An Eating Disorders Resource for Schools

A manual to promote early intervention and prevention of eating disorders in schools

Victorian Centre of Excellence
in Eating Disorders

Eating
Disorders
FOUNDATION OF VICTORIA Inc

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Eating disorders prevention - Literature review

A review of the eating disorder prevention and intervention literature is available online at the Victorian Centre of Excellence in Eating Disorders website, **www.ceed.org.au** and the Eating Disorders Foundation of Victoria website, **www.eatingdisorders.org.au**.

Additional copies of the Eating Disorders Resource for Schools

An updated version of this resource is available online at the Victorian Centre of Excellence in Eating Disorders website, **www.ceed.org.au** and the Eating Disorders Foundation of Victoria website, **www.eatingdisorders.org.au**.

To order copies of this resource, please contact the Eating Disorders Foundation of Victoria (EDFV) or the Victorian Centre of Excellence in Eating Disorders (CEED).

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Foreword

The Hon Bronwyn Pike MP, Minister for Health and Jacinta Allan, Minister for Youth Affairs

As a community, we all have a role to play to ensure Victoria's young people are able to live healthy, satisfying lives. It is recognised that eating disorders are becoming more common among Australian teenagers. Eating disorders, left untreated, can result in ongoing physical and emotional illness for sufferers and stress for their families and carers. We are also becoming increasingly aware of the critical importance of the role of early intervention in the prevention of eating disorders.

Teachers and schools are in the special position of having a medium to long-term relationship with young people. This relationship allows teachers and schools to identify significant changes in a young person that may indicate they are at risk of an eating disorder. An Eating Disorders Resource for Schools offers teachers a range of information and practical strategies to assist them to implement early intervention programs and practices that can support those students and their families.

An Eating Disorders Resource for Schools has been developed, drawing on the scientific literature and in consultation with school staff, researchers and health promoters in the area of eating disorders and adolescent well-being, people experiencing eating disorders during their school years, and carers.

This is an important resource that will support schools in their efforts to implement practical programs and reduce risk factors relevant to the prevention of eating disorders within their school communities.

We congratulate the Eating Disorders Foundation of Victoria (EDFV), and the Victorian Centre of Excellence in Eating Disorders (CEED), who have collaborated in the development of this timely resource.

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Introduction of project

The *Eating Disorders Resource for Schools* project is a joint project of the Victorian Centre of Excellence in Eating Disorders and the Eating Disorders Foundation of Victoria

The Victorian Centre of Excellence in Eating Disorders (CEED)

CEED was launched in January 2002 as part of the Victorian government's commitment to improving health care for people with eating disorders. CEED aims to reduce the risk, duration and impact of eating disorders in people of all ages by building Victoria's capacity to undertake effective prevention, early intervention and clinical care.

CEED's objectives are to:

- provide leadership in research, education, training and consultation in the field of eating disorders

- enhance the capacity of primary care and specialty services to respond to the early intervention, treatment and rehabilitation needs of people with eating disorders through training, education, research and consultation

- identify, develop and support the implementation of evidence-based best practice across the spectrum of care, including early intervention, for primary care and specialist services

- act as a resource and clearing house for contemporary approaches to prevention, early intervention and treatment of eating disorders across the life span

- identify and respond to particular service provision issues as they relate to regional and remote areas through the development/or support of appropriate service models

- improve partnerships and linkages between primary care, specialist services and other service sectors including welfare, education and employment in the interests of developing a comprehensive response to the needs of people with eating disorders

- ensure that those with eating disorders and their families are actively represented in the work of CEED.

The Eating Disorders Foundation of Victoria (EDFV)

The EDFV is a non-profit incorporated association founded in the mid 1980's to support those whose lives are affected by eating disorders, and to better inform the community about these disorders. The Foundation's community-based board of management comprises people who have a personal or professional interest in eating disorder issues.

EDFV's objectives are to:

- respond to the needs of both people experiencing eating disorders and carers – recognising the impact of eating disorders beyond the individual

- provide information, knowledge, support and resources in order to encourage resilience and recovery and lessen the impact of the eating disorder on the quality of life of individuals and families

- advocate for systemic change for improved access to treatment facilities for sufferers of eating disorders, support for carers and for the reduction of the stigma associated with eating disorders and other mental illnesses

- raise awareness of eating disorders by means of general community education and specialist training for specific sectors

- promote the need for a focus on prevention, early intervention and health promotion.

Project background

This project developed out of increasing requests from teaching and other school staff for accurate information about eating disorders in relation to intervention, treatment and prevention.

The aim of the project was to develop an eating disorders resource for schools that:

- assists teachers, coaches and other members of the school community in the prevention and intervention of eating disorders

- provides accurate information to respond to immediate situations

- encourages school communities to develop a whole school approach to the prevention of eating disorders, by focusing on building resilience in students and reducing risk factors within the school community.

Project summary

In early 2002, the Eating Disorders Foundation of Victoria initiated a consultation process with several people from the education sector about the need for a resource.

In May 2003, a project worker was employed by CEED to consult with relevant groups and develop the resource. With the support of a Steering Committee and a Reference Group, the resource was completed in early 2004.

Consultation process

This resource was developed in consultation with:

- the scientific literature

- school staff

- students with eating disorders

- parents of students with eating disorders

- people working in the area of prevention and intervention.

The scientific literature

A literature review of current intervention and prevention efforts in the area of eating disorders was completed. The review focuses on prevention efforts in educational settings and indicates that prevention of eating disorders within this setting is best addressed through creating a positive and supportive school environment.

The review is available at **www.eatingdisorders.org.au** and **www.ceed.org.au**

School staff

A total of 66 school staff from 37 schools attended one of six focus groups. Permission and/or support to contact schools was gained from the Catholic Education Office, the Association of Independent Schools of Victoria and the Victorian Department of Education and Training.

To ensure a representative sample, different school staff were invited from over 140 Catholic, Independent and Government schools. Participants included staff from over 30 different roles within the school such as health and PE teachers, School

Counsellors, Year Level Coordinators, School Health Nurses and Principals. Focus groups were held in different locations including Southeast, East and Western metropolitan Melbourne and regional Victoria.

The aim of the focus groups was to gain an understanding of the experiences of school staff and their information needs in relation to eating disorders. School staff provided valuable information about useful strategies and various difficulties when working with students affected by eating disorders.

Students and parents of people experiencing an eating disorder

Students, and parents of students experiencing an eating disorder were consulted through written surveys. The surveys were anonymous and voluntary and were distributed through two treatment and/or support agencies in Western and Eastern metropolitan Melbourne.

The aim of the survey was to gain an understanding of helpful and unhelpful practices within the school system and the needs of families and students affected by eating disorders.

A total of 37 surveys were completed; 19 from people supporting someone with an eating disorder and 18 from people experiencing, or having experienced an eating disorder as a student. The surveys provided valuable information about key areas to focus on in the resource.

People working in the field of prevention and intervention

Interviews were conducted with several people working in the area of prevention and/or intervention of eating disorders and related areas. Interviews provided information about challenges, related resources and strategies for working with this issue within the education sector.

Using this resource

This resource is designed for secondary school staff. It offers information and strategies to address the issues raised by eating problems and disorders within the school environment.

The resource reflects the four main areas outlined in Education Victoria's *Framework for Student Support Services in Victorian Government Schools – Teacher Resource:*

- prevention

- early intervention

- intervention

- restoring wellbeing.

While information presented in the resource will be relevant for the wider staff team, some sections are more relevant for staff with particular roles within the secondary school.

Chapter	Who in the school this information is most relevant for
Chapter 1 - Introduction of project	Relevant for all school staff.
Chapter 2 - Current information about eating disorders	Relevant for all school staff.
Chapter 3 - Prevention	Particularly relevant for decision makers within the school and other school staff involved in planning and facilitating whole school change. This chapter includes information about a whole school approach to creating an environment and philosophy that promotes student wellbeing.
Chapter 4 - Early intervention	Particularly relevant for anyone within the school who has contact with students, such as teachers, welfare staff and managerial/leadership staff (such as Year Level Coordinators and Principals). This chapter includes information about identifying potential problems before they develop into a disorder.
Chapter 5 - Intervention	Particularly relevant to staff who have a welfare or support role, but is also useful for teachers working directly with students experiencing eating issues or disorders. This chapter includes strategies and suggestions to support school staff working with young people with eating issues or disorders and their families and friends.
Chapter 6 - Restoring wellbeing	Particularly relevant to school staff who have a welfare/support or leadership/managerial role. This chapter includes strategies and suggestions to support school staff in their respective roles after a traumatic incident.
Chapter 7 - Additional resources	Relevant to all school staff. This chapter includes additional resources to support whole school change, prevention and intervention efforts and includes references of existing curriculum based resources and related support, referral and information services.
Supporting resources	Where relevant, some chapters have supporting resources that offer additional information and practical strategies to support policy implementation.

Icons

 The book icon refers to additional resources that may provide further information.

 The computer icon refers to additional web based resources that may provide further information.

Limitations of the resource

While this document is not intended to offer curriculum based prevention programs, **Chapter 3** – *Eating disorder and body image prevention programs* offers guidelines about what to include and avoid in curriculum based programs. **Chapter 7** includes references for curriculum-based resources.

While we recognise that the prevention and intervention of eating disorders is also relevant for primary schools, this document focuses on students at a secondary level; however many of the concepts and strategies will be applicable to primary settings.

There is some repetition built into the resource as readers may choose only to refer to relevant sections. Where other sections in the resource are applicable, the reader is signposted to that section.

People develop and experience eating issues or disorders differently. Not all strategies will be appropriate for each situation; they are intended as a list of potential options to guide intervention and prevention and are based on information gathered from a number of sources.

Current information
about eating disorders

Frequently asked questions

The following questions were derived from focus groups with school staff.

A student is not eating their lunch. What should I do?
I noticed a student didn't eat on the school camp. Is there a problem?

See **Chapter 2 – Current information about eating disorders** – *Warning signs and consequences*, **Chapter 4 – Early intervention** – *Identifying students at risk* and **Chapter 5 – Intervention** – *Approaching a student*.

I'm noticing some changes in a student, but I'm not sure if it is an eating disorder.

See **Chapter 2 – Current information about eating disorders** – *Warning signs and consequences* and **Chapter 4 – Early intervention** – *Monitoring and evaluating students at risk*.

A group of students are worried about one of their friends who they think has a problem.

See **Chapter 5 – Intervention** – *When a student approaches a teacher* and *Supporting friends*.

During physical education, I've noticed one of my students has been losing weight and is more focused on exercising.

See **Chapter 2 – Current information about eating disorders** – *Warning signs and consequences*, **Chapter 3 – Prevention** – *Promoting protective factors* and *Physical Education*, **Supporting Resource 6 – Increasing student participation – Physical education**, **Chapter 4 – Early Intervention** – *Identifying students at risk* and **Chapter 5 – Intervention** – *Approaching a student*.

How do I go about talking to a student?

See **Chapter 5 – Intervention** – *Approaching a student*.

How do I approach the family/parents of a student who I am worried about?

See **Chapter 5 – Intervention** – *Communication with parents or family members*.

What if I say the wrong thing and make it worse?

See **Chapter 5 – Intervention** – *What if I say the wrong thing and make it worse?*

A group of students are dieting together. What should we do?

See **Chapter 5 – Intervention** – *Copycat behaviour and co-dieting*.

We have a student returning to school after being hospitalised with anorexia nervosa. What do we need to consider?

See **Chapter 6 – Restoring wellbeing** – *Supporting students returning to school*.

One of our students has an eating disorder and other students are talking about it to the point where the student with the eating disorder is very uncomfortable coming to school.

See **Chapter 5 – Intervention** – *Supporting friends* and *Dealing with rumours*.

How do we make sure our school is not adding to or creating any eating disorder problems?

See **Chapter 3 – Prevention** – *Reducing risk factors* and *Promoting protective factors*.

We want to run a prevention program in our school. How do we go about it?

See **Chapter 3 – Prevention** – *Issues to consider when developing or choosing prevention programs for students* and **Additional resources** – *Curriculum based resources/guides for teachers*.

I am worried about a male student? Are the issues different with boys? What do I say?

See **Chapter 5 – Intervention** – *Talking to male students*.

Myths about eating disorders

Eating disorders are uncommon

The prevalence of eating disorders in the Western world is increasing. Approximately two to three in every 100 Australian females meets the diagnostic criteria for anorexia or bulimia nervosa, while approximately one in 5 young Australian women have symptoms of binge eating disorder.

Eating disorders only occur in females

One in four children and one in ten adults diagnosed with anorexia nervosa are male. For other eating disorders such as binge eating disorder, preliminary research indicates that males and females experience this disorder equally.

The incidence of males with eating disorders may be underreported for several reasons. Females are more likely to access help for eating disorders. Similarly, health practitioners may be more likely to diagnose females with an eating disorder.

Another consideration is the differences in symptoms for males and females. Females are more likely to focus on weight loss, where males are more likely to focus on muscle mass. Although issues such as altering diet to increase muscle mass, over-exercise or steroid misuse are not criteria for eating disorders as yet, there is a growing body of research that indicates males experience similar emotional and psychological symptoms to females when living with these symptoms.

