration of mental health issues as is strengthening the skills and capabilities of the individual at risk. For eating disorders, positive environments are required to facilitate the implementation and long term effects of more structured evidence-based prevention programs (Becker, 2011).

A positive environment for the prevention and early identification of eating disorders would be one in which the community at all levels from public policy, to organisations, professions and individuals has an understanding of eating disorders as serious and complex mental illnesses and the capacity to support the social and emotional wellbeing of members, respecting and valuing difference. Engaging the whole community starting from engagement of governments in "multilevel public policy initiatives to prevent eating disorders is the key to prevention on a population scale" (Paxton: not yet published).

Communicating for a purpose

2

This communications strategy has two general aims: (1) to change misconceptions about eating disorders and thereby improve treatment seeking and early intervention, and (2) to facilitate prevention of eating disorders by counteracting risk factors in the community.

Communication to change misconceptions

Eating disorders are often poorly understood and underestimated in contemporary society. There are mistaken beliefs that eating disorders are about vanity, a dieting attempt gone wrong, an illness of choice, a cry for attention, or a person "going through a phase". Eating disorders are also frequently believed to affect only adolescent girls. These types of misconceptions are not limited to the general public, but also affect the responses and explanations people receive when they present for professional help, contributing to a failure to identify and treat people with these illnesses (NEDC, 2010).

Communication in public health has the capacity to contribute to early intervention and prevention by:

- Increasing knowledge of health issues and appropriate solutions
- Correcting myths and misconceptions
- Demonstrating the benefits of behaviour change
- Prompting help seeking and individual action
- Facilitating consistency and cooperation across organisations and systems
- Influencing perceptions, beliefs, attitudes and social norms

Early intervention is dependent on the capacity of community members, both professionals and lay people, and people with symptoms of eating disorders and their supporters (Kelly et al, 2007), to recognise the health problem (Commonwealth Department Health and Aged Care, 2000). Lack of mental health literacy has been identified as a significant barrier to help seeking for mental illnesses (Rickwood, Deane & Wilson, 2007) and for eating disorders in particular (Hepworth & Paxton, 2007).

Recognition requires knowledge of the illness and warning signs, plus knowledge of pathways to access appropriate professional intervention. To be willing to act on this knowledge, people must perceive that help-seeking is a positive behaviour and that acknowledgement of a health problem will not incur stigmatisation.

Communication to facilitate prevention

Prevention requires support for the reduction of risk factors for eating disorders (e.g., body dissatisfaction) by use of evidence based prevention messages and programs at all levels from universal to indicated prevention. The long term impact of prevention messages may be strongly

influenced by the social environment, therefore to be most effective prevention programs should be delivered within a broader context of cultural change founded on widespread understanding of risk and protective factors (Commonwealth Department Health and Aged Care, 2000).

Cultural change requires consistent responses across a wide range of communication channels. Western culture is supported and disseminated through mass media and there is a need to counter-balance dominant messages which promote unhealthy behaviours or beliefs.

For all these interventions there is a need for the provision of ongoing training and support for frontline professionals, continuing monitoring, evaluation and research to determine effectiveness of interventions and cross sector partnerships which are inclusive of health, education, family, and community welfare (Commonwealth Department Health and Aged Care, 2000).

Table: Communication Objectives

Communication Objectives	Modifiable Risk & Protective Factors	Communication Actions
1. Support Prevention Programs Influence individual behaviour to prevent the development of high risk behaviours and beliefs	Dieting (see definition on page 16) Body Dissatisfaction and weight concern	• Educate to promote healthy eating and attitudes towards food and body shape • Educate to promote awareness of risks associated with extreme dieting practices • Promote respect for physical diversity • Promote awareness of diversity through media images
2. **Promote Resilience** Provide a supportive environment to enable people to adopt healthy behaviours and resist pressures towards high risk behaviours	Self Esteem and emotion regulation Media Literacy	• Educate to enable analysis of media messages building skills to resist social persuasion • Educate and support the development of self esteem and affect regulation thus strengthening the ability to resist cultural pressures
3. Encourage Help Seeking Eating disorders and risk factors need to be identified at an early stage, to lead to early intervention and reduction in the impact of the illness	Mental health literacy Professional screening, assessment and intervention	• Educate to enable recognition of the warning signs for eating disorders and appropriate responses • Increase awareness of the benefits of early intervention • Provide access to information on self-help, treatment and referral pathways • Inform and resource frontline professionals to enable screening, assessment and early identification of eating disorders
4. Enhance recognition of eating disorders to increase early identification, support and to reduce stigma	Mental health literacy Promote resilience Enable early identification and	• Increase awareness of eating disorders as serious and complex illnesses • Correct dominant myths and misconceptions about eating disorders

	intervention Foster supportive environments	

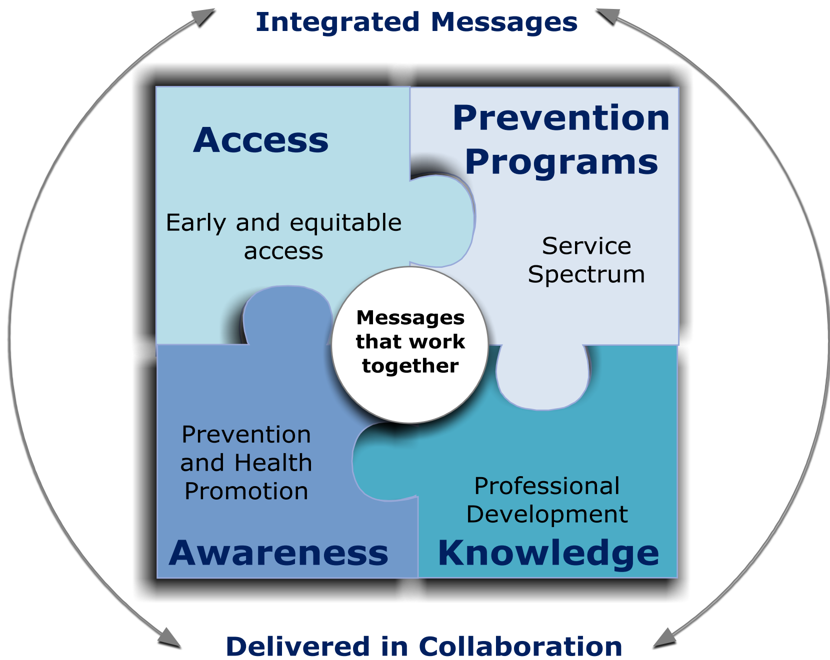
The table above identifies the objectives of communication to support prevention and early intervention for eating disorders, mapped to the targeted risk factors and proposed communication actions. To achieve these objectives, actions will be required in four domains:

Awareness: Communication with the general community and specific sub-groups within the community to raise awareness of eating disorders as serious and complex illnesses, raise awareness of risk factors for eating disorders, and counter-balance dominant cultural messages about weight and body shape.

Professional Knowledge: Communication with health professionals and professionals who influence the health decisions of others, especially young people, to equip them to recognise risk factors for eating disorders, screen and assess for eating disorders and respond appropriately to people seeking help.

Prevention Programs: Communication to support the uptake of evidence based prevention programs; communication to foster environments that support healthy self esteem, mental health, body image and eating behaviours, and media literacy.

Access: Supporting help and information seeking by ensuring that people have access to consistent, evidence based information, and to prevention and early intervention initiatives. Access underpins all other communication actions.



There is an expectation that each of these action domains will interact; for example, successful communication to raise awareness of eating disorders will result in increased demand for access to

information and prevention programs and increased consultation with health and other professionals. Raising awareness therefore can only be successful as a strategy if it is supported by action in the other three domains.

Complexity and Communication

The interface between eating disorders and obesity

The risk factors for eating disorders, and therefore communication about eating disorders, intersect with other health issues including obesity and depression, and are influenced by some of the same social environment and lifestyle issues (Becker, 2011).

Concerns have been raised that obesity prevention initiatives may increase concerns about body shape and weight and prompt unhealthy weight loss activities, particularly amongst children and adolescents. Similar concerns have been raised, that communication which is sensitive to the risk factors for eating disorders may condone obesity (O'Dea, 2005).

There are some documented concerns that educating the community and vulnerable young people in particular, about eating disorders may promote engagement in eating disorder behaviours. This claim of harm is controversial (Wilksch & Wade, 2009), however caution should be exercised in the way in which eating disorders are introduced to vulnerable audiences, avoiding specific details of eating disorder practices, and glamorisation or normalisation of these practices (O'Dea, 2005; Russell-Mayhew, Arthur, & Ewashen, 2007).

Misalignment between public health messages, particularly those related to obesity, eating disorders and body dissatisfaction can undermine the impact of these efforts and generate unintended consequences. Expert knowledge in eating disorders prevention is required to inform the development of public health messages. There is a need for strong cross-sector partnerships to promote a culture of physical, social and emotional wellbeing.

The conclusion, based on a limited number of studies that have examined the impact of 'obesity prevention' communication on risk factors for eating disorders, is that a focus on health rather than weight or shape may be an important step in avoiding harm (Academy of Eating Disorders).