Eating disorders are not a mental illness

Eating disorders are classified as a mental illness in the *Diagnostic Statistical Manual.*

Anorexia nervosa is the only serious eating disorder

All eating disorders can have damaging physical and psychological consequences. Although weight loss is a feature of anorexia nervosa, symptoms associated with other eating disorders can also be serious, such as the electrolyte imbalance associated with vomiting or laxative misuse. All eating disorders can have serious psychological consequences or co-morbidity such as depression and anxiety. (See *Warning signs and consequences* in this chapter).

Subclinical eating disorders are not serious

Although a person may not fulfil the diagnostic criteria for an eating disorder, the behaviour or consequences associated with their disordered eating (such as frequent vomiting, excessive exercise or anxiety) can have long-term consequences. These disorders are also serious and require intervention. Early intervention may also prevent the progression of an eating issue to a clinical eating disorder and the development of other physical, psychological and/or social consequences.

Dieting is normal adolescent behaviour

While fad dieting or body image concerns have become 'normal' features of adolescent development, weight loss dieting or frequent and/or extreme dieting is the biggest risk factor in the development of an eating disorder. A focus on health, wellbeing and body acceptance is preferable and any weight loss dieting should be monitored.

You can tell if someone has an eating disorder simply by looking at them

People develop and experience eating disorders differently. Some people may have obvious physical warning signs, such as weight loss or weight gain, but others may not. Additionally, people can become good at hiding the consequences of an eating disorder. For this reason, eating disorders can go undetected for months or years. (See *Warning signs and consequences* in this chapter).

Eating disorders are about appearance and beauty

Eating disorders are a psychological illness and have little to do with food, eating, appearance or beauty. This is indicated by the continuation of the illness long after a person has reached their initial 'target' weight. Eating disorders are usually related to emotional issues such as control and low self-esteem. (See *Causes* in this chapter).

Eating disorders are caused by unhealthy and unrealistic images in the media

While socio-cultural factors (such as the 'thin ideal') are contributing factors in the development of eating disorders, it is widely accepted that the causes are multi-factorial and also include individual, familial and precipitating factors. (See *Causes* in this chapter).

Not everyone who is exposed to media images develops an eating disorder. Eating disorders such as anorexia nervosa have been documented in the medical literature since the 1800's, long before magazines were developed and when prevailing notions of an ideal body shape for women were very different from today.

Eating disorders don't occur in adults

The onset of eating disorders occurs predominantly during adolescence. If untreated, eating disorders can persist long into a person's adult years. They can also develop for the first time in the adult years, or only become apparent in adult life despite earlier onset.

Eating disorders only occur in people of high socio-economic status

Eating disorders such as anorexia nervosa, binge eating disorder and bulimia nervosa exist across all socio-economic groups, age groups, and both genders.

Preliminary research indicates that anorexia nervosa may be more common in high socio-economic groups. However, these findings are largely based on treatment rates and may reflect greater access to treatment rather than an actual increase in incidence.

Recovery from eating disorders is rare

Recovery rates vary between different eating disorders. Early intervention improves the outcome of recovery regardless of the disorder. Recovery can take months or years, but the majority of people recover.

Most people who develop anorexia nervosa die or do not recover

Although anorexia nervosa is the most fatal of all psychiatric disorders, research indicates that about 50% of people with anorexia nervosa experience recovery, about 20% continue to experience issues with food and about 20% of people die in the longer term due to medical or psychological complications.

Eating disorders are an attempt to seek attention

The causes of eating disorders are complex and often involve individual, biological, familial and socio-cultural factors. People who experience eating disorders often go to great lengths to conceal their disorder due to feelings of shame.

Eating disorders are often symptomatic of deeper psycho-logical issues such as the need for control. The behaviours associated with eating disorders may sometimes be interpreted as 'attention seeking', however, they are an indicator that someone is struggling with issues and needs help.

Statistics

Research in the field of eating disorders is in its infancy. Statistics often vary and sometimes seem contradictory, reflecting the need for more work and larger studies upon which to base prevalence rates and other relevant information. The following statistics provide a snapshot about eating disorders and associated issues. Where possible we have tried to access Australian statistics.

Prevalence

- Eating disorders can be found in people as young as seven and as old as 70 years.[i]

- Although there is great variation in prevalence rates cited in various sources, according to strict clinical criteria it is generally estimated that in Australia, 2-3% of adolescent and adult females satisfy the DSM IV diagnostic criteria for anorexia and bulimia nervosa.[ii]

- Anorexia nervosa is the third most common chronic illness for adolescent girls in Australia (after obesity and asthma).[iii]

- The incidence of bulimia nervosa in the Australian population is five in 100.[iv] The true incidence of bulimia nervosa is estimated to be as high as one in five in the student population.[v] At least two studies have indicated that only about one tenth of cases of bulimia in the community are detected.[vi]

- The prevalence of binge eating disorder in the general population is estimated to be four in 100.[vii] The incidence of binge eating disorder in males and females is almost equal.[viii]

- A study of 15,000 18-22 year old Australian women found that one in five had symptoms of binge eating disorder.[ix]

Features

- The onset of anorexia nervosa is generally in adolescence; bulimia nervosa and binge eating disorder are more likely to first occur in late adolescence or early adulthood. The long-term nature of these disorders means that many people carry these conditions well into their adulthood.[x]

- It is common for people suffering from bulimia nervosa to keep their disorder hidden for eight to ten years, at great cost to their physical and psychological health.[xi]

- One in 10 young adults and approximately one in four children diagnosed with anorexia nervosa are male.[xii]

Wellbeing

- Young Australian women who start dieting before the age of 15 are more likely to experience depression, binge eating, purging, and physical symptoms such as tiredness, low iron levels and menstrual irregularities.[xiii]

- The overall mortality rate for anorexia nervosa is five times that of the same aged population in general, with death from natural causes being four times greater (e.g. cardiac arrhythmia, infection), and deaths from unnatural causes, 11 times greater. Risk of successful suicide is particularly high, being 32 times that expected.[xiv] Anorexia nervosa is the most fatal of all psychiatric illnesses. Mortality rates after 20 years are between 15-20%.[xv]

Weight loss dieting and associated behaviours

- Weight loss dieting is the greatest risk factor for the development of an eating disorder. Adolescent girls who diet only moderately are five times more likely to develop an eating disorder than those who don't diet, and those who diet severely are 18 times more likely to develop an eating disorder.[xvi]

- One in four seven to ten year olds have dieted to lose weight.[xvii] A Victorian study of adolescents aged 12 to 17 years classified over one in three girls and one in 10 boys as 'intermediate' to 'extreme' dieters (e.g. at risk of an eating disorder).[xviii]

- Reports in the US and Australia indicate that 6 – 12% of high school males have used steroids.[xix]

- A study involving 341 female and 221 male high school students in Victoria, found that almost one in two girls and over one in four boys occasionally used one or more extreme weight loss measures. Approximately 13 in 100 females and nine in 100 males used such measures weekly.[xx]

- One in three young women surveyed (between 18 and 23 years of age) reported that at some time they had at least experimented with unhealthy eating behaviours including making themselves purge, deliberately abusing laxatives or diuretics, or fasting for at least 24 hours in order to lose weight.[xxi]

- Excessive exercise has been found to be frequently used by males who are dissatisfied with their body shape and size.[xxii]

Culture

- Approximately one in three young males want their body to be heavier and one in three want their body to be lighter.[xxiii]

- One in two primary school children wanted to weigh less according to a survey of pre-adolescent Sydney children.[xxiv]

- Fashion endorses an emaciated female body shape, which for genetic and physiological reasons is impossible to attain on a healthy diet for the vast majority of women.[xxv]

- It has been estimated that young women now see more images of outstandingly beautiful women in one day than our mothers saw throughout their entire adolescence.[xxvi]

History

Eating disorders have existed in various forms and across different cultures for centuries.

The first known medical documentation of anorexia nervosa appeared in 1873 when two physicians, Sir William Gull and Dr E. C Lasegue published separate case histories.

Bulimia nervosa was first recognised as a separate eating disorder in the 1970s. It appeared in psychiatric diagnostic manuals for the first time in 1976.

Binge eating disorder was recognised as a distinct eating disorder during the 1990's.

Types of eating disorders

Eating disorders are a psychological illness with physical consequences. There are many forms of eating disorders; anorexia and bulimia nervosa, binge eating disorder and eating disorders not otherwise specified (EDNOS).

Additionally, there are many forms of disordered or subclinical eating problems that can result in physical and psychological problems that can later develop into clinical eating disorders.

Anorexia Nervosa	Bulimia Nervosa	Binge Eating Disorder	Eating Disorders Not Otherwise Specified-*EDNOS*
Anorexia is characterised by: • refusal to maintain weight at or above a normal weight for height, body-type, age and activity level • intense fear of gaining weight or becoming 'fat' • body image disturbance, for example, feeling 'fat' despite being underweight • loss of menstrual periods (females) • extreme concern with body weight and shape.	Bulimia is characterised by: • over-preoccupation with food and weight resulting in 'out of control' eating patterns, such as: - eating binges which involve the consumption of very large amounts of food. These usually occur secretly and are associated with a sense of loss of control and/or shame - attempts to compensate for binges and avoid weight gain by one or more of the following unhealthy measures: self induced vomiting; misuse of laxatives, fluid or diet pills; excessive exercise; periods of strict dieting.	Binge eating disorder is characterised by: • periods of uncontrolled, impulsive or continuous eating to the point of being uncomfortably full • repeated episodes of binge eating which often result in feelings of shame and self-hatred • no compensatory behaviour (such as vomiting, laxative abuse, excessive exercise) after bingeing. While obesity is not considered an eating disorder in itself, it can be the result of binge eating disorder. For information about resources and organisations that may assist schools in supporting students with obesity issues, see **Chapter 7 – Additional resources.**	There is a range of other disordered eating patterns that don't fall into specific categories. These conditions are still serious and intervention and attention are still indicated. EDNOS or other eating disorders may include: • those who have some, but not all of the characteristics of an eating disorder. For example, people who severely restrict food intake, but do not meet full criteria for anorexia nervosa • those who chew food and spit it out (without swallowing) • those who binge and purge irregularly, such as at times of increased stress • people who experience disordered eating or any subclinical symptoms.

Causes

There is no single cause of an eating disorder. Rather, it is recognised that eating disorders are complex conditions caused by a combination of individual, family, interpersonal, biological, socio-cultural, and precipitating factors.

Individual factors

Not everyone exposed to the same socio-cultural and family factors develops an eating disorder, indicating the relevance of individual factors in the development of an eating disorder. Common individual factors include:

- having high personal expectations
- feelings of lack of control in life
- self-esteem issues
- high need of approval from others
- social anxiety
- difficulty expressing personal needs
- difficulty being assertive
- depression or anxiety.

Interpersonal factors

- difficulty expressing emotions and feelings
- troubled personal or family relationships
- history of teasing or bullying based on weight or shape
- ineffective coping strategies.

Socio-cultural factors

- cultural idealisation of thinness
- focus on appearance
- marketing by the weight loss, fashion, fitness, cosmetic and pharmaceutical industries
- media representations of happy, successful, thin people
- socialisation of women and men
- the gender imbalance of power within the dominant culture.

Family factors

People with eating disorders or disordered eating do not come from one typical family 'type'. However, some family characteristics that may need to be addressed during the recovery process include:

- perception of communication and support within the family
- perception of emotional bonding within the family
- how the family deals with feelings
- family values in relation to the importance of appearance and achievement
- sexual or physical abuse
- perceived importance of family life
- parent's own body image/dieting behaviour.

Biological factors

The role of biological factors is still emerging. Possible factors include:

- predisposition to imbalances in serotonin (a neuro-transmitter involved in mood and brain function)
- reduced blood flow to the temporal lobe
- severe weight loss, fasting, over-exercise and vomiting may affect chemicals in the brain involved in mood control.

Precipitating factors

The onset of an eating disorder can be triggered by external factors such as:

- life crisis such as family loss, friendship loss, moving to a new home, school or job or personal disappointment
- accumulation of stress without adequate coping strategies, which may intensify the impact of cultural, family or individual factors during periods of stress
- weight loss, extreme and/or frequent dieting.

Warning signs and consequences

People develop and experience eating disorders differently. Consequently there is not a common set of warning signs. Some people exhibit many of the following signs, while others may only exhibit a few.

Eating disorders can go undetected for several reasons. Firstly, it can be difficult to distinguish a warning sign from a consequence. Secondly, eating disorders are secretive by nature and the first recognition of consequences does not necessarily indicate that the disorder is in its initial stages. Finally, some warning signs (such as moodiness) can be consistent with normal adolescent development making it difficult to distinguish an eating problem from normal adolescent development.

Early detection may be improved by being aware of clusters of symptoms from different behavioural, physical, social and emotional/psychological indicators.

Emotional/psychological

- preoccupation with body appearance and/or weight
- increased mood changes, irritability
- reduced concentration, memory and thinking ability
- anxiety or depression
- mental list of 'good' and 'bad' foods
- feelings of being out of control with food
- anxiety around meal times
- poor quality of life
- lack of assertiveness
- sensitivity to criticism
- guilt or self-dislike
- obsessive behaviours
- difficulty with relationships
- suicidal thoughts or behaviour
- drug and alcohol misuse.

Behavioural

- dieting or overeating
- increased interest in preparing food for others
- obsessive rituals such as only drinking out of a certain cup, eating certain foods on certain days
- impaired achievement at school or work
- wearing baggy clothes/change in clothing style
- excessive or fluctuating exercise patterns
- making frequent excuses not to eat
- very slow eating
- rearranging food on plate
- fast eating
- hoarding food
- trips to the bathroom after meals.

Social

- social withdrawal or isolation
- avoidance of social situations involving food
- decreased interest in hobbies.

Physical

Eating disorders are primarily psychological illnesses with physical consequences such as:

- weight loss or rapid fluctuation in weight
- loss or irregularity of menstrual periods (females)
- faintness, dizziness or fatigue
- sensitivity to the cold
- reduced metabolic rate (can lead to slow heart rate, low blood pressure, reduced body temperature and bluish coloured extremities)
- changes in hair, skin and nails (dry, brittle)
- oedema (retention of body fluid giving a 'puffy' appearance)
- hypoglycaemia (low blood glucose levels) which can cause confusion, illogical thinking, coma, shakiness and irritability
- reduced concentration, memory and thinking ability
- bowel problems such as constipation, diarrhoea or cramps
- dehydration
- sore throat, indigestion and heartburn
- easy bruising.

Treatment

It is common for several health professionals to work together to support someone through an eating disorder. Where a person accesses treatment depends on a number of things such as what kind of eating disorder the person has, their age, where they live and what they can afford. Some people may need to work with a number of different practitioners before deciding what feels right for them and their family.

Treatment providers

Private and public hospitals and clinics

Outpatient and community-based treatment are the mainstay of intervention, with hospitalisation reserved for those who are extremely unwell. Some hospitals and clinics offer specialist treatment as an in-patient (staying in the hospital), an out-patient (attending the hospital clinics or utilising its services) or a day-patient (attending a program most of the day but living at home).

Community mental health services

Community mental health services are divided by age into Adult Mental Health Services (AMHS) and Child and Adolescent Mental Health Services (CAMHS). Community mental health services are regionally based and offer assessment and treatment for serious psychological illnesses.

Community health and women's health services

Community health and women's health services may offer access to Dietitians, Counsellors, Social Workers and GP's. Services vary however, and may or may not be appropriate for the treatment of an eating disorder depending on the nature of the illness and the resources of the service.

Practitioners involved in treatment

Different health practitioners may be involved in the treatment of eating disorders. A multi-disciplinary approach to treatment is optimal for those with established and/or severe conditions. Health practitioners involved in treating or supporting someone with an eating disorder may include:

- General Practitioners
- Physicians
- Paediatricians
- Dietitians
- Psychologists
- Psychiatrists
- Nurses
- Social workers
- Counsellors
- Music/Art therapists
- Occupational therapists.

Types of treatment

A purely medical approach to the treatment of eating disorders (one that focuses on physical consequences and food) is unlikely to address the underlying causes or result in long term recovery. Ideally, treatment addresses both the physical and psychological aspects of the eating disorder.

Psychological therapy

Individual therapy

The basis of individual therapy is in forming a trusting relationship with the therapist through which complex issues can be addressed such as anxiety, depression, self esteem, confidence, difficulties with interpersonal relationships, body image concerns and identity formation.

Practitioners may use a particular type of therapy, or a combination of several different approaches such as:

Cognitive Behavioural Therapy
Emphasises the relationship between thoughts and feelings by focusing on a person's thought processes

Interpersonal Therapy
Focuses on addressing difficult relationships with others

Rational Emotive Therapy
Focuses on a person's unhelpful beliefs

Psychoanalysis Therapy
Focuses on a person's past experiences

Family therapy

Family therapy usually involves the people immediately around the person with the eating disorder, such as their parents, siblings and/or spouses. The family, as a unit, is encouraged to develop ways to cope with issues that may be causing concern, including the eating disorder. The success of this treatment is dependent on the family being willing to participate and make changes to their behaviours.

Family therapy can also offer education to family members about eating disorders and how better to support the person they care about. Overall, the family is encouraged to develop healthy ways to deal with the eating disorder.

Family therapy also acknowledges that every family has issues that are difficult to deal with. As part of a person's recovery from an eating disorder, it can be useful to address issues in the family context such as conflict or tension between members, communication problems or difficulty expressing feelings.

Group therapy

The main purpose of group therapy is to provide a supportive network of people who have similar issues. Groups can address many issues ranging from alternative coping strategies, exploration of underlying issues, ways to change behaviours and long-term goals. Groups are generally for a specific period of time, for example, 8 weeks.

Support groups

Support groups differ from therapy groups in that they are intended to offer mutual support, increased understanding and information. Where a therapy group is generally closed in attendance and runs for a specified period, support groups are generally open in attendance (people can attend when they choose to) and meet on a regular basis (e.g. fortnightly). Generally, support groups are not run by professionals, but by people who have had experience with eating disorders, either personally or indirectly.

Medical treatment

Many physical complications can result from an eating disorder. Left unattended, they can lead to serious health problems or even death. It is important that physical health is monitored, preferably by a medical practitioner with experience in the area of eating disorders. Generally, physical complications of an eating disorder will resolve once healthy eating and normal weight have been achieved.

Drug therapy may be used to treat specific complications. Anti-depressants belonging to the Serotonin Specific Reuptake Inhibitor group (SSRI) such as Zoloft and Prozac are commonly prescribed although they have variable effects, especially with anorexia nervosa.

Anti-depressants should be used in association with other forms of therapy such as Cognitive Behavioural Therapy. They can be useful in suppressing the binge/purge cycle, particularly for people with bulimia nervosa. For people experiencing anorexia nervosa, they may be useful in stabilising weight recovery.

Different anti-depressants work better for some individuals than others. Similarly, the side effects experienced can be more or less disturbing for different individuals.

Nutritional counselling/advice

Dietitians or nutritionists can be useful in the treatment of eating disorders as the establishment of a well-balanced diet is essential to recovery. Nutritional counselling and advice may be useful to help the person identify their fears about food and the physical consequences of not eating well. Education about the nutritional value of food can be beneficial, particularly when the person has lost track of what 'normal eating' is.

Alternative therapies

For some people, alternative therapies may complement psychological and medical treatment of eating disorders. Alternative therapies are not recommended as the primary or sole treatment. Each approach is different, however, alternative therapies are generally concerned with treating the person as a whole, including their mental and physical health and may include naturopathy, acupuncture, aromatherapy, meditation and homeopathy.

Prevention

Who in the school is this information most relevant for?

The information presented in this chapter and the corresponding supporting resources focuses on using a whole school approach to create an environment and philosophy that promotes student wellbeing.

This chapter is of particular relevance to administrators and decision makers within the school, however, other school staff involved in planning and facilitating whole school change may also find this information useful.

Why focus on prevention in schools?

Prevention aims to reduce the incidence of eating disorders by targeting risk and protective factors.

Risk and protective factors for eating disorders and other adolescent health concerns exist within the individual, the family system, the school environment, peer relationships, other relationships and the wider community. A coordinated whole school approach is an effective means of addressing multiple risk factors concurrently.

- Schools have the potential to influence the development of a young person's life skills. For example, young people learn about relating to others, coping and communication skills at school.

- Teachers and schools are in a unique position to initiate and maintain prevention efforts due to the sustained and medium to long-term relationships they develop with young people.

- For some students, school is the only place that they feel safe.

- The school setting has the potential to provide both opportunities and environments that foster resilience. These qualities assist in the prevention of a range of adolescent health issues, including eating issues and body concerns.

- Student learning is related to student welfare. The wellbeing of students affects their ability to learn and achieve at school.

Eating disorder prevention in schools - summary of the literature

> *"Students have a great need to perceive themselves as being able and competent, and their sense of self worth is closely tied to their feelings of competence."*
>
> (Covington, cited in Brown and Woodruff, 1999. pp. 230)

Interest in the prevention of eating disorders dates from the 1970's. The eating disorders prevention literature indicates that prevention within the educational setting is best addressed through creating a positive and supportive school environment. This whole school approach has been found to be effective in reducing the incidence of other adolescent health and wellbeing issues.

Prevention is ideally informed by theories that provide a framework for understanding the risk and protective factors associated with a health issue. Although theoretical models differ in their emphasis of particular risk factors, there is general support for the notion that the causes of eating disorders are multi-factorial and include:

- psychological factors such as individual or personality characteristics

- familial or psychosocial factors such as perceived importance of family life

- external social and cultural factors such as the dieting culture and the distribution of power within the wider cultural system.

Research indicates that weight loss dieting, extreme and/or frequent dieting is a common precursor to the development of eating disorders. Additionally, there is some consensus about the importance of socio-cultural factors in the development and/or maintenance of eating disorders.

Although research in the area of eating disorders prevention is in its initial stages, some prevention and intervention programs have been implemented and evaluated. A collaborative, holistic approach is thought to increase the effectiveness of these programs.

The World Health Organisation's *Health Promoting Schools Framework* provides a basis to develop prevention programs. Health promotion programs such as *The Gatehouse Project, Mind Matters* and the *Comer Process for Change in Education* have highlighted the potential of a whole school health promotion model.

Many of the principles highlighted by research and other models of whole-school change have been incorporated into the *Framework for Student Support Services in Victorian Government Schools* (Education Victoria, 1999). This Framework provides a useful model within which to address the issues of eating disorder prevention.

A review of the literature regarding eating disorder prevention is available at **www.eatingdisorders.org.au** and **www.ceed.org.au**.

Creating a positive school environment – a whole school approach

Effective prevention requires a coordinated approach across multiple domains. Risk and protective factors exist within the individual, the family system, the school environment, peer relationships, other relationships and the wider community. Multiple intervention strategies that aim to concurrently address risk factors and promote protective factors are more effective than focusing on separate or individual risk factors, and this requires a coordinated whole school approach.

Steps in creating whole school change

Facilitating change at a whole school level requires a cyclic process of planning, implementation and evaluation. Below is an outline of some suggested stages and corresponding tasks.

While it is beyond the scope of this resource to provide information and strategies for all of the tasks required for

whole school change, further practical information can be found in *Integrated health promotion: A practice guide for service providers*.

See **Chapter 7 – Additional resources** – *Health Promotion*.

Stage	Possible tasks
Planning	• Identifying or developing a health promotion model for whole school change
	• Reviewing issues or problems within the school community (a needs analysis)
	• Prioritising issues
	• Consultation with the school community
	• Developing school policies that promote protective factors and resilience
	• Developing school policies that reduce risk factors
Implementation	• Consultation with the school community
	• Developing practice and protocols that support policy implementation
	• Obtaining resources and support to implement polices, e.g. developing partnerships with the local community
	• Delegation of tasks
	• Problem-solving
	• Dealing with resistance
Evaluation	• Planning and developing monitoring and evaluation techniques
	• Monitoring policies and their relevance
	• Evaluating implementation strategies
	• Celebration of achievements

For eating disorder specific checklists to evaluate current practice and potential gaps relating to creating a positive and supportive school environment, see **Supporting resource 1.**

For information about facilitating change at a whole school level, including implementation models and dealing with challenges, see **Supporting resource 4.**

Planning

Identify and/or develop a health promotion model for whole school change

Several health promotion models have been created to guide whole school change. A number of these models utilise principles from the World Health Organisation's *Health Promoting Schools Framework*. There is consequently considerable overlap between the models.

Some of these models primarily address general adolescent wellbeing, while others have been developed with a specific focus on eating disorder and body dissatisfaction prevention. These models generally provide a conceptual framework for instigating and maintaining change within schools. The range of models available allows schools to choose a model/s that is suitable to their individual needs.

For a list of *health promotion models* specifically supporting whole school change see **Supporting resource 2**.

Policy development

Developing and implementing policies can be an effective way of initiating a whole school approach to an environment and philosophy that promotes student wellbeing. Enacted policies can provide and/or facilitate:

- a shared understanding of school priorities and values

- a school environment and philosophy that promotes wellbeing

- the reduction/prevention of factors that may contribute to disordered eating such as bullying and weight-related teasing

- the promotion of protective factors or resilience in young people such as opportunities to participate

- early detection and intervention of eating disorders and other risk behaviours or mental health concerns

- best practice models based on current knowledge of prevention

- consistent responses to incidents including critical incidents

- legal protection.

For guidelines and suggestions for developing and writing school policies, **see Supporting resource 3.**

Implementation

Develop practice and protocols to support policy implementation

Reducing risk factors

Risk factors are those that increase a student's susceptibility to social, behavioural and psychological problems. A number of risk factors relevant to the prevention of eating disorders and disordered eating have been identified through theory, research and practice. For example, *The Report on Eating Disorders Research 1993* (NSW Department of School Education, 1998), identifies three main issues within schools that contribute to body dissatisfaction:

- bullying, teasing, and discrimination (including sex-based harassment)

- 'healthism' (a term used to describe an unhealthy focus on weight, low-fat foods, weight loss dieting and weight-loss exercising, which can result in people feeling blamed or responsible for their size or shape)

- some aspects of sport and physical education.

School policy focusing on the following areas can be useful in addressing these issues in the wider school community.

Bullying, teasing and discrimination

> *"Schools need to be vigilant in addressing all forms of bullying to prevent feelings of inadequacy that are manifested in problems such as eating disorders."*
>
> (Student recovering from an eating disorder, Eating Disorders Resource for Schools Consumer Consultation, 2003)

Bullying and teasing have the capacity to affect a young person's self esteem, body image and mental health. In its extreme forms, bullying or teasing constitute harassment. Weight-related teasing has been identified as a risk factor for the development of eating disorders and problems.