Finding Common Ground

The choice should not be one of prioritizing prevention of obesity or prevention of eating disorders (Becker, 2011). The Academy for Eating Disorders (AED) observed that "obesity and eating disorders are not opposite ends of the same spectrum". Obesity and eating disorders may be viewed as occurring at the same end of a spectrum with healthy beliefs, attitudes, and behaviours at one end, and problematic beliefs, attitudes, and behaviours (and ultimately clinical disorders) at the other end. Among the variety of weight- and eating-related problems, there are some separate and some overlapping protective, risk and maintaining factors.

Integrated, coordinated messages targeting both obesity and eating disorders are possible. Although further research is required, conceptually, this would involve targeting shared risk and protective factors, and avoiding increasing risk of specific problems. There is an urgent need to develop integrated prevention initiatives which encourage body esteem, healthy eating and lifestyle

behaviours without prompting engagement in fad diets, unsustainable weight loss attempts and the diet-binge cycle (Darby et al, 2009; Neumark-Sztainer, 2005; O'Dea, 2005; Russell-Mayhew, 2007).

High risk strategies for people at risk of eating disorders include a focus on weight or shape, even when these are embedded in otherwise helpful communication campaigns. Alternative approaches are already identifiable in current commercial and social marketing strategies. Positive approaches for heart health, obesity prevention and eating disorders focus on themes such as increased energy and enjoyment in life, gaining the ability to 'do the things I've always wanted to do'.

Integrated messages require a shift in focus - from weight or shape to health; from comparison to individual identity and self worth; from negative motivators such as fear of illness or social exclusion to positive motivators of personal wellbeing and achievement. Integrated messages require a holistic view of health that addresses both physical and psychological risk and protective factors.

This is a more complex message than is usual in social marketing. It challenges the approach of standardisation or simplification in order to foster recognition of and support for the individuality of health and wellbeing. Achieving a cultural change of this magnitude will take time. It will also require a committed collaboration across many sectors to ensure consistency of messaging.

The NEDC paper, "Evaluating the risk of harm of weight related to public messages" (NEDC 2011), providing guidance on weight related messages, is available as appendix 4 to this report. The Academy for Eating Disorders Guidelines for Childhood Obesity Prevention Programs (Danielsdottir, Burgard and Oliver-Pyatt) have informed the principles and key messages in this communication strategy and provide a suitable starting place for a collaborative response to both obesity and eating disorders.

Definition: Dieting

In the context of communicating about eating disorders the term "dieting" describes eating behaviours such as a reduction in energy intake below daily requirements, fad dieting, rigid eating patterns and cutting out whole food groups mainly for the purpose of weight loss.

As such, dieting is distinct from healthy eating which includes a variety of foods sufficient to meet daily energy and nutritional requirements, supported by a relaxed attitude to eating that can accommodate flexibility and adaption to eating patterns in response to changing needs.

Key Messages | 4

Key messages to improve eating disorders awareness must address the most common misconceptions about the disorders. These have been summarized as a belief that eating disorders are a lifestyle choice not an illness and that therefore there is no need to intervene or provide support for the person concerned.

Key messages to support prevention must target the most proximal of eating disorder risk factors, which have been identified as shape and weight concern (Wilksch & Wade, 2009). Successful approaches to prevention combine a focus on protective factors, such as self esteem, with specific risk factors such as social pressures regarding weight and appearance (Neumark-Sztainer et al, 2006).

The key messages in this report are intended to provide broad guidance to the essential information to be communicated. The actual wording used in a communication activity would change depending on the context in which the key messages were used.

The key messages identified by the NEDC address both eating disorders awareness and knowledge of risk factors for eating disorders. Key messages for awareness are based on an understanding of the facts and misconceptions about eating disorders. Prevention messages have been identified from Australian research with young people, addressing risk factors such as body dissatisfaction and dieting.

Each message is supported by an outline of content suitable to elaborate upon the key message, and principles and precautions providing guidance on how the messages may be safely and appropriately used in communication.

Communication to Raise Awareness of Eating Disorders	
Promoting Recognition & Help Seeking	
Key Message:	**Key Message Themes**
Eating disorders are serious illnesses, not a lifestyle choice	• ED are complex illnesses affecting both physical and mental health • Of all mental illnesses, eating disorders pose the greatest risk of death in young women. • No one can be blamed for developing an eating disorder. There are genetic, and personality vulnerabilities and social and environmental triggers. Eating disorders are caused by multiple factors – no one factor causes an eating disorder • Eating disorders are severe illnesses and people can't "just stop" their eating disorder A person with an eating disorder is in distress and needs help • Eating disorders are not just about food or weight, vanity, will power or control. They are fuelled by distress, anxiety, stress and cultural pressures • Food and exercise are used as coping mechanisms to help people deal with other issues such as anxiety, depression, or confusion • People with eating disorders require treatment for both mental and physical health: addressing the underlying psychological issues and the impact on physical health • For some people, the process of recovering from an eating disorder can be long, slow and challenging for everyone involved, and requires support from a number of areas • Treatment early in the development of the disorder can reduce the duration and severity of the illness. • There is hope for recovery and improved quality of life at all stages of illness
People from all walks of life may experience an eating disorder	• Eating disorders affect both men and women • People in all age groups can experience eating disorders • People from all cultural backgrounds experience eating disorders • People who engage in particular sports (e.g. gymnastics, athletics, rowing), dancers and models may be at an increased risk of experiencing an eating disorder • People who are experiencing high levels of stress may experience eating disorders • Women going through significant life changes such as pregnancy or menopause may experience eating disorders • People who have other mental illnesses, such as anxiety or depression, may also experience an eating disorder • People who have other physical illnesses, such as diabetes, may also experience an eating disorder
Early intervention is crucial **Acting on the warning signs of eating disorders could save a life**	Information that should be included in communication about the warning signs of eating disorders includes: • There are warning signs of eating disorders. You can be trained to recognise and respond. • You can't judge whether a person has an eating disorder based on their weight, shape or appearance; A person's weight may not indicate how much danger they are in • Restrictive dieting, body dissatisfaction and excessive exercise can be indicative of the development of eating disorders • People at risk of developing an eating disorder may have a problem with food, and/or an intense dislike of their bodies or appearance and/or place a great deal of emphasis on weight and shape and/or display perfectionist traits and/or suffer from low self-esteem • Many people with an eating disorder are reluctant, fearful or ambivalent about

	seeking help and may benefit from the action taken by people in their support network (e.g. parents, family, friends). • When you see the warning signs get help as soon as possible • Early intervention can prevent the development of an eating disorder or reduce the severity of illness • For most people, the earlier help is sought, the more likely they are to recover • Recovery is achievable and worthwhile • We do have effective treatments for many types of eating disorders

Principles for Communicating about Eating Disorders

Principles

Communication about eating disorders should:

- Be developmentally appropriate for the intended audience
- Support understanding of eating disorders as serious, complex illnesses
- Provide accurate, evidence based information which is supported by identification of the source of information e.g. author or publishing organisation, indication of expertise in eating disorders and a publication date
- Respect the experience of people who have eating disorders
- Assist people to make appropriate decisions about help seeking
- Include on-going monitoring and evaluation of the impact on audiences to ensure the continuing safety and appropriateness of content
- Balance representation of males and females, diverse cultures and age groups, unless specifically addressing a single target audience (e.g. teenage boys)
- Communication about eating disorders should always be supported by information about appropriate sources of help
- Be reviewed for ambiguity and possible risk of harm before dissemination.

Precautions

Communication about eating disorders should not:

- Describe details of how to engage in behaviours that are symptomatic of eating disorders (e.g. how to induce vomiting)
- Normalize, glamorise or stigmatize eating disorder behaviours
- Use or provide information on personal measurements in relation to people who have experienced an eating disorder (e.g. weight, body proportions, amount of exercise, number of episodes in hospital)
- Use judgemental, stigmatising or value laden language
- Use objectifying language that detracts from recognition of the personal experience of illness
- Focus exclusively on Anorexia Nervosa without consideration of other eating disorders

Target audiences

- People who have an eating disorder or disordered eating and their support network

  Raising awareness of eating disorders in people who have or are at risk of developing an eating disorder may not improve patterns of help-seeking or contribute to early intervention. The target audiences for awareness of eating disorders are therefore adults in positions of influence, especially over children, young people and family members, including but not limited to families, teachers, physical activity coaches, health professionals and the media

- In general, children under the age of 12 years do not need information on eating disorders. Communication with children should focus on positive behaviours for good health, body image and self esteem and general mental health literacy.

- For young people aged 12 to 25 years, information on eating disorders may contribute to recognition of risk factors in themselves and others and the development of supportive community environments. Information on eating disorders should be supported by information on positive behaviours for good health and self esteem.