Discrimination refers to making a distinction between individuals based on personal characteristics such as weight, race, physical appearance and gender. Discrimination may be apparent through comments and behaviours (such as ignoring), or more subtly such as through the inequitable distribution of resources.

For practical strategies to support the implementation of anti-bullying, teasing and discrimination policies, see **Supporting resource 4**.

Policies relating to anti-bullying, teasing and discrimination may address:

- the school's stance on bullying, teasing and harassment

- the different roles of people within the school when dealing with bullying, teasing and discrimination, for example, the roles of teachers, welfare staff and managerial/leadership staff may vary

- promoting acceptance of diversity in shape and size

- discouraging comments about weight, size and physical appearance from both staff and students

- ensuring equitable processes and resources across the school community.

Including students and members of the wider school community (such as parents) in policy development can foster a sense of ownership over the policies and their implementation.

Promoting protective factors

A supportive school environment

> *"Self-esteem is contagious."*
>
> (Fuller, 1998, pp. 9)

Protective factors are those that decrease a student's susceptibility to social, behavioural and psychological problems. Key protective factors in an adolescent's life include:

- connectedness to family

- connectedness to peers and fitting in at school

- feeling respected by teachers

- opportunities and rewards for school involvement.

A supportive school environment is associated with many positive educational and personal outcomes for both students and school staff. A sense of school connectedness and opportunities and rewards for school involvement are important protective factors for young people. For example, school connectedness is linked with increased self-esteem, lower levels of emotional distress and suicidal behaviour, and less frequent use of substances such as tobacco and marijuana.

For practical strategies to support the implementation of policies relating to a whole school approach to an environment and philosophy that promotes wellbeing, see **Supporting resource 5.**

Policies relating to a supportive school environment may address:

- positive relationships between staff and students

- positive relationships between students

- a confiding relationship with at least one adult

- communication protocols between all members of the school community

- opportunities to participate

- opportunities for rewards for a range of activities and achievements

- collaborative decision-making within the school

- structured support networks

- shared care and responsibility within the school

- acceptance and promotion of diversity

- a sense of physical, emotional and social safety

- role modelling of communication, self acceptance and acceptance of others.

Physical education

> *"Apart from organised sport, girls rarely use the playground for physical activity."*
>
> (NSW Department of School Education, 1998, pp. 105)

Physical education programs can promote physical and psychological wellbeing in students. However, they also have the potential to inhibit activity for some students, for example, by focusing on 'healthism', ability and/or weight.

Body image concerns and the culture around physical education within the school have been identified as factors that can inhibit students' enjoyment or willingness to participate in physical activity.

Several factors may contribute to poor student participation:

- students (male and female) feeling they have to be muscular and/or 'good' at sports in order to participate

- concern over body image or self-consciousness about the body

- fear of exposing one's body in public

- feeling 'too fat'

- fear of weight-related bullying, teasing or harassment.

Policies relating to physical education and sports within the school may address:

- availability of varied physical education and sports activities

- the balance of competitive and non-competitive physical education and sports activities offered

- the rewards offered to students around physical education and sporting activities

- the relationship between body image and involvement/enjoyment in physical activity

- conversations around potentially sensitive issues (e.g. weight, body shape and size, competitive performance)

- staff attitudes around health, fitness, body shape and size

- staff encouraging or suggesting dieting to students (or talking about diets to colleagues)

- staff as role models for positive body image

- measuring student performance and achievement (e.g. the use of scales, calliper tests, ranking students against each other rather than themselves)

- the culture around, and participation levels at sports days and carnivals

- imbalance in the level of participation, for example, gender, age groups, social groups

- the relationship between Health and Physical Education in the school curriculum

- the relationship between competitive sports and the development of clinical eating disorders

- the different roles of people within the school around policy implementation.

For practical strategies to support the implementation of policies relating to inclusive physical education and sports programs, see **Supporting resource 6**.

For further resources to support inclusive physical education in schools, see **Chapter 7 – Additional Resources** – *Inclusive physical education and sport programs.*

Developing partnerships with the local community

"Neighbourhood family events and informal networks have to be re-established and reaffirmed because they support and protect all children regardless of their individual family condition."

(Hernandez, 1999, pp. 49)

Feelings of connectedness and opportunities to participate in the wider community have been identified as important protective factors. Working with the wider community can have multiple benefits for the school, the individuals within the school and the wider community.

Benefits of working with the community

Individual student support

- Facilitating a connection between a young person and a community agency can provide support when it is lacking in the home environment.

- Facilitating resilience by:

  - providing opportunities for young people to positively participate in their wider community

  - creating opportunities for young people to experience rewards from a range of domains in their life.

- Accessing specialist support and information for families and/or students which can share responsibility for the wellbeing of a young person.

- Specialist organisations may provide secondary consultation to schools, for example, providing information to teachers about supporting students from culturally and linguistically diverse backgrounds.

Collective responsibility for wider social and cultural issues

- Shared responsibility for addressing risk factors in the wider community, for example, a culture around weight loss, frequent and/or extreme dieting or an increased availability of drugs.

- Facilitating consistent messages in young people's lives. For example the local youth centre staff, community service staff and school staff may:

  - attend the same training on working with young people around weight loss dieting or body image issues

  - develop a policy and procedure statement with the purpose of facilitating consistent messages to young people about issues such as weight loss dieting.

- Sharing resources, for example, a local youth worker may attend a school camp or a youth centre and school may co-host an education forum.

- Developing collaborative projects or programs for the benefit of the community. For example, a community art project.

- Sharing professional development, for example, two or three schools may share the costs of professional training in an identified area of need.

- Diversifying students' experience by creating opportunities for young people to participate in a broad range of activities.

- Community connections can facilitate the sharing of information that may aid the identification of additional relevant social and cultural issues that need to be addressed.

For practical strategies to develop partnerships with the local community, see **Supporting resource 7.**

For information about monitoring implementation strategies, see **Supporting resource 4** – *Monitoring and evaluation of policies and practices* and *Monitoring change.*

Eating disorder and body image dissatisfaction prevention programs

While this document is not intended to offer curriculum-based prevention programs, evaluation of existing programs provides valuable information about issues to consider when developing, selecting and/or delivering prevention programs.

> *"It is really hard to know what to say about eating disorders when in every class there may be students who are overweight or have anorexia."*
>
> (Secondary School Teacher, Eating Disorders Resource for Schools School Staff Consultation, 2003)

For a list of curriculum based resources, see **Chapter 7 – Additional resources –** *Curriculum based resources/guides for teachers*.

Eating disorder prevention and body image dissatisfaction have often been addressed in the same prevention programs. For a detailed evaluation of existing prevention programs please refer to:

Paxton, Susan. (2002) *Research Review of Body Image Programs. An overview of Body Image Dissatisfaction Prevention Interventions.* Prepared for the Victorian Government Department of Human Services, Melbourne, Victoria.*

Department of Human Services, Victoria. (2002) *Shapes: Body Image Program Planning Guide.* Rural and Regional and Aged Care Services Division, Melbourne, Victoria.*

*Available at
www.health.vic.gov.au/healthpromotion/quality/body_image.htm

Summary of prevention program reviews

What seems to be helpful

- Prevention programs are more effective if they concurrently target risk and protective factors from a range of domains (e.g. social, environmental and individual factors).

- Risk and protective factors from different domains are likely to require different prevention strategies.

- Prevention programs are likely to be more effective if they look beyond medical definitions of eating disorders and address sociological and environmental explanations. These provide a useful framework to understand the relationship between, gender, self-image and eating disorders.

- Prevention efforts are more effective if they are long-term rather than one-off responses.

- Prevention programs focusing on self-esteem show promise, as they have led to both immediate and long-term changes in participants.

- Prevention programs that challenge dominant cultural messages such as 'thin equals healthy' and 'fat equals unhealthy' may be useful.

- Secondary prevention programs (programs offered to young people at greater risk of eating disorders) may be more effective than primary prevention programs (programs offered to all young people).

- Interactive, participatory teaching strategies are more effective than didactic strategies when delivering prevention programs.

- Prevention efforts can increase identification of eating disorders, therefore it is important to have clearly defined protocols in place for supporting and dealing with the issue, for example, referral sources or in-school counselling strategies for students with eating disorders or body image concerns.

- It is important to have written protocols in place for students who self-disclose during a session.

- Providing basic selected information about eating disorders to students.

- When evaluating programs it is important to recognise that an increase in awareness or knowledge does not necessarily lead to immediate behaviour change (such as a reduction in weight loss dieting or extreme and/or frequent dieting). A lack of immediate behaviour change does not necessarily imply that the program has been unsuccessful. Prevention efforts need to be sustained.

What appears to be ineffective

- One-off prevention efforts, such as guest speakers.

- Fear tactics, such as presenting images of people with eating disorders.

What we need to know more about

- Eating disorder prevention is in its infancy. Evaluating prevention programs is important in order to increase the body of knowledge around effective prevention strategies.

- There is limited support for the effectiveness of including information about nutrition and healthy eating in prevention programs. While this may be useful to cover in other aspects of the curriculum, it does not appear to be an effective prevention technique.

- There is no strong evidence to suggest that eating disorder prevention programs have been effective in reducing behaviours associated with eating disorders in the long-term. However, some programs have shown an increase in knowledge and/or awareness of issues relating to eating disorders (which potentially may lead to behavioural changes in the long-term).

- There is some evidence to indicate that eating disorder prevention programs have been harmful (e.g. lead to an increase in body dissatisfaction or disordered eating in participants). Two studies have indicated a potential increase in eating disturbance, however, independent critiques of this research indicate non-conclusive results due to methodological issues (Paxton, 2002).

- Further research is necessary to clarify if prevention techniques/programs are potentially damaging. While most of the evaluated prevention programs to date have been well designed, it is important to determine effective ways of promoting protective factors and reducing risk factors relevant to eating disorders prevention programs.

- Deciding on a primary versus secondary prevention strategy is complicated by:

  - the difficulty in distinguishing risk factors from early symptoms or general adolescent issues

  - the variability in the course of eating disorders from person to person.

> For suggested strategies to evaluate prevention programs or strategies, see **Supporting resource 4** - *Monitoring and evaluation of policies and practices* and *Monitoring change.*

Issues to consider when developing or choosing a prevention program for adolescents

The theoretical basis of the prevention program

Prevention is ideally informed by theories that provide a framework for understanding the risk and protective factors associated with an illness. For example, programs that focus on socio-cultural factors may address media messages, while programs that target individual factors may focus on building self-esteem, decision-making skills and communication skills.

Addressing multiple risk factors

Different risk factors potentially require different strategies. Evaluation indicates that prevention is more likely to be effective if factors from multiple domains in the adolescent world are addressed on an on-going basis, including family, friends, school environment, individual factors and media.

One of the limitations of existing prevention programs is that they have predominantly focused on individual factors without addressing other factors such as weight-related teasing or bullying in the school.

Risk factors can be further defined into three categories:

- predisposing factors (e.g. individual characteristics, history of abuse)

- initiating factors (e.g. weight-related teasing, increased stress)

- sustaining factors (e.g. lack of support, wider cultural pressure).

Consult current research regarding risk factors

Current research indicates that there is a strong relationship between the following factors and disordered eating:

- negative body image or body image dissatisfaction

- depression

- dieting (research indicates that weight loss, extreme and/or frequent dieting is the most common risk factor in the development of an eating disorder - reducing the incidence of dieting may be a way to reduce the incidence of eating disorders).

Consult current research regarding protective factors

Prevention programs that focus on reducing risk factors and increasing protective factors (resilience) appear to be most effective.

Several potential protective factors have been identified:

- self-acceptance

- self esteem, self worth and positive regard

- life skills such as decision-making skills, dealing with attribution errors in thinking

- valuing diverse body shapes and sizes

- effective social skills

- media literacy skills (analysing and critiquing cultural messages)

- assertiveness skills.

Fostering the development of resiliency in young people requires a long-term, consistent whole school approach. Considering on-going ways to increase resilience is important for long-term change.

> See also **Promoting protective factors** – *A supportive school environment* in this chapter.

The aims of the prevention program

- What is the program trying to achieve?

- What is/are the key message/s of the program?

- Who is/are the best person/s to deliver the messages?

- What are the most useful teaching strategies to facilitate learning?

- What is a realistic number of sessions?

- What evaluation strategies will be useful?

- How will the messages/aims of the program be reinforced in the wider school culture and community (e.g. through the wider curriculum and school activities).

The target group

Secondary versus primary prevention

Consideration has been given to the effectiveness of primary prevention programs (including all students) as opposed to secondary prevention programs (focusing on students at greater risk of an eating disorder). Programs where students have elected to participate appear to be more effective.

Some of the factors that have been identified to guide the selection process for secondary programs include students who:

- diet for the purpose of weight loss (or diet frequently or by using extreme techniques)

- are overweight

- experience/d bullying or weight-related teasing

- have perfectionist qualities

- have issues with self-esteem, anxiety or depression

- have a family history of eating disturbance/disorders, or other mental health concerns

- have a history of physical or sexual abuse

- experience family pressure around weight, exercise or food consumption

- nominate to participate in the program.

Some of these factors may also be early warning signs, see **Chapter 4 – Early Intervention** – *Potential risk factors*.

Gender

Both males and females experience issues with eating and body image, although in different ways. There is support for providing non-gender specific programs as the causal factors of eating disorders may be similar for both genders. However it is useful to be aware of the different experiences males and females have in relation to body, self-worth and the influence of ideal images, for example:

- females report being more dependent on verbal approval than males and are more likely to internalise others' opinions

- females tend to dislike themselves more when they perceive their bodies do not meet dominant cultural ideals

- females associate being slim with approval from others and the ability to attract a partner

- males report distress related to their perceived failure to measure up to the stereotypical male ideal

- males are less likely to experience as much appearance-related teasing as females

- dominant cultural ideals perpetuate diametrically opposed stereotypes for males and females; the female ideal is thin, while the male ideal is muscular.

Single versus mixed gender prevention programs

While most prevention programs have focused on females, the issue of developing and implementing prevention programs with mixed gender groups has been raised.

Arguments for mixed-gender interventions include:

- both genders may gain an understanding of the cultural pressures the other is exposed to

- both males and females play a part in the wider social and cultural pressure each is exposed to. Awareness of this may reduce perpetuation of damaging dominant cultural messages.

Consideration of separate interventions for males and females includes:

- females may feel inhibited discussing body image and eating issues in front of males. This may also be the case for males with females

- male and female experiences of body image concerns and eating disorders are different and may require different prevention strategies

- in an adolescent population, the maturation levels of males and females may be different. For example, an educator may work with separate groups until year 10 level, after which it may be more successful to combine the groups.

Age

Eating issues and body image concerns intensify in early adolescence.

There is no consensus about the best time to offer prevention programs. However, developmentally appropriate programs offered throughout childhood and adolescence may be most effective at consistently supporting the development of protective factors and reducing the impact of risk factors.

The teaching style

Evaluations indicate that interactive, participatory teaching strategies such as group discussion, group activities and peer based learning are more powerful than didactic styles when delivering prevention programs.

The content of the program

Potential areas to address in prevention programs	
Self esteem and life skills	Self esteem (or positive regard), has been identified as a key variable in determining resilience and wellbeing. It is considered an important factor in the prevention of eating disorders and body image dissatisfaction, and other issues such as substance abuse, depression and suicidal behaviour. Programs that support students to recognise and foster their individual qualities and develop coping, decision-making and stress management skills have had positive, longer-term effects.
Social and cultural influences such as media	Young people are the target of intensive media generated messages about the ideal body and appearance. Media literacy skills, such as critically evaluating media messages and images, have helped to reduce the internalisation of the thin ideal in some prevention efforts. These critical evaluation skills may be useful in combating other messages from the young person's immediate social environment (for example, appearance-related comments from others).
Normal physical growth	Discussing and providing information about puberty, normal growth and development, expected and natural increase in body fat during adolescence (in females) and the influence of genetics over body shape and size have been useful in preparing adolescents for physical change.
Body awareness	This may include teaching about how the body regulates itself through hunger sensations and appetite and the value of listening to these body cues.
Changes in life/self issues	Discussing and providing information about changes often associated with adolescence such as relationships with family and friends, teasing and bullying and life experiences may support adolescents in their efforts to cope with these changes.

Potential areas to avoid in prevention programs	
Information about eating disorders	There is no evidence to suggest that talking about the causes, symptoms and detrimental effects of eating disorders or the use of case studies are effective prevention techniques. Further, there is some research to indicate that talking about certain aspects of eating disorders, for example symptoms, is potentially harmful as it may 'normalise' or glamourise the illness. Other health promotion efforts (e.g. substance abuse prevention) have also found that scare tactics are not a useful prevention strategy. Information about the causes, symptoms and detrimental effects may be useful to aid identification of eating disorders, but may be more useful to present in Professional Development sessions with teaching and school staff.
Information about nutrition or healthy weight ranges	Eating disorders and body image concerns are more commonly related to underlying issues such as self-esteem or an inability to cope, rather than food. Students have reported that programs focusing on nutrition, health and healthy weight reinforce the detrimental 'heathism' message (that we can control our body shape and size through food and exercise which can result in the young person feeling blamed and/or responsible for their body size and/or shape).

Guidelines for talking about eating disorders in the classroom

"Students want to know about eating disorders."

(Secondary School Teacher, Eating Disorders Resource for Schools School Staff Consultation, 2003)

Typically eating issues and disorders may be addressed in the school curriculum through welfare studies, physical education or other directly related subjects. However, integrating discussion and learning about eating disorders and related issues across the school curriculum may assist in promoting a consistent message across the school. For example, the issue may be integrated into the following subjects:

- self and society (e.g. cultural influences on self concept)

- home economics (e.g. principles of food preparation)

- personal development (e.g. self esteem, life skills)

- career and personal planning

- English

- history (e.g. the historical context of beauty)

- cultural studies (e.g. differences in the representation of beauty across cultures)

- family studies (e.g. the role of food in families)

- information technology (e.g. media)

- physical education (e.g. the value of activity for mental, physical and social health)

- science (e.g. biological changes in the human body during puberty).

Suggested strategies

- Conduct information sessions and discussions about mental illness in general.

- Be mindful of language that may ostracise or blame people who experience mental health concerns. For example, referring to a person as 'someone who is experiencing bulimia nervosa' rather than referring to them as 'a bulimic'.

- Be aware of your own personal issues and/or attitudes around body image, healthy eating, weight loss dieting, people who are overweight and people with eating disorders.

- Don't avoid questions about eating disorders, as this may reinforce the mystery that sometimes exists around them.

- Focus discussions about eating disorders on several aspects of the issue, not just the extreme physical consequences of anorexia nervosa that the media often portrays. For example, it is quite common for people to focus on the physical consequences (such as people who have died) without focusing on the social, emotional and psychological consequences.

- Avoid being overly focused on food, as eating disorders are more complicated than a food issue.

- Promote increased understanding and acceptance of a range of illnesses and the people who experience them.

- Encourage, normalise and promote help-seeking for emotional issues. For example, talk about everyone's need for support at different times in their lives.

Increasing staff awareness of eating disorders

"There is a great need for more education and knowledge regarding eating disorders in school staff, so that the issue is not one that strikes so much fear and avoidance."

(Former student who has recovered from an eating disorder, Eating Disorders Resource for Schools Consumer Consultation, 2003)

Increasing teacher's skills and knowledge is a primary prevention strategy. Awareness can assist in:

- early identification, prevention and restoration of wellbeing

- reducing fear around addressing the issue

- increasing staff awareness about the potentially damaging effect of comments about body shape, size, ability or weight on student's wellbeing

- shared responsibility for supporting students and their families

- knowledge of where to go for assistance

- the boundaries of their role.

Suggested strategies

- Provide professional development for school staff that facilitates:

  - understanding of the complexity of eating disorders and related mental health issues

  - a balanced understanding of the range of risk factors

  - knowledge of early warning signs

  - effective early intervention.

- Provide more specific professional development for school welfare and support staff that facilitates:

  - their capacity to support students with eating disorders

  - their capacity to support teachers working with students experiencing eating disorders

  - their capacity to support family members and friends of students with eating disorders

  - their understanding of treatment and how best to work with the treating health professionals

- their understanding of specific issues related to eating disorders that may impact on their support role. For example, career counsellors being aware that students experiencing anorexia nervosa may place an undue amount of pressure on themselves to succeed

- the boundaries of their role.

• Provide opportunities for staff to talk about their concerns and/or fears around eating disorders. As well as providing support to staff, this may indicate areas where staff feel they need additional information.

• Liaise with a service provider that treats eating disorders for the purpose of professional development and secondary consultations.

• Nominate a member of staff who is responsible for updating the school staff team about new services, information and issues around eating disorders. This staff member may access or become a member of professional bodies in the area of eating disorders.

• While it is being addressed in the wider community, develop activities to support existing community health promotion initiatives such as *Eating Disorders Awareness Week* and *No Diet Day*.

• Provide access to curriculum and educational resources specifically for teachers.

See **Chapter 7 – Additional resources** – *Curriculum based resources/guides for teachers*.

• The Curriculum Coordinator and the Student Welfare Coordinator may work together to facilitate the inclusion of eating issues and disorders across the curriculum so that all staff see it as a relevant issue.

• Accept invitations to participate in research around eating disorders.

Including parents in the school community

"Working with parents is important. We might do all this good stuff at school...that isn't reinforced at home."

(Secondary School Teacher, Eating Disorders Resource for Schools School Staff Consultation, 2003)

Parents, families and teachers share a common interest in the wellbeing of young people. Families and teachers can actively work together to create positive environments around students in and outside school, resulting in both academic and emotional benefits.

"When you get parents involved in the life of the school, you increase children's chances to succeed."

(Frazier, 1999, pp. 55)

Involving parents/families in the school community is an effective prevention strategy. A whole school approach to student wellbeing is based on positive relationships and open communication between all members of the community.

Suggested strategies

Creating positive relationships with parents/families

"Educators who truly welcome parents find the benefits virtually limitless."

(A school principal cited in Frazier, 1999, pp. 52)

• Develop communication protocols and opportunities with parents/families (for example, newsletters, email address lists, information evenings, parent/teacher interviews, more active support for families facing crises).

• Develop a *School Parent Team* that is responsible for involving parents/families across the school community. This team may work with other teams or committees within the school such as a *Student and Staff Support Team*.

• Actively involve parents/families in all levels of school activity from decision making to special events, for example:

- invite parents/families to be involved in planning and implementing new school initiatives

- have parental representation on all school committees or working groups

- invite parents/families to be involved in specific events (including planning, initiating and evaluating events)

- involve parents/families in the curriculum, offering support to teachers where appropriate

- involve parents/families in decision making (surveys, meetings, discussion groups)

- utilise the skills of parents/families, for example, a parent may be a landscaper who offers their time to develop a school vegetable garden

- maximise the number of parents/families involved in the school life by developing varied roles requiring different levels of commitment.

- Consider the continuity of relationships between the family and school staff. For example, a Year Level Coordinator may progress through the school years with students or the school may appoint a Home/School Communications Coordinator.

- Inform parents/families about new initiatives the school is taking on so that they can support this in the home environment.

Informing parents/families about eating disorders

"Encouraging active lifestyles has become more difficult in the last 10-15 years…parents are less likely to encourage their kids to walk or ride places because of neighbourhood safety. Also changes in family units…like one parent families or both parents working long hours means young people have more time alone, and prepare more of their own meals."

(Secondary School Teacher, Eating Disorders Resource for Schools School Staff Consultation, 2003)

- As a school, consider the messages you want to portray to parents/families about weight-loss dieting, eating and wellbeing.

- Include feature articles in school newsletters that will facilitate parents' understanding of the complexity of eating issues and disorders and the importance of protective factors.

  For information to include in newsletters, see **Chapter 7 – Additional resources** – *Support, referral, education and information services.*

- Consider directly posting or emailing newsletters to parents/families.

- Establish a *Parent Resource Centre* or library that contains literature and videos about adolescent issues and general parenting issues. Actively promote the library.

- Provide lift out information sheets for parents about various topics that may facilitate detecting an eating issue. Topics may include communication or effective conflict resolution skills.

  Information is more useful when presented:

  - in an entertaining way, for example, by students as a drama performance

  - as a suggestion rather than a direction

  - in a positive way (e.g. "here are some options" rather than "you shouldn't")

  - with clear headings

  - using bullet points.

- Provide support for parents in their role. For example, the school may work with parents to become aware of the value of enhancing protective factors and reducing risk factors in the home environment. This may be done formally or informally.

- Provide opportunities for parents/families to interact socially, for example, designate a parents' meeting room within the school or host parent morning teas.

- Establish a *Family Interactive Centre*.

"…As you walk into this fairly large room, you see couches…fresh tea and coffee…computers, work areas, the parent's library. Parents with infants…exchange parenting tips. Workshops are held on nutrition, the social services…The Family Interactive Centre helps families to…understand the practices that support their children's education…In the Centre, informal relationships develop that are powerful and meaningful."

(Hernandez, 1999, pp. 49)

- Provide specific programs for parents/families aimed at increasing their knowledge around eating disorders and their parenting skills. It may be useful to include information/discussion about:

  - normal adolescent changes (physical, emotional, social)

  - effective, supportive parenting (a young person's need for stability, boundaries, support, parental confirmation, trust)

  - risk factors in the development of eating disorders (addressing factors across different domains, such as cultural, social, familial, psychological)

  - protective factors against the development of an eating disorder (opportunities to participate, positive rewards, life skills, self esteem)

  - parental attitudes around weight, healthy eating, weight loss dieting, body image and eating behaviours and the impact these may have on their son or daughter

  - practical skill development such as effective communication, conflict resolution and relaxation skills.

- Provide a joint program for parents and their son and/or daughters. This may be a useful forum to explore common issues. Consider employing an experienced family therapist to run these programs.

- Parents and families can sometimes feel blamed for the development of the eating issue or disorder. This is not helpful for anyone involved. Where appropriate, inform parents of additional models explaining the causes of eating disorders (for example, focus on the psychological, social and cultural factors, not just family system models).

- Offer details of specific information and support agencies to parents/families that may assist them in times of high need.

  See **Chapter 7 – Additional resources** – *Support, referral, education and information services*.

- Encourage parents/families to examine their own feelings and/or concerns with body image, weight, healthy eating, weight loss dieting and exercise. Encourage parents/families to be positive role models around general wellbeing (which includes a positive relationship with food and exercise).