Communicating Safe Messages that Support Eating Disorder Prevention

Promoting Resilience	
Key Message: **There is a strong link between dieting and Eating Disorders** **Prevention messages:** **" Skipping meals makes you feel starved so you overeat and feel bad"** **"Don't be fooled by fad diet promotion in the media"**	**Safe messages about dieting and weight loss** Communication and health promotion strategies that include reference to dieting, or weight loss that are safe and relevant for eating disorders prevention will emphasize: • Fad diets are dangerous to health • Dieting, weight dissatisfaction, low mood, unhealthy weight control behaviours, and over-exercising are all associated with the development of eating disorders • Regular use of extreme weight loss strategies may contribute to long term weight gain • Promote and encourage healthy eating, weight management and exercise strategies • Promote the pursuit of personal self-care goals such as addressing diagnosed health problems, and increasing energy and engagement in life. • Promote a flexible approach to food that can be adapted to personal needs and energy requirements as life changes • Promote a calm relationship with food and physical activity, responding to the state of the body, such as hunger, thirst and tiredness (as opposed to rigidly imposed diet or exercise regimes)

Key Message: **Appearance ideals are determined by fashion and constantly change** **Prevention message:** **“Your value doesn’t depend on appearance”** **“Comparing yourself to unrealistic ideals is dangerous”** **“Media images have been altered and are unreal**	• Respect diversity in appearance; environments that recognise and accept diversity contribute to social and emotional wellbeing • ‘Fat talk’ and weight related teasing are unacceptable and can contribute to the development of eating disorders • Self esteem is a protective factor for eating disorders • Body dissatisfaction can lead to unhealthy dieting and depression as well as eating disorders • What we see in the media isn’t real life. Images are chosen and manipulated to show unrealistic ideals
Key Message: **Everyone has a role to play to build a culture that values people for who they are, not for what they look like** **Enhancing protective factors for eating disorders is good for everybody’s health**	• Risk and protective factors for eating disorders occur in everyday life, in the home and family relationships, schools, workplaces, recreational and sport activities, and media and social influences • The way we behave as a society directly affects our mental health, especially for children and young people • Improving mental health literacy for everyone will help to reduce the stigma associated with eating disorders and other illnesses • The media plays an important role in communicating social values. Media promotion of body shape, weight and food as indicators of social success contributes to an unhealthy social environment. • Improving media literacy and awareness will help to challenge and change culture • Groups and organisations in the community have a responsibility to create safe and healthy social environments (e.g. school or workplace culture) • Families can support their loved ones to build a positive body image and develop healthy eating behaviours • Regular family meals, and positive talk about healthy behaviours and personal strengths may help to build resilience • Peers can support their friends to build a positive body image and develop healthy eating behaviours • Fitness, sport and dance instructors influence how people understand their bodies. They have an important role to play in helping people to develop body acceptance and healthy exercise practices. • Acceptance of weight and shape diversity may reduce discrimination and stigma

Principles for Safe Messages to support Eating Disorder Prevention
Principles
Communication and health promotion strategies that focus on issues related to eating disorders (e.g. weight, dieting, exercise, self esteem, mental health literacy) should be evidence based and safe for vulnerable people, including those who may be at risk of developing an eating disorder.

Message content can contribute to the prevention of eating disorders by:

- Promoting healthier and balanced thinking on body image, shape, eating and weight, nutritional and exercise knowledge and behaviours
- Accurately conveying the impact that lifestyle behaviours have on overall health
- Promoting nutrition and physical activity for energy and engagement
- Being delivered from a compassion-centred approach that encourages self-care rather than as prescriptive injunctions
- Respecting individual and cultural diversity including body diversity
- Promoting and encouraging self esteem, body satisfaction, self worth and resilience
- Enabling critical evaluation of media messages on the thin body ideal, 'healthy' behaviour and the nature of success
- Challenging stereotypes and stigmatisation
- Promoting community responsibility for safe, healthy social environments
- Promoting the development of policies and practices to support safe social environments (e.g. school policies on issues such as bullying or recording student weights)
- Promoting cultural change (e.g. by promoting change in media representation of body appearance, weight and health issues)

Precautions

All messages should be reviewed and monitored for safety and efficacy for vulnerable audiences including:

- People who have or are at risk of developing an eating disorder
- People who are obese or are at risk of developing obesity
- People with health issues that may increase their risk of developing an eating disorder or obesity (e.g. diabetes)
- Children and young people

Communications about health that relate to weight, diet, exercise, or body image should avoid the use of:

- Directive words or rigid rules (e.g. do's and don'ts; "never" and "always")
- Appearance language to address weight issues (e.g. "thin" or "fat")
- Labelling foods or food groups as 'good' or 'bad'
- Attributing virtues (such as success, popularity, intelligence) to people based on their appearance or weight
- Use of images of extreme body weights or shapes
- Use of language or images that ridicule or stereotype people based on their appearance
- Measurement:
  - Avoid the use of personal physical measurements such as weight, waist measurements etc
  - Avoid the use of prescriptive or competitive targets for physical activity

Target Audiences

Ideally, prevention messages need to reach their audience before the establishment of high risk behaviours or early signs of eating disorder. A critical period for intervention is the age group 10 to 14 years.

Messages communicated to young people should always be communicated to adults in their sphere of influence as well to ensure a consistent and supportive environment. People in spheres of influence include, but are not limited to: Families, Teachers, School Counsellors, Youth Workers, Physical activity instructors, GP's

When designing key messages for other communication campaigns that could impact on people at risk of developing eating disorders, the following guidelines should be taken into consideration. Messages should:

- Seek to change the beliefs that lead to stigma
- Be constructed from a holistic perspective, where consideration is given to physical, emotional, social, occupational, intellectual, spiritual, and ecological aspects of health
- Promote self-esteem, body satisfaction, and respect for body size diversity;
- Accurately convey the impact that lifestyle behaviours have on overall health outcomes
- Focus on modifiable behaviours where there is evidence that such modification will improve health e.g. weight is not a behaviour and therefore not an appropriate target for behaviour modification
- Be delivered from a compassion-centred approach that encourages self-care rather than as prescriptive injunctions to meet expert guidelines (Bacon & Aphramor, 2011)
- Be developmentally appropriate, both in terms of dealing with issues that are relevant to the particular age group and in terms of cognitive capacity (Paxton, Wertheim, Pilawski, Durkin, & Holt, 2002)
- Be evidence based, clearly identifying the source of information
- The impact of messages should be considered within an appropriate ethical framework.

Evaluating the Safety of Communication Campaigns

New advertising addressing the topics of general health, weight and body shape appears in the mass media on a regular basis. The following table summarizes the key principles for the development of messages which are safe for all audiences. It is intended to provide an initial checklist to identify the risks associated with a proposed or existing campaign, before a more detailed analysis is initiated.

Risk	Or	Protection
Focus on weight or shape The campaign focuses on weight or body shape as the key issue and target for change. Images show tape measures, scales, or extreme physical shapes. The words 'weight' or 'shape' are a prominent part of the message.	→	**Focus on good health** The campaign takes a holistic view of health, promoting physical, social and emotional wellbeing.
Stereotypical images Images portray 'Western cultural ideals' e.g. thin women; muscular men; nuclear two parent families; blond fair skinned people. Images are manipulated to portray 'perfection'.	→	**Healthy diversity** Images portray a range of real people of different appearances including ethnic difference; range of healthy body images; male and female images; different age groups.
Measurement The campaign encourages people to assess their health through measurement of physical dimensions (such as waist measurement or weight) or encourages a focus on measurement of calorie intake or hours of exercise.	→	**Personal achievement** The campaign encourages people to engage in healthy eating and exercise to achieve personal goals that relate to doing things that the person wants to do in their lives, or experiencing positive feelings.
Rules The campaign promotes simplistic rules that everyone must follow e.g. labels foods as 'good' or 'bad'	→	**Informed choices** The campaign provides evidence based information to help people make healthy individual choices about food, exercise, and help seeking.

Fear/stigma	→	**Self worth**
The campaign motivates people to act based on fear of illness or social exclusion. The campaign attributes success or popularity to people based on their weight or appearance.		The campaign promotes self esteem and encourages change based on self-worth

Target audiences

for early intervention and prevention messages

Communication to support prevention and early intervention for eating disorders should target people who are at risk and those in positions of influence for people at risk including families, health professionals, educators, physical activity instructors and the media.

Eating Disorders in Adolescence

Mental disorders often arise for the first time in adolescents or young adults (Kelly et al 2007).
The peak period for the onset of eating disorders is between the ages of 12 and 25 years. For anorexia, the average age of onset is around 17 years, with some data indicating bimodal peak onset at 12 to 14 years and 17 to 18 years. Individuals with bulimia tend to develop the illness at a later stage, around 16 to 18 years. Binge Eating Disorder appears to have an average onset in early adulthood (NEDC, 2010).

This is a period in which the body and brain undergo significant changes. It is also a period of emotional adjustment; identity formation and significant behavioural change. Adolescents are particularly prone to risk-taking behaviour, with potentially injurious consequences for physical health and mental development (Government Office for Science, 2008).

Heightened self-awareness during youth makes adolescents more vulnerable to self-doubt and unfavourable social comparison. Socio-cultural pressures related to appearance and success that activate feelings of inadequacy make identify formation and self-acceptance a difficult task (Shure et al, 2011).

The stresses associated with transition from primary to secondary school, the increasing reliance on peer and social relationships, together with brain development and increases in negative urgency (Pearson et al, 2010) contribute to making this period important for the prevention of and intervention for eating disorders.

Without the protective factors and environmental supports necessary to successfully negotiate the pressures of adolescence, young people are at risk of developing mental health issues (Shure et al, 2011.) Disordered eating behaviours are mental illnesses that may result from both risk taking behaviour and the struggle for identity formation in a stressful environment.

A broad demographic

Eating disorders have traditionally been regarded as illnesses which primarily affect adolescents and in particular, girls and young women. While the majority of people receiving treatment for eating disorders are female there is evidence which indicates that anyone of any age, cultural background or gender, may experience an eating disorder.