- Encourage parents/families to be supportive of their child at any weight or shape.

- Inform parents/families of the potential harm of comments or teasing (from siblings or parents) about weight, body shape or size. Encourage parents to discourage teasing from siblings.

- Organise information evenings/forums for parents/families with guest speakers. Schools in a region may get together and share the planning and costs. Consider a broad title that will reduce stigma with attending such as *Healthy eating, body image and eating issues* rather than *Eating disorders*.

- Implement the *Creating Conversations* model. *Creating Conversations* is a program designed to encourage conversation between young people and their parents. It has been implemented and evaluated in several Victorian schools through the Victorian Department of Education and Training.

  See **Chapter 7 – Additional resources** – *Models of intervention*.

- Be mindful that not all families have the same access to financial or personal resources.

Chapter summary

Schools are in a unique position to initiate prevention efforts because of the sustained and long-term relationships they develop with young people. Risk and protective factors for eating disorders and other adolescent health concerns exist within the individual, the family system, the school environment, peer relationships, other relationships and the wider community. A coordinated whole school approach is an effective means of reducing risk factors and increasing protective factors concurrently.

Case examples

A group of schools in a region got together to host an education evening for parents and other members of the school community. Melbourne-based practitioners specialising in the area of dieting and eating issues were invited to speak.
Secondary School Teacher, Eating Disorders Resource for Schools School Staff Consultation, 2003

A public school has developed a position in the school welfare team as Home/School Communications Coordinator. This person's role focuses on facilitating communication between the school and the student's family.
Welfare team member, Eating Disorders Resource for Schools School Staff Consultation, 2003

A school organised a Pancake Day, where parents and staff cooked pancakes for students. This is an interactive way of promoting food as social and enjoyable to everyone in the school community including parents, students and teachers.
Year Level Coordinator, Eating Disorders Resource for Schools School Staff Consultation, 2003

PE cooking program - As part of the regular PE program, a school devotes a two-week period to cooking and nutrition. The program aims to educate students and their family about nutrition in an interactive way. Teachers prepare menus and provide an information sheet to parents about the program, its purpose and what is required of each student. Each lesson, students are responsible for bringing one of the ingredients to prepare a meal together. Parents are involved in the process of supplying the ingredients.

The teachers found that parents supported the program (at times supplying additional ingredients) and were interested in what students were learning about nutrition.
PE and Health Coordinator, Eating Disorders Resource for Schools School Staff Consultation, 2003

Early intervention

Who in the school is this information relevant for?

The information presented in this chapter and the corresponding supporting resources focuses on identifying potential problems before they develop. This chapter is of particular relevance to anyone within the school who has contact with students, such as teachers, welfare staff and managerial/leadership staff (such as Year Level Coordinators and Principals).

> *"The Welfare Teacher said something to us at the same time that we noticed the evidence."*
>
> (Parent, The Experiences and Needs of Carers and Families Living with an Eating Disorder, Beyondblue Consultation, 2004)
>
> *"Early intervention minimises potential harm by improvements in identifying, assessing and managing students at risk."*
>
> (Education Victoria, 1999, pp. 30)

Why focus on early intervention in schools?

Early intervention (also known as secondary prevention), targets people who are either at greater risk or show early signs of an eating disorder.

Early intervention is an effective way of reducing the likelihood that eating issues and mental health concerns will develop into eating disorders. Early intervention in the area of eating disorders is important for several reasons:

- most eating disorders begin in adolescence
- disordered eating (or subclinical eating disorders) are common and increasing in prevalence
- eating issues and disorders have the potential to substantially derail a young person's life - physically, academically, emotionally, psychologically and socially
- early intervention improves the outcome of treatment. Treatment duration and intensity tend to increase the longer an eating problem has been present.

Early intervention - summary of the literature

Eating problems, weight loss dieting and body dissatisfaction are prevalent in young people. These issues are of particular importance as they are associated with the onset of eating disorders. Australian research with adolescents/children has found that:

- almost one in two females and one in three males reported using extreme weight loss measures at some point
- almost seven out of ten 15-year-old females reported being on a diet. Of these, almost one in ten were dieting severely

- one in four seven year olds has dieted to lose weight
- over one in three adolescent females regularly overeat to the point of discomfort or nausea
- over one in four females felt unable to control the urge to eat at times.

Identification of risk factors is important in early intervention. However, it can be difficult to determine a set of identified risk factors for eating disorders because:

- factors leading to the development of an eating disorder differ between individuals. There is no single causal pathway
- eating disorders do not have a clearly defined onset or offset point
- distinguishing a correlate from a risk factor can be problematic. For example, a factor may be a result of, rather than a cause of, an eating disorder
- there is overlap between some risk factors for eating disorders and common adolescent developmental behaviours, such as dieting.

Despite difficulties in identifying causal factors for eating disorders, there is considerable consensus about some factors. Weight loss dieting or extreme and/or frequent dieting, psychological morbidity and socio-cultural factors have been identified as factors in the development of an eating disorder. Targeting dieting and socio-cultural factors may be an effective early intervention strategy.

A review of the literature regarding early intervention and eating disorders, is available at **www.ceed.org.au** or **www.eatingdisorders.org.au**

Facilitating early intervention in the school

"All teachers have a responsibility to respond when students experience difficulty with their schooling, so it is imperative that they identify and act on their concerns to enable early and effective intervention for students."

(Education Victoria, 1999, pp. 6)

Like prevention, early intervention in schools requires an integrated approach. Different people within the school may be responsible for different levels of intervention. For example, managerial/leadership staff may primarily be involved in identifying and modifying risk factors within the school environment, while teachers may have a role to play in identifying changes in a student's wellbeing.

Students at risk

"The school teacher at the high school pinpointed it and I am so grateful to that lady."

(Parent, The Experiences and Needs of Carers and Families Living with an Eating Disorder, Beyondblue Consultation, 2004)

Teachers are in a unique position to identify changes because of the long-term, sustained relationships they develop with students. While it is expected that teachers are able to detect when the majority of students aren't 'travelling well', they are not responsible for diagnosing or identifying the issues a student may be dealing with.

There are multiple risk factors for the development of eating disorders. However, the development of eating disorders differs from person to person, and may vary between:

- individuals
- different eating disorders
- different age groups
- different cultural groups
- males and females.

Potential risk factors

"The transition from primary school to secondary school seems to have been when it started."

(Parent, The Experiences and Needs of Carers and Families Living with an Eating Disorder, Beyondblue Consultation, 2004)

Not everyone who is exposed to the following risk factors will develop an eating disorder. However, those who are exposed are at greater risk.

- Adolescence. The peak onset for anorexia nervosa is around the age of 13 to 15 years, while bulimia nervosa has a peak onset time in the later adolescent years.
- Weight loss dieting or frequent and/or extreme dieting. Females who diet severely are eighteen times more likely to develop symptoms of an eating disorder, while females who diet moderately are eight times more likely to develop an eating disorder. Dieting behaviour is the most common precursor to the development of disordered eating. Early intervention may best be aimed at reducing the incidence of dieting.
- Athletes, and people involved in high level sports and fitness, including gymnastics and ballet.
- Being exposed to unhelpful messages around health and weight. For example, undue emphasis on 'healthism' (an unhealthy focus on weight, low-fat foods, weight loss dieting and weight-loss exercising). 'Healthism' promotes the message that our body shape and size are predominantly determined by what we eat and do, invariably assigning 'blame' to young people who do not fit a prescribed healthy weight range.
- Attitudes around body weight and image from role models such as teachers, particularly PE teachers and sports coaches.

  For further information about addressing the risk factors above, see **Chapter 3 – Prevention –** *Promoting protective factors – Physical education.*

- Young people with features of mental illness (such as depression or anxiety).
- Young people who are, (or have been) overweight.

  See also *Supporting students at greater risk because of issues with excess weight* in this chapter.

- Students involved in activities such as drama and dance, where weight and body shape are considered a factor affecting performance.
- Teasing, bullying, sex based harassment and weight related teasing.
- Young people with difficult peer relationships.
- Young people who experience conflicting pressures from different cultures.
- Concern about appearance in primary and high school.
- Periods of high stress, such as transition from primary to high school, exam times or year 12.
- Young people with perfectionist qualities.

  See also *Supporting students at greater risk because of perfectionist qualities* in this chapter.

Assessment of risk factors within the school

Policies relating to the assessment of risk factors may include:

- descriptions of risk factors relating to eating disorders

- methods of detecting risk factors within the school environment

- standard reporting protocols and procedures regarding identified risk factors for teachers, parents/families and students

- monitoring changes in students.

Suggested strategies to support policy implementation

- Create awareness of early warning signs within the school community by:

  - providing professional development for teachers and other school staff that focuses on understanding warning signs

  - holding education forums or discussion groups for parents/families

  - newsletter articles

  - inviting guest speakers to talk to students about general wellbeing issues and risk factors.

- Create opportunities for the school community to identify and report risk and protective factors (e.g. surveys).

- Develop and promote reporting protocols and procedures to inform appropriate people (e.g. the welfare team) of risk factors existing within the school environment.

- Reward students when they inform relevant people about potential risk factors.

- Review discipline/student management practices. For example, facilitate discussion of how reward and punishment practices within the school may affect students who have perfectionistic qualities.

Identifying students at risk

Policies relating to identification of students at risk may include:

- descriptions of risk factors relating to eating disorders

- documentation of procedures for teachers noticing changes within students

- reporting protocols and procedures for teachers, parents/families and students regarding students who may be at risk

- the different roles people within the school have around early identification. For example, teachers can play a role in identification of students experiencing difficulties, while welfare staff can play a role in intervention

- the school's stance on confidentiality and duty of care in relation to eating disorders

- follow up steps and who is responsible for any subsequent action.

Suggested strategies to support policy implementation

- Develop reporting protocols and procedures to inform appropriate people (e.g. the welfare team) of students who may be at risk.

- Facilitate communication between staff and students so students are less likely to conceal changes in their own or others' wellbeing.

- Encourage teachers to document observations of all students to facilitate accurate identification of any changes. Documentation does not have to be lengthy. For example, teachers may monitor and document:

  - school and/or class attendance

  - academic performance

  - concentration or interest levels in class

  - behavioural patterns

  - socialising patterns

  - unusual behaviour

  - general concerns.

- Conduct face-to-face wellbeing surveys across year-levels or other groups within the school (e.g. sporting groups). This can be used to identify students at risk, but the information can also be used to monitor changes in students.

Case example

In a rural school, staff members (such as the Secondary School Nurse and a member of the welfare team) make the time to meet with each student (in a year level) and provide an opportunity for that student to raise any concerns. Additionally, the nurse asks the student standard questions about their physical, social and emotional wellbeing to explore any concerns further.

This provides an opportunity for early identification of any physical, social or psychological concerns, but also reinforces the role of the welfare team in the school.

School Health Nurse, Eating Disorders Resource for Schools School Staff Consultation, 2003

Support systems within the school

Policies relating to support systems within the school may include:

- coordinating support for students

- a standard internal referral process for school staff to follow when concerned about a student

- the different roles and responsibilities of people within the school

- enhancing informal support networks within the school

- guidelines for contacting parents/families or external support agencies

- the school's stance on confidentiality and duty of care in relation to eating disorders

- ensuring equitable access to support systems for all students within the school.

Suggested strategies to support policy implementation

- Develop and promote guidelines for internal referral within the school so that different members of the school staff team follow a consistent process that ensures students experiencing difficulties are linked into the school's formal support systems.

- Find ways to maintain or improve the coordination between staff involved in formal support networks, for example:

  - develop and implement communication protocols between members of different support teams (e.g. regular meetings between welfare staff and managerial/leadership staff such as Year Level Coordinators)

  - a common documentation procedure (such as a form) that facilitates consistent reporting of concerns.

- School Counsellors and the welfare team may function as a primary resource for teachers and parents/families as well as for students. For example, they may also:

  - support teachers who are working with students who are at risk. The welfare team may invite them to relevant meetings (if appropriate), or offer information and strategies

  - provide the role of family liaison

  - provide a *Parent Support Program* for parents/families concerned about, or experiencing difficulties with their son/daughter. This group may meet as needed for a designated period and focus on relevant skills such as communication skills, conflict resolution and sharing strategies

  - ensure confidentiality is appropriately addressed at all levels within the school.

See also **Chapter 5 – Intervention**– *Finding a balance between confidentiality and potential risk* and *Providing information to other people.*

- Provide opportunities for the welfare staff (including School Health Nurses and Counsellors) to participate in the wider school community to increase their presence in the school. For example the welfare team may:

  - be involved in sports days or other school events

  - speak at assembly

  - meet with individual classes about specific issues or general wellbeing

  - run support groups for specific issues.

- Document policies around confidentiality and make these available to students. *Students report greater levels of satisfaction with counselling and school support systems when confidentiality is explained to them.*

- Develop a support plan in consultation with individual students who may be at an increased risk. Identify the student's counselling/support needs and the key person to work with the student.

- Provide professional development and training for the welfare team about eating disorders and their treatment.

- Develop a database of local individuals or organisations that provide specialist services around eating disorders and body image.

- Facilitate the development of peer support systems such as buddy systems, support groups and discussion groups targeting issues. For example, a regular discussion group may meet to discuss different topics relating to body image, weight loss dieting and eating issues.

Case example
An example of early intervention in a school

It was one young person's friend at school who noticed over a few weeks that she wasn't eating and they contacted teachers. A teacher spoke with the girl and then talked with the parents, who, while they hadn't noticed anything themselves, did say their eldest daughter had talked with them a few nights before, saying that she felt something was wrong, that her sister was throwing up her lunch at school…The school referred them to me, and we decided on a way to approach their daughter…The girl didn't deny it; she acknowledged that she was worried about how she looked and wanted to lose weight to be like her older sister, who, in fact, had a completely different body shape. It seemed the non-eating had been triggered about six weeks before when the older sister had played the leading role in a ballet performance – tall, thin, attractive, graceful and beautiful. She wanted to be like that, too. I didn't actually ever see this young woman. I did support the parents and the teacher as they helped her to see that she…had talents and abilities that her sister didn't have. They were able to help her to be more accepting of herself.

Due to the awareness and action of the school, this situation was arrested before it developed. One further outcome was that the parents took the girl to a dietitian who was very empathetic…helped her to understand how she could eat and exercise to feel good about her body and herself. The girl had expressed some concerns about the amount of weight she had put on in the last year…This was only a concern at this stage, not a morbid fear, and was easily dealt with. So within a couple of months this young woman had turned herself around. Would it have developed into diagnosable anorexia? Possibly.

Harris, 1996, pp. 47-48

Monitoring and evaluating students at risk

See also **Chapter 5 – Intervention** – *Approaching a student.*

Monitoring a student's wellbeing and evaluating the effectiveness of any implemented strategies may form part of the early intervention process.

Policies relating to monitoring and evaluating students at risk may include:

• monitoring procedures

• evaluation procedures

• documentation procedures

• reporting changes to relevant people.

Suggested strategies to support policy implementation

• Decide on a person or people who will take responsibility for monitoring changes in the student's wellbeing.

• In accordance with confidentiality principles, liaise with other people in contact with the student, e.g. teachers, parents and friends (if appropriate).

• Decide on a teacher who will take on the role of engaging informally with the student for a period of time each week, for example, 10 minutes. This may involve an informal chat in the playground or before school.

For more information about the protective value of a supportive adult, see *The Advocacy Project*, **Chapter 7 – Additional resources** – *Health promotion.*

• Develop check-lists of physical, social, behavioural and psychological signs for teachers to facilitate monitoring the development of potential problems so that they can refer a student to specialist support for diagnosis if necessary.

Developing early intervention programs

While this document is not intended to offer curriculum-based intervention or targeted programs, evaluations of existing programs provide information about issues to consider when developing, selecting and/or delivering programs.

"Students learn better when they don't realise they are being taught."

(School Welfare Coordinator, Eating Disorders Resource for Schools School Staff Consultation, 2003)

For a list of curriculum-based resources, see **Chapter 7 – Additional resources** – *Curriculum based resources/guides for teachers*.

See **also Chapter 3 – Prevention** – *Eating disorder and body image dissatisfaction prevention programs – summary of prevention program reviews* and *Issues to consider when developing or choosing a prevention program for adolescents*.

Policies relating to the development of early intervention programs may include:

- guidelines around choosing and/or developing programs to address the needs of students at increased risk

- guidelines around facilitator conduct and choice (e.g. is the facilitator a teacher with additional training or someone from an external agency?)

- the process of inviting students with an increased risk to be involved in an early intervention program

- evaluating procedures regarding any early intervention programs implemented within the school

- reporting procedures around the outcomes of the program

- promoting the meaning and aims of the early intervention programs across the whole school environment and culture.

Suggested strategies to support policy implementation

- Offer both short and longer-term activities/programs during high-risk times such as the transition from primary to high school, exam periods and Year 12.

- Invite a psychologist or another health professional from the local community to periodically come and talk about looking after yourself physically and emotionally during exam periods (rather than a talk on eating disorders). Strategies such as this are not effective in isolation. Support students in implementing strategies by running follow-up programs.

- Periodically invite trained professionals from the local community to deliver programs to students addressing related areas such as body image and self-esteem (rather than a talk on eating disorders). Again, strategies such as this are not effective in isolation. Support students in implementing strategies by running follow-up programs.

- Invite a member of the community specialising in relaxation (or some related discipline like yoga or meditation), to offer lunchtime or after-school sessions for students.

- At the beginning of Year 12, conduct interviews with each student about what they want to achieve during the year and their support needs. This strategy can also be used at the beginning of Year 7 focusing on any questions or concerns students have and how they are fitting in to the school generally.

- Incorporate learning about personal coping responses and decision-making skills (and other life skills) into the existing curriculum. This will support students who are at greater risk, but it will also serve as a prevention strategy for students who are not.

- Run issues-based groups such as anger management groups, stress management groups, assertive skills training or body image management groups. Consider the strategy you use to invite students to attend issues-based groups as some students may feel targeted. When students self-select to attend a program, the benefits are usually greater.

Supporting students at greater risk because of issues with excess weight

The school can play a role in minimising the impact of this risk factor on students.

Note - Being overweight has been an identified risk factor for the later development of an eating disorder. However, being overweight can also be a symptom of the clinical eating disorders, *binge eating disorder* or *bulimia*.

- Treat students equally regardless of their weight or size. For example, invite all students to be part of all activities.

- Affirm qualities in the student that are not appearance related.

- Provide opportunities to develop qualities in the student that are not appearance related. For example, the *Game Sense* Model (Australian Sports Commission, 1999) provides practical session plans that foster the development of life skills.

See **Chapter 7 – Additional resources** – *Inclusive physical education and sports programs.*

- Consider ways of addressing the needs of students who are experiencing issues with excess weight or obesity. For example, consult with professionals who are experienced in this area.

See **Chapter 7 – Additional resources** – *Special interest organisations.*

- Consult documents that provide practical examples and suggestions of how to include students with both physical and psychological barriers to participation. For example *Give it a Go. Including people with disabilities in sport and physical activity* (Australian Sports Commission, 2001).

See **Chapter 7 – Additional resources** – *Inclusive physical education and sports programs.*

- Develop strategies that are mindful of not blaming or drawing attention to the student while supporting them in a way that is useful to them, for example:

  - Create a lunchtime walking group. While promoting an active, healthy lifestyle rather than weight loss exercise, a walking group may also create and strengthen protective factors such as a sense of community and peer relationships within the school, particularly for young people who may not be linked into a social group.

  - Organise optional lunchtime activities. For example, students may be invited to walk to a nearby park or recreation area. This may provide an opportunity for students to use recreational equipment that they may otherwise not use at school.

  - Create a gardening group. This offers an opportunity for young people to actively participate in their environment.

- The *Walking School Bus* is a practical concept that is being used in Victoria, Australia and other countries. The concept involves trained community members (sometimes parents) acting as the 'bus driver' and 'conductor'. The bus follows a set route to and from the school.

  It has many benefits for the immediate and wider community. For example:

  - relieves parents/families of transporting students to school

  - provides a safe travelling alternative for young people who may not otherwise travel with anyone

  - may actively engage other community agencies (e.g. council may fund the project, community members may act as 'bus driver')

  - promotes an active/healthy life style rather than weight loss exercise

  - provides an opportunity to create and strengthen a sense of community and relationships within the school, particularly for young people who may not be linked into a social group

  - lessens traffic congestion around school zones

  - reduces environmental pollution through less car travel.

For more information about *The Walking School Bus*, see **Chapter 7 – Additional resources** – *Models of intervention.*

For other strategies to promote physical activity and wellbeing for each student regardless of body size, shape or ability see **Chapter 3 – Prevention** – *Promoting protective factors – A supportive school environment – Physical education.*

Case example

A PE teacher developed a lunchtime discussion and gentle exercise program for students who were unable to participate in the general physical education program (target group - students over 120 kilos). Students were invited to attend a wellbeing program (not focused on weight loss). The program created an opportunity for students to exercise gently and discuss any issues they raised in a non-competitive environment with the support of a PE teacher and each other.

Parents were informed about the aims of the program and were encouraged to work with and support the students.

PE Teacher, Eating Disorders Resource for Schools School Staff Consultation, 2003

Supporting students at greater risk because of perfectionist qualities

Perfectionistic qualities have been identified as a risk factor for the development of eating disorders, particularly anorexia nervosa. Although it is the teacher's role to value and encourage students to excel academically, at times this may be counterproductive. In such cases, teachers can find it difficult to find a balance between encouraging students academically while maintaining their educational role.

- Praise selectively. For example, praise what the student has achieved rather than the process or how well they achieved it.

- Identify what is 'good enough' with the student.

- Model 'safe failing' at school. For example, emphasising that people have talents in different areas and no one is good at everything.

- Explore the positives and negatives of meticulousness with the student.

- Consider using a competent/not yet competent marking system (as opposed to a graded system) for some non-essential assessment.

- Emphasise the process of learning rather than getting the best mark. For example, rather than failing students, provide opportunities for students to re-submit work (focusing on their learning rather than on the assessment or grade).

- Be aware of the language you use as a teacher with all students (e.g. use positive language such as "*You are on the right track, have another go at …..*" rather than "*You haven't passed this assignment*.")

Chapter summary

Early intervention is an effective way of reducing the likelihood that eating issues and emotional concerns will develop into eating disorders. Schools may be involved in assessing risk factors within the school environment, identifying students at risk of an eating disorder, supporting, monitoring and evaluating students at risk and developing early intervention programs.

Intervention

Who in the school is this information relevant for?

The information presented in this chapter, and the corresponding supporting resources, offers strategies and suggestions to support school staff working with young people with eating issues, or disorders, and their families and friends. The information is of particular relevance to staff within the school who have a welfare or support role, but is also useful for teachers directly working with students experiencing eating disorders.

"Student learning cannot be separated from student welfare."

(Education Victoria, 1999, pp. 6)

"Intervention involves a range of student support services for a smaller number of students with serious problems."

(Education Victoria, 1999, pp. 8)

"The school, through the Year Level Coordinator, have been a fantastic support to us."

(Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)

Why focus on intervention in schools?

Schools can be actively involved in supporting students and their families through an eating disorder. Eating disorders can lead to physical, psychological and emotional consequences and can be difficult for all people involved. An eating disorder can impair a young person's capacity to function and maintain usual school work and activities.

Different staff within the school may be involved in:

- identifying changes in a student's wellbeing
- following internal referral guidelines to ensure students have access to the school's formal support systems
- notifying parents/families
- encouraging referral for medical assessment
- supporting the student and their family
- supporting friends of the student
- liaising with the student's family and the treating health team
- providing academic support for the student
- being flexible
- maintaining appropriate levels of confidentiality.

It is not the school's role to:

- diagnose eating disorders
- provide treatment for eating disorders.

Roles and responsibilities

Being aware of the roles and responsibilities of the people involved in intervention can help to determine appropriate action. Different people may be involved in the treatment and/or support of a student with an eating disorder. For example:

- staff directly teaching the student
- the designated school welfare/support team
- the external professional/s or treating health team
- the student's family
- the student's friends.

The role of the school

- Schools have a responsibility to ensure that the student welfare team is in a position to support students who are at risk of, or who have developed, an eating issue or disorder.
- Schools have a responsibility to establish and promote internal referral guidelines for all school staff to follow when concerned about a student.
- Schools can contribute to ensuring effective communication occurs between relevant members of the school community while maintaining the student's confidentiality.
- Schools have a responsibility to have a documented and easily accessible crisis management plan to ensure staff and students are supported through any critical incidents.

The role of the student welfare/support team

- To respond to internal referrals from within the school.

- To identify potential eating issues or disorders.

- To liaise with and/or refer to external professionals or a treating health team.

- To provide ongoing support to the student around the eating issue or disorder.

- To support and provide information to teachers working with the student.

For suggested strategies to support students, see *Providing ongoing support to students - The student support service/welfare team* in this chapter.

The role of the teacher

"I taught her…so I was aware of what was going on but I didn't want to make a big deal of it. Do you play it down? Or do you just quietly let them know that you are aware and that you are there to support them – which was probably the angle that I took…I think you feel lost. You've got to come back onto your own resources all of the time and you think, 'How do I deal with this kid? What do I do?"

(Teacher - Report on the Eating Disorders Project 1993, NSW Department of School Education, pp. 109)

"Sometimes they (teachers) expect me to be able to concentrate when at times it's rather difficult."

(Student experiencing an eating disorder, Eating Disorders Resource for Schools Consumer Consultation, 2003)

Teachers report feeling frustrated and at a loss when dealing with students who are experiencing an eating disorder. Teachers may experience confusion about whether they are doing enough, especially if the recovery phase is slow. This is complicated by the fact that every case is different and what works for one student or family may not work for another.

If you are identified as one of the staff to provide ongoing support to the student, see also *Providing on going support to students – Teachers identified as part of the support team* in this chapter.

Teachers' roles may involve:

- Identifying when students may be experiencing an issue or problem. Teachers are not responsible for identifying what the issue may be.

- Following the school's internal guidelines about referring students they are concerned about to the student welfare/support team.

- Following the school's policies and procedures about supporting students with mental health concerns. This will ensure that teachers have a consistent approach towards students and will take the pressure off individual teachers in deciding the best course of action.

- Working with the team supporting the student. Communicating with the team about their experiences with the student and/or any changes they notice.

- Where possible, maintaining the student's confidentiality. For example, consulting with the student welfare team in hypothetical ways.