Men and Eating Disorders

Current research statistics suggest one in ten people experiencing anorexia nervosa and bulimia nervosa is male, while EDNOS are somewhat more prevalent in men and rates of binge eating disorder in men may be as high as 4 in ten (Weltzin et al, 2005). An increasing rate of men with eating disorders is being observed in a number of European countries (Nunez-Navarro et al, 2011) and a national study of eating disorders in the US found that men made up 25% of people with anorexia or bulimia and 40% of people with binge eating disorder (Hudson et al., 2007)

There is an increase in reports of body dissatisfaction and eating problems in young males including the use of weight control and weight gain behaviours that may be injurious to their health (O'Dea, 2005). Studies have found that up to 50% of boys want to change the size of their body (Weltzin et al, 2005). Eating disorder symptoms were found in a study of boys aged under ten years, with 10% reporting binge eating and 4.2% reporting self-induced vomiting (Pearson et al, 2010).

Older Women with Eating Disorders

Eating disorders and disordered eating are emerging as issues for older women, with stressful life changes such as marriage, pregnancy, menopause, and divorce being potential triggers (Pereira & Alvarenga, 2007).

There is a growing awareness that maladaptive eating attitudes and behaviours are common in older women. Eating disorder symptoms are present in middle to older age women and are similar in severity to those of younger individuals. The estimated point prevalence rate for clinical eating disorders in women over 45 years is 4.5% (Keel et al 2009). A study of women aged 60 to 70 years found that 80% were trying to control their weight, 3.8% met criteria for an eating disorder and 4.4% reported a single episode of eating disorder (Mangweth-Matzek et al, 2006). Similarly, a study of 200 women aged 35-65 years identified that 17% probably had an eating disorder (McLean et al, 2009). Levels of bulimia nervosa have been found to be similar for women over 45 years to those in younger women (Procopio, Holm-Denoma, Gordon & Joiner 2006).

In a review of 48 cases of women over the age of 50 with eating disorders, over half of whom were older than 65 years, anorexia nervosa was the most frequent disorder (81%) and bulimia nervosa (10%). Of these 48 cases, 20% died from eating disorder complications (Lapid et al, 2010).

A study in Western Australia found that 25% of patients from a sample of consecutive referrals experienced late onset of an eating disorder, aged 30 years or over. No significant differences were found between the experiences of women presenting at an older age and those with early presentation (Fursland et al, 2010).

Athletes and Eating Disorders

People engaged in competitive physical activities, including sports, fitness and dance, are at risk of developing body dissatisfaction, disordered eating and eating disorders. Participation in sport has been identified as a risk factor for males, with a Norwegian study finding that rates of eating disorders are twice as high amongst male athletes as amongst the general population (Weltzin et al, 2005).

The pursuit of 'optimal' fitness and body shape for sport or dance has been identified as a factor in the development of eating disorders in females. Three inter-related medical conditions of disordered eating, amenorrhea and osteoporosis have been called 'the female athlete triad' in recognition of the frequency with which these conditions are diagnosed in female athletes by comparison with the general population (Rocci, 2002).

For both male and female athletes, eating disorders and disordered eating may occur in people who are regarded by society as being extremely fit and healthy.

Eating Disorders, Pregnancy and Early Childhood

Pregnant women and mothers of young children are identified as a target audience for two reasons. Firstly, the physical changes that occur during and post pregnancy may trigger disordered eating or eating disorders, especially for women who may have experienced episodes of illness earlier in life. Secondly, mothers play an important role in modelling healthy eating and body satisfaction and their behaviours and attitudes will provide a foundation for the subsequent development of self esteem and mental wellbeing in their children.

The physical and emotional changes that occur in pregnancy and postpartum challenge the thinking and behaviours associated with eating disorders. For some women, the motivation to protect the child contributes to symptom reduction or remission, however for some women, pregnancy exacerbates their eating disorder. Fear of weight gain is frequently identified as a trigger for the increasing intensity in eating disorder symptoms. These women have been shown to give birth to smaller infants (Newton & Chizawsky, 2006).

Unfavourable outcomes have been found for infants of women with sub-threshold anorexia nervosa or bulimia nervosa, including growth retardation, low birth weight, increased incidence of congenital anomalies, increased risk of premature birth and higher peri-natal mortality. The use of laxatives and diuretics in purging behaviour has been implicated in the development of cancers in the fetus (Newton & Chizawsky, 2006).

The health and development experiences of infants and young children play a part in determining whether mental illnesses will develop later in life (Robinson et al, 2008). The development of risk factors for eating disorders in early childhood may be influenced by genetic factors, early health trauma and behaviours role modelled by the parent.

Given the potential severity of risk to the both mother and fetus, Newton and Chizawsky (2006) recommend screening for eating disorders as a routine part of obstetrical assessments.

Younger Children and Eating Disorders

Body dissatisfaction and dietary restraint have been identified in girls as young as 6 years of age (Wade et al, 2003).

Recent research in the UK identified that eating disorders affect about 3 in every 100,000 children under the age of 13. Of the 208 cases of confirmed early onset eating disorders examined in this

study, 37% of the children were diagnosed with anorexia nervosa, 43% were classified as having an eating disorder not otherwise specified and 19% had symptoms of disordered eating, such as food avoidance and being underweight (Nicholls, Lynn & Viner, 2011). A study of early onset eating disorders (EOED) in 5-13 year olds in Australia concluded that it is imperative that attention should be directed at understanding why such young children are developing severe eating disorders (Madden et al, 2009).

Eating Disorders in Migrant Populations

Eating disorders and disordered eating are less common in non-Western societies, yet they are increasingly being reported in a wide global distribution (Becker, 2003). There are also limited studies demonstrating that migrant populations in Western societies may be at increased risk of developing eating disorders (Bhurga & Jones, 2001).

The stress of migration, cultural identity and the social 'fit' within the new host culture have all been suggested as contributors to the development of mental illness in migrants (Becker, 2003). Social isolation and stress, together with potential dissonance between ethnic appearances, cultural values of the country of origin and the Western ideals for appearance and success may contribute to the development of eating disorders or disordered eating.

Meeting Information Needs | 6

Children, young people, families and individuals

Children

Experiences throughout childhood and adolescence provide the platform for later mental health (Commonwealth Department Health and Aged Care, 2000). Beliefs, attitudes and behaviours that influence self esteem, eating and general physical health are established at an early age. There are opportunities to target young children and their families with messages to promote health and reduce the development of risk factors.

Young People

The peak onset period for eating disorders is typically mid to late adolescence (Wilksch & Wade) with a median age of onset at around 18 years (Hart et al, 2009). Prevention messages should ideally reach their audience before the establishments of risk factors or early signs of disorder (Paxton, Wertheim, Pilawski, Durkin, & Holt, 2002). Research on prevention of eating disorders identifies early adolescence (approximately ages 10 to 14) as a critical period for the initiation of prevention efforts (Shure et al, 2011).

Young people aged 10 to 14 may benefit from prevention messages which support self esteem and self determination, target perfectionism, thin-ideal internalisation and educate about media literacy and socio-cultural pressures (Wilksch & Wade, 2009).

Prevention programs targeting college aged young adults tend to demonstrate stronger effects than universal approaches for younger groups as participants are already engaging in, and potentially experiencing the health consequences of, high risk behaviours (Wilksch & Wade).

Tailoring messages to meet the needs of young people

Education approaches are most successful when messages are specifically tailored to meet the needs and preferences of relatively homogenous groups (Kelly et al, 2007). The way in which young people respond to messages will vary with age, gender, personal interests and exposure to risk factors. The preferred style of messages may be very different for adults, young adults and adolescents (Kelly et al 2007), for males and females, for people in specific interest groups such as athletes.

The perceptions and needs of young people who have a high risk of developing an eating disorder may be different to the needs of young people in general. For example, girls demonstrating high levels of body dissatisfaction and dieting behaviour may perceive messages about the risks of dieting as less believable than girls who do not have these risk factors (Durkin, Paxton & Wertheim, 2005).

The selection of prevention programs and communication messages should take into consideration the audience's developmental stage and exposure to risk factors for eating disorders (Wilksch & Wade).

Raising Awareness of Eating Disorders for Children and Young People

In general, children under the age of 12 years do not need information on eating disorders. Communication with children should focus on positive behaviours for good health, body image and self esteem and general mental health literacy.

For young people aged 15 to 25 years, information on eating disorders may contribute to recognition of risk factors in themselves and others and the development of supportive community environments. Information on eating disorders should be supported by information on positive behaviours for good health and self esteem. Wilksch and Wade (2009) suggest that programs targeting universal populations younger than 15 years of age should avoid discussion of disordered eating behaviours.

Appropriate target audiences for awareness of eating disorders are adults, including young adults.

Young adults are more likely to seek help, or encourage peers to seek help, when they recognise mental health problems and have the knowledge, skills and encouragement to seek help. Lack of recognition of mental health problems among young people is a major barrier to help seeking (Rickwood, Deane & Wilson, 2007).

7-10 Years
Primary School

In general, children under the age of 12 years do not need information on eating disorders. Communication with children should focus on positive behaviours

In school prevention programs focus on:

- Good health
- Body image and self esteem
- General mental health literacy.

10-14 Years
Middle School

Transitional years of puberty are a critical period for intervention.
In school prevention programs focus on:

- Self esteem
- Perfectionism
- Media literacy and 'ideal body shape' internalization
- Healthy eating
- Risks of dieting
- " Natural changes and variations in body shape
- " Standing up to peer pressure
- " Building a peer environment that supports positive body image

15-18 Years
High School & Tertiary

For young people aged 15 to 25 years, information on eating disorders may contribute to recognition of risk factors in themselves and others and the development of supportive community environments.

This age group may be at higher risk, having already engaged in disordered eating behaviours. Messages should be tailored to meet the needs of high risk audiences.

Messages should include ways to challenge the thin ideal

18-25 Years
Tertiary & Employment

As for 15-18 year olds, this group may be at higher risk and require specifically targeted messages to address established risk behaviours.

Awareness of eating disorders is required to enable peer and partner support.

Messages may target specific occupations and interest groups at higher risk including athletes, entertainment industry, and employers of young people.

Raising Awareness of Eating Disorders with Families

Families are the first source of influence on the development of attitudes, beliefs and behaviours in children and young people, and the preferred source for information and help. In 2010, Mission Australia's annual *Youth Survey* revealed that young people place great emphasis on the importance of family relationships. Friends and family are often consulted first when health issues arise and therefore have a significant role in facilitating prevention and early intervention (Rickwood, Deane & Wilson, 2007).

In this context, families are understood to include parents, adult siblings, partners, grandparents, aunts, uncles, and non-related carers or mentors; in other words, all of the adults in a personal rather than professional relationship with a person at risk who may be influential in that person's life. A broad definition of family ensures that older adults who may have their own issues with disordered eating, body dissatisfaction or eating disorders are potentially influenced by eating disorders messages.

Families need an accurate understanding of eating disorders and risk factors to enable them to recognise potential risks and address these at the earliest opportunity. Hart and colleagues (2009) concluded that extensive community education is required to assist families (including parents, siblings and partners) to identify symptoms and to encourage help seeking.

Families may benefit from parenting guidance on issues such as the value of shared family mealtimes, family conversation and the avoidance of weight or shape related teasing together with help for parents to teach healthy eating patterns from a young age.

Families also need to receive prevention messages to address their own internalisation of dominant cultural messages. Some parents will be struggling with body dissatisfaction and dieting issues of their own and these must be addressed to enable the parent to role model appropriate behaviour for the young person and to enhance recognition of risk.

Pregnant women and mothers of very young children require information that will enable them to protect their own health and that of their children. Both prevention messages and eating disorder awareness messages are appropriate for this audience.

Communicating with individual adults

Given the prevalence of eating disorders in both men and women, communication to support prevention and early intervention must broadly target all adults firstly for the protection of their own health and secondly because of the influence they have on the social environment and the attitudes and beliefs of children and young people. Communication should not be limited to people living in families with children.

Young People outside the School System and Homeless Youth

Many young people at high risk of mental health problems do not have links to work, school, or supportive family. These young people may have contact with Out of Home Care services, Supported Accommodation Programs or Youth Programs. For these young people, community service workers, including social workers, youth workers and foster carers may take on the role of family as role models and advisors (Rickwood, Deane & Wilson, 2007).

These organisations and professional groups should be included in the target audiences for individual communication as well as in professional and organisational communication strategies.

Awareness and Prevention Messages for Specific Interest Groups

Young people and young adults who are engaged in interests or occupations identified as high risk environments for the development of eating disorders will require messages that target the specific issues and concerns of those environments.

For example, young men and women who compete in sports with specific body ideals will require information on exercise and nutrition that fit with their chosen activity, rather than general messages about dieting.

People engaged in athletic activities, including sports, dance and fitness, may consider disordered eating practices or excessive exercise to be part of a necessary pathway to achieve their optimal health and fitness level. The most effective communication approach will provide education that enables people to engage in their chosen activities in a healthy way (Rocci, 2002).

Meeting information needs

Professional and Organisational Audiences

Frontline professionals

One of the most helpful methods towards treatment and recovery is to talk with people who understand the illness (Patching & Lawler, 2009). People who receive unhelpful advice or judgemental attitudes at first contact may fail to seek further treatment.

A number of professionals work in relationship to people at risk of developing eating disorders, including young people. These professionals are well placed to identify warning signs and provide information and support for help seeking (Russell-Mayhew, 2007). . Their advice may be influential in determining the behavioural and help-seeking choices of young people.

Professions that may influence both the development of risk factors for eating disorders and the development of protective factors and help seeking include:

- Teachers
- School Counsellors
- Physical activity instructors (e.g. sport, dance, fitness)
- Youth workers
- General Practitioners

Frontline professionals require information and resources that will enable them to recognise eating disorders, screen people who are potentially at risk, and provide appropriate supportive responses including immediate advice and referral if required. Professional resources include access to training, screening tools, practice guidelines appropriate to each profession and information on appropriate engagement strategies to promote discussion and support for help seeking with people at risk.

As members of the general community, frontline professionals also need to hear general messages about eating disorders and risk factors that can dispel misconceptions and help people to address their own internalisation of dominant cultural norms and myths.

General Practitioners

General practitioners are uniquely placed to recognise and respond to the early symptoms of eating disorders (Yeo & Hughes, 2011). General practice is often the first point of contact for families and people at risk. In many instances, people may present for medical problems and this provides an opportunity to investigate mental health issues. There is a need to support GPs to recognise mental health problems, including eating disorders, by providing access to training, screening tools and information on treatment pathways (Rickwood, Deane & Wilson, 2007).

Soft entry points to the health system

Some young people prefer to access health information or services through youth-friendly clinics and outreach programs. Headspace centres are an example of these soft entry points to the health system. Staff within these services need information and training to support recognition, screening, assessment and referral for people with eating disorder symptoms, as well as enabling a depth of understanding of the nature of the illnesses and how to respond to people at risk.

Printed resource materials on eating disorders, disordered eating and body dissatisfaction could also usefully be provided through clinics and youth health programs.

Other Health Professionals

Given the frequent co-morbidity of eating disorders with other mental and physical illnesses and the reluctance to seek treatment for eating disorders displayed by many people at risk, the first point of contact may frequently be a specialist in another health field. The following health professionals have been identified as people who need to be aware of eating disorders and to be equipped to screen patients for eating disorder symptoms:

- Diabetes educators
- Gynaecologists, obstetricians and midwives
- Sports medicine specialists
- Dentists
- Dietitians

Darby and colleagues (2009) conclude that all professionals involved in treating obesity or eating disorders must gain an understanding of each condition in order to identify people presenting with eating disorders who also experience obesity, and people presenting with obesity as a health issue who also have symptoms of eating disorders.

Eating disorders frequently co-occur with other mental illnesses such as anxiety and depression. Psychologists and counsellors in general practice also require professional knowledge of eating disorders.

The role of schools

Schools have been a focus of attention for prevention initiatives, given the peak period of onset for eating disorders in early to mid adolescence (Wade et al, 2003). Schools provide an opportunistic setting enabling communication to simultaneously reach young people, their peers and families in an environment that supports long-term educative approaches.

'Whole of school' approaches may be required to ensure uptake of prevention programs and support the messages delivered in prevention programs. All school staff require access to information on the development of safe environments that are free from weight or appearance related bullying, and enhance mental health and wellbeing.

Within schools, school counsellors, and other welfare and pastoral care staff have a major role in recognising mental health problems and referring young people to appropriate services (Rickwood, Deane & Wilson, 2007). These frontline professionals require training and resources to support the early identification of eating disorders in students.

Communicating with the Media to influence the Community

The media is a major source of information and a powerful influence on public opinion, mediating public understanding of health and social issues (Commonwealth Department Health and Aged Care, 2000). The media has a major role to play in community education regarding eating disorders and could be a powerful tool for strengthening community capacity to make good health decisions and create supportive environments for people at risk (Keleher & Armstrong, 2005).

The media, here defined as the combined activities of journalism, entertainment and advertising, are the primary conduit for prevention and health promotion messages. These messages are delivered within a context that supports cultural norms and the interplay of the two types of message will impact on the effectiveness of media campaigns within social marketing strategies.

Young people are particularly vulnerable to cultural influences from the media. In the stress, self-appraisal and social comparison associated with the changes that occur in adolescence, young people seek the certainty of cultural standards as expressed in the media (Shure et al 2011). People of all ages tend to prefer that which is known and familiar and this also contributes to the desire to achieve appearance standards set by frequently viewed images (Winkleman et al 2006).

Media advocacy, influencing the media's selection and representation of issues and images, is a necessary first step in communicating eating disorder awareness and prevention messages to the community.

To change cultural norms related to appearance and dieting would require a change in standards and practices across the three areas of media, and across both word and visual representation of appearance. Because of the broad range of activity within the media, and by the internal influencers on each media outlets behaviour, it will be necessary to work closely with all groups within the media to educate, raise awareness and to improve reporting of eating disorders.

The Mindframe National Media Initiative (www.mindframe-media.info) provides easily accessible information resources for the media much of which is directly relevant to eating disorders and is a suitable vehicle for engagement with media professionals including journalists, editorial personnel, and scriptwriters. However, current information provided on eating disorders is not entirely consistent with the interpretation of evidence by the eating disorders sector and these resources would require review and integration of eating disorder key messages.

Images and the fashion industry are currently outside the scope of Mindframe and would need to be engaged as a separate initiative. The fashion industry, advertising and fashion magazines all communicate with each other and are linked in their approaches. The influence of the industry will flow into advertising styles and body image presented in magazines. Influencing the advertising sector may also require changes to the Advertising Standards with particular reference to their role in presenting messages and images associated with body image.

There may also need to be additional strategies to target specific entertainment genres such as TV shows about weight, popular success and the fashion industry.

Summary of Audience Needs

Awareness & Prevention Messages	Audience
Awareness of Key Messages	Community – all audiences
Eating Disorder Mental Health Literacy	Families, young adults, frontline professionals
Family Guidelines	Families including pregnant women, partners and older adults
Specialist fact sheets and guidelines for specific sports and occupations	Physical activity instructors, employers
Media Literacy	Community – all audiences
Health resources: • Training: screening, assessment, early intervention • Clinical Guidelines • Screening Tools • Referral Pathways • Strategies to engage and respond to people at risk	General Practitioners Youth Health Centres Psychologists Counsellors Dentists Nurses Dietitians
Gatekeeper resources: • Training • Warning Signs • Strategies to engage and respond to people at risk	School Counsellors Teachers Youth Workers Social Workers
Prevention Programs • Self Esteem • Media Literacy • Mental Health Literacy • Perfectionism • Body Image • Healthy Lifestyles	Children, youth and young adults, with programs selected for developmental stage and level of risk for eating disorders

Access to information | 8

the selection of channels of communication

Social Marketing – Media Campaigns

There is evidence that mass media campaigns designed to reach the general public can achieve positive outcomes in terms of mental health literacy. Research also indicates that campaigns are particularly effective when they involve more than one form of media, and include community-based components and/or direct interventions (Centre for Health program Evaluation, 2002).

The social marketing aim is therefore to act as a catalyst for a societal shift in attitudes and behaviours. Rather than merely telling people what to do through an education campaign, an effective social marketing approach would motivate people to participate in a supportive social movement designed to make lives healthier. This interactive as opposed to didactic approach is consistent with research evidence on the most effective approaches for the delivery of prevention programs (Jacobi et al, 2004).

The NEDC is not aware of any evidence based national population health project that has specifically attempted to prevent eating disorders. In seeking to address the prevention of eating disorders on an organised national basis, Australia is taking a leadership role and generation of evidence through exploratory activity will be a key component of any communication strategy.

There have been a number of projects internationally which have worked to raise eating disorders awareness. These projects typically create social events as a vehicle for public education on eating disorders. The strategy has not been evaluated as a prevention approach. Examples of this educative approach include Body Image and Eating Disorder Awareness Week and International No Diet Day.

There have been a number of social marketing strategies addressing the issue of body image. This approach has proved popular, successfully generating discussion, particularly in the media. At this point, there is no clear evidence of a relationship to eating disorders prevention although the approaches are strongly supported by leading experts in the eating disorders prevention field.

Further market research is required to assess the viability of a media campaign as part of an eating disorders awareness communication strategy.

Internet

The Internet has been identified as a useful primary source of information on health issues. Young people are avid users of the Internet and are willing to use the Internet a source of health information (Australian Communications and Media Authority, 2008; Inspire Digital, 2010; Rickwood, Deane & Wilson, 2007). The Internet has also been identified as a useful source of information for people in rural areas who may not have ready access to face to face services, and for busy health professionals who may access information or resources after business hours.

However, there is already extensive information available on the Internet about eating disorders, dieting and body image. A simple Google search for the term 'eating disorders' identifies 21,700,000 results, many of which are sites which support engagement in disordered eating behaviours and eating disorders.

Most approaches to eating disorders awareness have used the internet as a primary source of information and hub for organisation of awareness building activities, including the use of blogs and e-newsletters. The number of different internet based sources of information may cause confusion for some people.

To be effective, information to raise awareness of eating disorders and contribute to prevention that is made available on the Internet should be:

- Evidence based, developed by people with expertise in eating disorders, clearly identifying the source of information and publication date
- Endorsed by a reputable authority such as the Department of Health and Ageing or the National Eating Disorders Collaboration
- Interactive content, such as chat rooms, blogs and noticeboards should be professionally moderated
- Regularly monitored and evaluated

Due to the vulnerabilities of young people and the difficulties in controlling other forms of social media, further investigation is required before these are used extensively to communicate about eating disorders.

Stories of Recovery: the use of Personal Stories in Communication Campaigns

Stories from experience can have a powerful role to play in raising awareness and demystifying illness. Evidence suggests that people relate to issues of mental illness most readily when they are presented as an understandable response to circumstances rather than as a disease state (Queensland Alliance).

A review of the effective components of anti-stigma programs targeting young people identified that contact with a consumer helped to overcome misconceptions (Kelly et al, 2007). Feedback from people with experience of eating disorders indicates that hearing stories of real experiences can be helpful in motivating people to seek help and persist towards recovery (Evidence from Experience Report, 2011).

However, care must be taken in promoting information about eating disorders in order to ensure positive outcomes. Inappropriate content in eating disorder promotion and prevention initiatives can potentially increase disordered eating or eating disorder risk factors in recipient audiences (NEDC, 2010a).

Safe, effective stories illustrate the core themes of the communications strategy:

- Eating disorders are serious and complex mental and physical illnesses
- Eating disorders affect people of all ages and in all walks of life
- Prevention and early intervention are vitally important and achievable

- Effective, evidence based treatment and support strategies are available that can make a real difference in people's lives
- Recovery is desirable and achievable

The safety of people who share their stories and the people who read or hear them is the first priority. The content of proposed publications must be reviewed for 'risk of harm'. Highly sensitive information (e.g., abuse) and specific details of eating disorder behaviours should not be included.

Stories that will be shared with the general public should not contain specific details of how a person engaged in eating disorder behaviours. There is a risk that this information may encourage other vulnerable people to try these behaviours for themselves.

Stories should avoid the use of measurements or other quantifiable details (e.g. Weight, BMI, number of admissions to hospital, number of hours of exercise or number of repetitions of exercise, calorie intake etc.). People who have or are at risk of eating disorders can be quite competitive and inclusion of this information may suggest targets for other people to try to achieve.

Everyone's experience of eating disorders is different. Personal stories should not attempt to represent definite answers on what causes eating disorders or recommend one type of treatment over others as the right approach. If the purpose of the story requires reference to the causes of eating disorders or treatment for eating disorders, this information should be supported by references to evidence based research or expert opinion.

Stories which are specifically collected for the purpose of training health professionals and eating disorder support workers may include specific details of eating disorder behaviours. The criteria for publishing these stories should clearly identify restrictions on their use outside the learning context.

To reduce the risk of harm, all publication strategies should be monitored on an on-going basis and adapted as issues are identified. All publication should include contact details for support services, including helpline telephone numbers.

For further information on ethical guidelines for the collection and publication of personal stories, refer to Appendix 5.

Collaboration as a channel of communication

Collaboration with government health promotion services and existing providers of information about mental health and eating disorders will provide an efficient and cost effective approach to the integration of eating disorders key messages into health promotion initiatives, ensuring the consistency, reach, accessibility and impact of messages.

To be effective, information on eating disorders must be consistent, evidence based, motivating behaviour change and help-seeking and linked to sources of further information or assistance.

A number of projects and organisations, particularly those addressing mental health issues, already promote information about eating disorders. Written at different times and from different perspectives, the information provided about eating disorders is somewhat different from each provider. Few sources of information outside the eating disorders sector provide evidence informed messages to motivate people to change behaviour or seek help.

There is therefore a need to review and align the information on eating disorders provided by different credible organisations, especially for those resources available from the Internet. An endorsement process is desirable that would readily identify for audiences information and resources that is safe, appropriate and evidence based.

Several mental health initiatives, such as MindMatters, and KidsMatter, provide in-school prevention programs of a general nature that target risk factors shared between eating disorders and other mental illnesses.

MindMatters uses a whole-school approach to mental health promotion which supports the development of safe environments in which young people feel safe and valued and are enabled to develop the social and emotional skills required for resilience. This approach targets identified protective factors for eating disorders and is consistent with the aim of creating supportive environments for the implementation of eating disorders prevention initiatives.

KidsMatter, an Australian Primary Schools Mental Health Initiative, provides information resources for school staff and parents to support the development of a positive school environment and social and emotional learning for students. Resources for parents and teachers on helping children with mental health difficulties include resources on anxiety which is a correlate of eating disorders but do not specifically address young children's concerns regarding body dissatisfaction or problem eating. There is scope to review the resources of KidsMatter to identify opportunities to strengthen information content for the prevention of eating disorders. The initiative could also provide a platform for dissemination of family guidance on healthy family activities such as shared meal times and family conversation.

Both initiatives provide a suitable foundation for the delivery of more specific eating disorder prevention programs within a complementary suite of activities to prevent eating disorders and support general mental health.

Collaboration, defined as the act of 'voluntarily and cooperatively working together to achieve a common goal' is the core operating principle of the NEDC. The NEDC recognises that the development of an evidence based, consistent and long term strategy for promotion, prevention and early intervention of eating disorders will require sustained engagement with a diverse range of stakeholders. The objective of collaboration is to bring these stakeholders together in an environment of knowledge sharing and collaborative problem solving which will provide the necessary foundation for the development of a consistent national approach to the prevention and management of eating disorders.

In this context, relationships will be required with the following sectors and organisations in order to achieve the objectives of the communication strategy:

Sectors	Professions and Organisations
Health Promotion To develop integrated health promotion and prevention messages	State and Federal Government initiatives to promote health and prevent: • Obesity • Body dissatisfaction • Youth mental illness and suicide Mental health literacy initiatives (e.g. Mindmatters and Kidsmatter)
Education and Community Services To promote the uptake of evidence based prevention programs	• Public and private schools • Tertiary institutions • Youth welfare services (Out of Home Care, Supported Accommodation Programs, Youth services)
Mental Health To ensure access to consistent eating disorder information through all potential points of access	• Soft points of entry to health services (e.g. Headspace) • Depression related services (e.g. beyondblue) • Suicide prevention services (e.g. Lifeline) • Mental health literacy programs
Physical Health To ensure access to consistent eating disorder information through all potential points of access	• Dieticians Association • Diabetes Educators • Endocrinologists • Obstetricians and Midwives
Frontline Professionals To equip professional gatekeepers with resources to identify, screen, assess and respond to people with eating disorders, disordered eating or body dissatisfaction	• General Practitioners • Counsellors • Psychologists • School Counsellors • Sport and fitness instructors
Media To support change in dominant messages about dieting and body ideals; to ensure appropriate, non-stigmatising messages about eating disorders and mental illness	• Mindframe • Fashion industry • Advertising

Evidence Generating Approaches | 9

The evidence base for eating disorder prevention programs is limited, with few systematic evaluations (Stice & Shaw, 2004). While many programs have been successful in increasing participants' knowledge about eating disorders, there are still questions about the most effective approach to modifying attitudes and changing behaviours (Sjostrom & Steiner-Adair, 2005).

These findings support the continued development and implementation of eating disorder prevention programs with further research and evaluation to extend the evidence base.

A core principle of the draft National Standards Schema for Eating Disorders is the implementation of evidence informed and evidence generating approaches in all areas of eating disorders prevention and management.

Evaluation of prevention approaches is strongly encouraged in order to ensure that harm has not been caused (Wilksch & Wade, 2009).

Evidence informed and Evidence-generating approaches

Research and evaluation are integral to the design and delivery of health promotion, prevention, early intervention, and treatment approaches. Basing approaches on evidence ensures that people have access to the most effective approaches and that all approaches develop in response to emerging evidence. People with personal experience of eating disorders are involved at all levels of service development and evaluation.

There is a need to continue to evaluate evidence based prevention approaches as they are implemented in different Australian contexts.

Given the limited evidence base on the effects of 'obesity prevention' messages on risk factors for eating disorders, further work is required in this area to ensure that messages are safe for all audiences.

New messages focussing on health and diversity, designed to balance the issues of general health, obesity prevention and eating disorders prevention will require testing to ensure their effectiveness across diverse audiences.

Research in eating disorders prevention would be significantly improved if the incidence of eating disorders in study participants was measured prior to and following intervention (Fingeret et al, 2006).

In general, data on the incidence and progression of eating disorders is essential for the evaluation of effective communication strategies. At present there are no data collection strategies in Australia that capture the full national picture including the diagnosis of all eating disorders and information on people who receive treatment outside the hospital system. Data collection on prevalence is of particular significance for communication strategies as it provides a measure of the impact of communication actions. While the development of health data collections systems of this magnitude is not a part of a communications strategy it is noted as a factor for the effective promotion and prevention of eating disorders.

The National Eating Disorders Collaboration

A part of the brief for the NEDC in its second phase is to support implementation of the communication strategy, with a particular emphasis on engaging collaboratively with existing physical and mental health prevention and health promotion strategies and organisations.

Steps to implementing a strategic approach

The following steps will be required to initiate approaches to communication for prevention and early intervention in a way that compliments public health messages for other disorders:

1. Develop a baseline of consistent evidence based information on eating disorders and risk factors
2. Engage identified stakeholders in collaborative dialogue to identify scope for integrated approaches
3. Working with stakeholders, align health messages and information resources across sectors
    a. review existing resources
    b. test new messages and the feasibility of combined health promotion approaches
    c. integrate eating disorder information into existing mental and physical health information
4. Equip frontline professionals with evidence based information, training and screening resources
5. Promote the uptake of evidence based prevention programs

Opportunities for Collaboration

As a collaboration representing expertise in eating disorders, including the expertise of lived experience, the NEDC will continue to provide a focal and access point for expertise on eating disorders during the implementation of the communications strategy.

Stakeholders are invited to join the collaboration to directly work with the eating disorders sector on mutual problem solving and the development of communication that is safe and effective for all audiences.

The NEDC has the capacity to convene panels of eating disorder experts to review proposed communication, on request, and provide advice in the context of this communication framework. Expert review is the essential step towards endorsement of communication as evidence based and appropriate from an eating disorders perspective.

Development of Information and Resources

In addition to implementing these five steps, the NEDC will be actively engaged in 2012 and 2013 in development and implementation of the following communication resources:

Access: National Eating Disorders Collaboration Website

Designed as a central access point for consistent and appropriate information on eating disorders,

the website will provide resources as a key contribution to the 'Access' strategy and will act as a portal facilitating access to other websites providing information and services for people with or at risk of developing eating disorders.

To be launched in March 2012, the website will comprise:

- A clearinghouse of recent research on eating disorders
- Information resources for professionals and families
- Professional development information linking to available training and tertiary consultation support
- Information and links to organisations and services providing support for people with eating disorders

Prevention Programs: Prevention and Early Intervention Report

A report detailing evidence based options for early intervention and prevention will be published in 2012 as a key contribution to the 'Prevention Program' strategy. This will be supported by workshops for the key frontline professionals engaged with people at risk of developing eating disorders, including school counsellors, teachers, physical activity instructors and youth workers.

Professional Knowledge: Professional Development Resources

A number of resources have been developed to support professional development. Professional resources and links to professional training will be accessible through the NEDC website. A professional e-network will be accessible through Facebook. The series of Annual National Workshops will be continued in 2012 and 2013.

Awareness: Developing Community Understanding of Eating Disorders

The NEDC will engage each identified level of audience in different ways to raise awareness of eating disorders in Australia. Raising awareness will require a partnership approach with existing

Individuals: The NEDC will work with existing providers of information, health promotion and prevention programs to identify mutual needs and align information resources

Professions and Organisations: The NEDC will work with professional associations and peak bodies to identify resource and training needs and to promote the awareness of the warning signs of eating disorders.

Community: The NEDC will work with State and Federal governments to identify social marketing opportunities to promote awareness of eating disorders amongst adults, with a focus on families, frontline professionals, young people and adults in target 'at risk' groups.

The NEDC will continue to develop evidence based information resources for dissemination through the NEDC website and through partner agencies together with an endorsement scheme that will identify Australian information resources that are evidence based.

The NEDC will convene a media and related industries advisory group to engage the sector in collaboration for the promotion of healthy social values and behaviours.

The NEDC will also support further exploration of youth preferences and social media technologies as a medium for connecting with young people, taking into consideration the risks associated with communication that is not moderated by a skilled and informed adult.

Policy: The NEDC will assertively disseminate the National Framework and its partner report, a Gap Analysis Report (to be published in 2013) as a foundation for engagement with State governments and peak professional bodies.

Communication: A Vital Part of a National Approach to Eating Disorders

The communication framework is designed to achieve core principles from the proposed National Standards Schema for Eating Disorders:

Prevention, early identification and intervention

Prevention, early identification and prompt intervention are necessary to reduce the severity, duration and impact of the illness. Early intervention for eating disorders includes strategies that enable people to access services as soon as they are needed: early in the development of the illness, early in help-seeking and early in recurrent episodes of illness, with immediate access to treatment and support; and

Equity of access and entry

People have access to treatment and support services when and where they are needed, early in the illness and early in each episode of illness. The requirements of regional and rural areas are recognised and technological solutions to providing accessibility are included. The entry requirements and the costs, subsidies or fee rebates for treatment take into consideration the long term and complex nature of eating disorders and the need to ensure they are accessible and affordable to all. Clearly identified entry points, ideally located in the community, assist people to make informed decisions about treatment options and enable them to engage with accessible and affordable services; and

A skilled workforce

An effective system is founded on a skilled and supported workforce. All health professionals receive training in eating disorders to raise their awareness of the serious nature of eating disorders and to enable them to identify, assess and contribute to the treatment of eating disorders. Training includes the development of attitudes and practices that support early identification and intervention and a person centred and recovery oriented approach. General Practitioners are recognised as being the first point of contact in many instances and are educated on how to interview the patient and their family to facilitate an early diagnosis; and

Communication to ensure an informed and responsive community

Consistent and appropriate messages are provided to make sure that the community is aware of eating disorders as serious mental and physical illnesses. Such messages also educate the community to reduce the stigma that hampers help seeking. Eating disorder prevention integrates with wider physical and mental health promotion strategies to provide consistent health information that promotes wellbeing. Frontline professionals with a duty of care and who influence young people (e.g. school counsellors, teachers, and youth workers) are trained to recognise and respond appropriately to eating disorders. Training includes attitudes and practices that support early identification, intervention, recognition of the ambivalence and fear that is prevalent in this population and a recovery oriented approach.

Appendices

Appendices in this report:

1. Fact sheet: Warning signs

2. Working with the Media

Appendices available as separate documents:

3. Eating Disorders: A Current Affair – an introduction to eating disorders

4. References

5. Evaluating the Risk of Harm of Weight-related Messages

Appendix 1:

Key Message: Early intervention is crucial

"Acting on the warning signs of eating disorders could save a life"

Behavioural warning signs

• Dieting behaviours (e.g. fasting, counting calories/kilojoules, avoidance of food groups)
• Evidence of binge eating (e.g. disappearance or hoarding of food)
• Evidence of vomiting or laxative use (e.g. taking trips to the bathroom during or immediately after meals)
• Excessive, obsessive or ritualistic exercise patterns (e.g. exercising when injured or in bad weather, feeling compelled to perform a certain number of repetitions of exercises or experiencing distress if unable to exercise)
• Changes in food preferences (e.g. refusing to eat certain 'fatty' or 'bad' foods, cutting out whole food groups such as meat or dairy, claiming to dislike foods previously enjoyed, a sudden concern with 'healthy eating', or replacing meals with fluids)
• Development of rigid patterns around food selection, preparation and eating (e.g. cutting food into small pieces or eating very slowly)
• Avoidance of eating meals, especially when in a social setting (e.g. skipping meals by claiming they have already eaten or have an intolerance/allergy to particular foods)
• Lying about amount or type of food consumed or evading questions about eating and weight
• Behaviours focused on food (e.g. planning, buying, preparing and cooking meals for others but not actually consuming; interest in cookbooks, recipes and nutrition)
• Behaviours focused on body shape and weight (e.g. interest in weight-loss websites, books and magazines, or images of thin people)
• Development of repetitive or obsessive behaviours relating to body shape and weight (e.g. body-checking such as pinching waist or wrists, repeated weighing of self, excessive time spent looking in mirrors)
• Social withdrawal or avoidance of previously enjoyed activities

Physical warning signs

• Weight loss or weight fluctuations
• Sensitivity to the cold or feeling cold most of the time, even in warm temperatures
• Changes in or loss of menstrual patterns
• Swelling around the cheeks or jaw, calluses on knuckles, or damage to teeth from vomiting
• Fainting

Psychological warning signs

• Pre-occupation with food, body shape and weight
• Extreme body dissatisfaction
• Distorted body image (e.g. complaining of being/feeling/looking fat when a healthy weight or underweight)
• Sensitivity to comments or criticism about exercise, food, body shape or weight
• Heightened anxiety around meal times
• Depression, anxiety or irritability
• Low self-esteem (e.g. negative opinions of self, feelings of shame, guilt or self-loathing)
• Rigid 'black and white' thinking (e.g. labelling of food as either 'good' or 'bad'

(Source: Mental Health First Aid: Eating Disorders First Aid Guidelines, 2008)

Appendix 2: Working with the Media

The following information was provided to the NEDC by Primary Communications:

Working with the media

Media, including news reporting, advertising, fashion, entertainment and social media provides the common background to social beliefs and behaviour that potentially influences people across age groups, locations and life circumstances. The way in which media responds to issues can influence the type and level of response a community makes to an issue. Media support is therefore vital for any effective healthy eating and eating disorder promotion and prevention strategy. A supportive media environment is also needed to affect appropriate reporting and coverage behaviour by the media of eating disorder and negative body image incidents, issues within the broad community that are known to play a negative contribution to eating disorder sufferers and at risk members of the community.

The media includes all elements of media development, such as writers and photographers, plus the key influencers of media activity, which includes advertisers and, most particularly industry sectors such as fashion and entertainment, food and weight loss.

Engaging with the various components of the media industry in voluntary collaboration offers the most effective approach for the development of consistent and viable national approaches to the representation of body image and to the dissemination of evidence based information resources and professional development resources for people in relevant roles.

A supportive media landscape would also be greatly enhanced by the adoption of the Media and Industry Code of Conduct which has recently been proposed for the Australian Government's National Body Image Strategy. The proposed code of conduct encompasses positive content and messaging; the digital alteration of images; realistic and natural images of a diverse range of people; selection of models who are of healthy weight; and promotion of fashions in a variety of sizes could also positively contribute to the development of a supportive media landscape.

Primary Communication evaluated the media landscape associated with eating disorders. The evaluation revealed a broader and more extensive relationship beyond the media to include all levels and affiliates (staff organisations and key influencers) of related industries that create, influence, control, write and distribute information identified as risk factors for eating disorders, body image and obesity.

Primary Communication characterized these in three groups; wordsmiths, the image makers and the decision makers. All three groups are interconnected commercially and culturally and need to have individual strategies developed to meet their specific requirements and behaviours while empowering each group to make informed decisions, which recognise commercial and cultural realities.

The following activities may contribute to meaningful self-determined behavioural change and a two-way engagement with the eating disorder Sector, the community and the Government on the identified issues.

The Wordsmiths

Media professionals, stage and screenwriters, tertiary education public relations and journalism students.

These professionals have been successfully engaging with an extremely successful set of programs, managed by the Hunter Institute of Mental Health noted that eating disorders are already included as part of their work around mental illness.

One approach to engage wordsmiths with eating disorders would be extending these programs, managed by the Hunter Institute of Mental Health, to encompass issues associated with eating disorders, body image and obesity reportage in the media. The Hunter Institute of Mental Health noted that eating disorders are already included as part of their work around mental illness.

The types of strategies and activities that could be covered in an expansion of the current Mindframe projects include, but are not limited to:

- Expansion of the Mindframe website to include more targeted information about eating disorders and body image for journalists and editors, the mental health sector and stage and screen, with links to the Knowledge Warehouse.
- A quick reference card for media on eating disorders and related issues, to accompany the current suite of resources.
- Targeted media briefings for magazines and other key media on the portrayal of eating disorders in feature and editorial content.
- Targeted professional development workshops for spokespeople and organisations working this area about Mindframe and issues specific to eating disorders.
- Targeted briefings with Australian television programs that may deal with body image issues or eating disorders.
- Additional case studies on eating disorders and body image from the Response Ability journalism and public relations curriculum resources.
- These programs could be expanded to recognise and address the growing role social media commentators (e.g. bloggers, websites) play in the media. There is a need to:
- Set up a two-way relationship with this new media group
- Identify social media commentators who are reliable, have expert knowledge who are popular with identified target groups
- Develop new or amend appropriate resources
- Provide a forum where new media representatives can engage in the issues, resource and contribute to the development of behavioural change associated with the key risk factors for Eating disorders

As a complementary and supportive activity for the wordsmith group, the Media and Industry Code of Conduct proposed for the National Body Image Strategy could be extended to include eating disorders and obesity issues.

The Image Makers

Photographers, photo editors, graphic artists and designers, advertising and marketing creative teams, directors, producers, cameraman, cinematographers, fashion designers and celebrity and talent agents.

The role the ‘image makers’ play in contributing to the risk factors associated with eating disorders is significant. Individuals and teams working in this group can create images that are instantly recognised, provide lasting influence and can reinforce negative stereotypes relating to eating disorders, body image and obesity with editorial, branding, advertising and marketing.

The role the’ Image Makers’ play in contributing to the risk factors associated with eating disorders is significant. Individuals and teams working in this group create images that are instantly recognised, provide lasting influence and can reinforce negative stereotypes relating to eating disorders, body image and obesity associated with editorial, branding, advertising and marketing.

Identifying and working closely with industry representative organisations would provide a collaborative basis for the development of an appropriate media landscape to support eating disorder messages. Building these relationships will assist in establishing industry acceptance and provide pathway for communication to industry sectors. The following list is representative of image maker industry organisations:

- Media Arts Alliance
- Screen Producers Association
- Australian Cinematographers Society
- Australian Directors Guide
- Australian Association of National Advertisers
- Australian Fashion Council
- Photo Marketing Association International (Australia)
- Public Relations Institute of Australia
- Advertising Federation of Australia
- Australian Graphic Design Association

As this is a new target group that has not previously been engaged around mental health issues there will be a need for an initial scoping study to assess the industries willingness to participate in self-determined activity that contributes to their professions understanding and behavioural change activity associated with eating disorders.

Evidence based on resources will be required to inform and educate the image makers. These resources will need to be developed in consultation with an ‘Image Makers’ reference group.

The Decision Makers

Product development managers, marketers, business development and brand owners, sponsorship, events and marketing agencies (including brand developers, direct marketing agencies, image consultants and media buying firms

The decision makers play a critical role in determining the direction a company, brand and product will take. They set budgets, guide marketing and positioning and approve all activity under taken by the 'image maker' group on their behalf. They also play a key role in influencing the 'wordsmith' group through advertising budgets, corporate social responsibility programs and the placement of their activity and brand within the community.

The role that the decision makers play in the media landscape cannot be underestimated. An effective eating disorder communication strategy would require active engagement with industry representative organisations for this group to establish industry acceptance and provide a pathway for communication to the industry sectors. The following list is representative of the 'decision maker' group:

- The Marketing Association of Australia and New Zealand
- The Australian Marketing Institute
- Australasian Professional Services Marketing Association
- The Direct Marketing Association of Australia
- Australasian Marketing Association
- Sponsorship Australasian Association
- Public Relations Institute of Australia
- Australian Sponsorship and Marketing Association
- Market Research Society
- Advertising Federation of Australia