The role of the student

Although support is essential for a person recovering from an eating disorder, it is important that the young person takes an active role in his or her own recovery.

Reducing the young person's responsibility by being overly responsible can be counter-productive. Although flexibility is essential, it is important to find a balance between being flexible and accommodating the behaviour associated with eating disorders. Accommodating such behaviour can reinforce it.

For example, it is important to maintain boundaries for inappropriate behaviour. Not imposing consequences means that the school learns to co-exist with the eating disorder, rather than the student with the eating disorder learning to co-exist with the school.

Students are responsible for:

- their own recovery, including the pace, progress and process of therapy

- their behaviour

- adhering to the school's expectations/guidelines

- asking for help and support and communicating their needs.

The role of parents and/or the family

Parents and families vary in their involvement in the treatment and support process. Some young people prefer that their parents/families don't know they are receiving support at school. Whether a young person receives medical treatment without parental knowledge is a concern for medical professionals, not the school. However, this needs to be assessed on an individual basis and balanced with the school's duty of care.

Parents/families may:

- Provide information to the school support team about:

  - the student's changing needs

  - external treatment, including progress and process

  - support the school may provide.

- Obtain medical and psychological treatment for their child.

When is a problem a problem?

See also **Chapter 4 – Early Intervention** – *Identifying students at risk* and **Chapter 2 – Current information about eating disorders** – *Warning signs and consequences*.

Although it is not the responsibility of school staff to diagnose an eating issue or disorder, it is within their role to identify students who might be experiencing a problem.

Identifying a problem can be complicated by several factors, including:

- the shame and secrecy often associated with eating issues or disorders

- the overlap between some early warning signs for eating disorders and general adolescent developmental issues (such as body image concerns)

- different signs and symptoms from person to person.

Guidelines for identifying possible eating disorders

- As a general rule, treat any symptoms seriously as it is never too early to act. Early intervention improves the outcome of treatment.

- Look for clustering of symptoms. Be aware of warning signs across different domains such as behavioural, psychological, physical and emotional symptoms.

  See **Chapter 2 – Current information about eating disorders** – *Warning signs and consequences*.

- Eating disorders can be concealed by the person. Initial observation of symptoms does not necessarily indicate the eating disorder is in its initial stages.

- Match the level of intervention to the immediacy and severity of the problem. In some cases it may be appropriate to monitor the student's behaviour and coping while offering regular support. In other cases it may be more appropriate to discuss the situation with the student's parents, encourage a direct referral to a GP and actively assist the student to access support and help.

For example, the approach the school takes may differ for the following scenarios:

- A student whose marks and attendance have been dropping, and who is displaying decreased concentration and socialisation in class, as well as unusually aggressive behaviour. Recently this student's parents separated and their father moved interstate.

- A student who talks about hating their body, wishing they were thinner, who has begun wearing baggy clothes in PE.

Approaching a student

"I think there is a definite place for schools…to sensitively approach both the students and the parents with the utmost confidentiality about the perceived problem."

(Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)

Deciding how and when to approach a student who has a potential eating disorder can be difficult. Although there is no uniform way to do this, below are some suggestions and considerations.

Before talking to the student

These suggestions may be useful for both teachers and school welfare staff, depending on who approaches the student.

- If you are not part of the welfare team, speak to the School Counsellor or welfare team first about your concerns to:

  - consider the best person to approach the student

  - consider an appropriate time to approach the student

  - determine any immediate intervention and who is responsible for it, for example, approaching family members.

To protect the student's confidentiality, you may choose to speak about the situation without using the student's name. (If you are part of the welfare team, consult with other colleagues).

- Document any incidents or changes you have noticed with the student (including the dates and any action you took). Documentation should be factual and include specific, observed behaviours, rather than opinions or suspected diagnosis. This documentation provides clear and specific information for health professionals, other school staff and family. This information may also be useful if the young person denies any problems exist.

  For a list of things to look out for, see **Chapter 2 – Current Information about Eating Disorders** – *Warning signs and consequences*.

- Consider the overall aim of approaching the student. Generally it is useful to aim to:

  - encourage the young person to seek further support and help (rather than convincing them they have a problem)

  - build positive communication between yourself and the student

  - build/maintain a trusting and supportive relationship with the student.

- Consider having another colleague present for additional support (for both yourself and the student).

- Consider your knowledge of the student and what they are most likely to respond to.

- Consider what you are going to say. This will depend on your degree of concern for the student, your relationship with the student, the age of the student and the immediacy of your concerns.

- Consider how you will respond if the student denies there is a problem or becomes angry, defensive or dismissive of you.

  See also *Working with different reactions* in this chapter.

- Consider the most appropriate time and place to maximise the likelihood of the student feeling comfortable and willing to talk. For example, lunch time, when the student may be stressed around eating, may not be the best time.

- If necessary obtain information about eating disorders so that you have a basic understanding of them. You may choose to consult with a professional or phone an information line specifically for eating disorders.

  See **Chapter 7 – Additional resources** – *Support, referral, education and information services*.

Talking to the student

See also *Duty of care and confidentiality* in this chapter.

Talking to a student can lead to many different outcomes. While following standard guidelines may help to increase the likelihood of the conversation being productive, eating disorders are complicated and things may not always go as planned.

See also *Working with different reactions* in this chapter.

- Be prepared for different reactions such as denial, anger, rationalising of their behaviour, dismissiveness and sometimes relief.

- Promote an open, safe, non-threatening conversation by:

  - avoiding labels (it may not be necessary to mention the term eating disorders as this can often lead to defensiveness)

  - not mentioning food or weight (these are symptoms rather than the problem, and are usually points of tension)

  - not commenting on appearance (e.g. telling someone they have lost weight or that they look fine just as they are)

  - using open questions to encourage the student to talk and disclose. For example:

    How have things been for you lately?
    What do you need at the moment?

  - using paraphrasing skills to check and convey understanding. For example:

    It sounds like you are having a really hard time at the moment, am I on the right track?

    For further information about communication skills, see **Chapter 7 – Additional resources** – *Effective communication texts*.

- Be clear about your role and duty of care from the start.

- Affirm the student's ability and/or willingness to talk about something that is bothering them. This can be a big step for young people who are not used to seeking help.

- Keep in mind that eating disorders are emotional issues and are usually an attempt to deal with other issues such as self-esteem, fear or other unresolved issues.

  Begin by telling the student you are concerned about them. Prefix your observations with '*I am concerned…*' rather than '*You seem…*'. This can reduce the potential judgment the student may feel. For example:

  I am concerned about you at the moment. I have noticed that you seem to be preoccupied (or distant, agitated, fidgety, unhappy) lately.

- Offer a few specific observations about their behaviour to illustrate why you are concerned. However, be mindful that the student may feel they have been 'watched'. For example:

  A few weeks ago when we were getting into groups to discuss the novel we were reading, I noticed that you stayed on the periphery and did not join in. I've also noticed that you have started to sit on your own more in the past few weeks.

  I've noticed that you are working out and training even when you have an injury. Last year when you had the shin splint, you took it easy so it could heal.

- Avoid direct questions about their issues or behaviour. For example, questions such as *When was the last time you ate? Are you vomiting? Have you lost weight lately?* are likely to lead to defensiveness and/or shame while avoiding the real issues.

- Aim to show empathy and support. Listen to what the student is saying without interrupting, making judgments or promises.

- Ask the student what kind of support they would like. This may provide useful information about how to proceed, but it may also facilitate a sense of trust and safety with the student.

- Inform the student of what informal and formal support is available to them.

- Avoid lecturing the student, especially about what they 'should' be doing or eating.

- Accept what the student says. In most cases, a student will benefit from simply being heard. This is likely to facilitate open communication between yourself and the student in the future.

- Do not disagree with the student. Implying they are wrong is likely to damage current and/or future communication.

- Explore if they have told anyone, especially their parents, about what's on their mind. This will provide information about their support network, but also indicates who the student is comfortable with knowing.

- Let the student know about the limitations of your role. For example, if you are part of the school welfare team, you may suggest that the student seek support from specialist health professional/s. If you are a teacher, you may suggest that the student seek support from the welfare staff or School Counsellor. For example, you may say something like:

This is out of my area of expertise, but I'd like to support you as much as I can. How would you feel about us going to the School Welfare Coordinator together?

- Decide on the next step with the student. Give the student several options and **allow them to have as much control over the process as possible**. For example you may suggest the following options depending on the immediacy of your concerns:

  - *I am happy to come and have a talk again with you in a few days, once you've had a chance to think about this.*

  - *I am happy to come with you when you meet the School Counsellor and support you while you tell them how things are for you.*

  - *I can meet with you and your parent/s (this is usually the role of a member of the student welfare team rather than a teacher).*

- Keep in mind that some of the physical consequences of eating disorders include confused thinking and an inability to concentrate.

- Give the student a brochure or other information (such as numbers for telephone support lines or local GPs) if appropriate.

- Be aware of your role as a support person. Do not diagnose or offer therapy.

- Don't agree to things you can't maintain, such as keeping it a secret.

- Thank them for speaking with you, regardless of the outcome.

Talking to male students

Although the above principles apply to approaching any student, it is important to consider potential issues when talking to or supporting a male student:

Stigma. Eating disorders are promoted predominantly as a female concern. Males may feel a greater sense of shame or embarrassment. It may be even more important not to mention the term 'eating disorders', but rather the specific behaviours you have noticed.

Different presentation. Although the emotional and physical consequences of eating disorders are similar for both genders, males are more likely to focus on muscle gain, while females are more likely to focus on weight loss.

Talking to students with different eating disorders

Warning signs and consequences of eating disorders vary between individuals. There are however, some features specific to different eating disorders that may be useful to consider when approaching a student. For example, people with anorexia nervosa may be more likely to be experiencing the psychological and medical effects of malnutrition, whereas people with binge eating disorder are more likely to be experiencing extreme shame in relation to their eating.

For further information see **Chapter 2 – Current information about eating disorders** – *Types of eating disorders.*

When a student approaches a teacher

Often students will approach a teacher on a friend's behalf. Occasionally, a student may disclose their eating disorder to a teacher or another member of staff.

- Consider where the disclosure has occurred. If it is during a class for example, practise *protective interrupting*. For example:

Thank you for sharing that… I'd really like to follow this up with you after class.

- Be aware that the student has chosen the particular teacher for a reason.

- Follow the school's internal guidelines about referring students you are concerned about to the support/welfare team.

- Acknowledge to the student how difficult disclosing personal concerns can be.

- Refer to the steps outlined in *Talking to a student* above.

Working with different reactions

"You get very angry…because the person manipulates your concern.. You're trying so hard to help them and they kick you in the face all the time and you become very close to saying 'get stuffed, I couldn't care less' and that makes you feel even worse, because you really do care. It's guilt stuff for teachers."

(Teacher – Report on the Eating Disorders Project 1993, NSW Department of School Education, pp. 109)

Denial or dismissiveness

Denial is a common reaction. This can be difficult for support people as it can be hard to know how to proceed.

Students may deny the problem or dismiss you in order to protect themselves. Alternatively, a student may deny a problem if they feel ashamed or embarrassed.

Suggested strategies

- Be patient with yourself and the student. Eating disorders are complicated. Acknowledgement of a problem can take time (often after several attempts at discussing the problem).

- Be respectful of denial or defensiveness, it usually has a function, for example self protection.

- Ask the student if there is anything you can do for them right now.

- Don't argue with them about your concerns. Trying to convince them that they have a problem is likely to damage any trust or communication and is unlikely to be effective.

- Where collaboration with the student is not successful, inform the student of your next step. For example:

  It is my role to do what I can to support you, so I am going to talk to the Counsellor about our talk. I won't mention your name to start with. I would like to see how you are in a few days.

- Focus on your overall aims:

  - encourage the young person to seek further support and help (rather than convincing them they have a problem)

  - build positive communication between yourself and the student

  - build/maintain a trusting and supportive relationship with the student

- Focus on listening and providing a safe space for the young person to talk.

- Minimise questions. The student may feel interrogated.

- Remind them that you believe they deserve support. For example:

  I believe we all deserve a bit of support sometimes. Even if things aren't really bad, it can help to stop them getting worse.

- Acknowledge their feelings. Simply reflecting a person's feelings can help them feel supported. For example:

  I get the impression that you are feeling frustrated right now.

- Try to collaborate with the student about the next step. **Give them time to make decisions.**

- Remind the student of your role to support students who may be experiencing difficulties.

- Do not persist with a conversation that isn't going well. This may damage future communication and threaten the student's sense of trust and safety. To end a conversation that isn't going well:

  - acknowledge that they don't want to talk about it (affirm their choice)

  - reiterate your concern for them

- leave the door open by reassuring them that you are available to talk anytime

- let them know that you will talk with them again soon.

  For example you may say something like:

  I can see that you would rather not talk about this at the moment, and that's OK with me. I am still concerned about how you are though, so if at any time you'd like to catch up with me, I'd be more than happy to have a chat with you. I will talk to you again soon.

- Remind them of both the informal and formal support available at school.

- Keep trying. Use your knowledge of the student to determine the best time and place to approach them again. This may be as simple as making a point to ask them how they are when you cross paths.

- If you are a teacher, consult with the student welfare team regarding your next step. This may depend on the student's age, the severity of the perceived problem and if other people know.

Anger or defensiveness

Students may become angry if they feel attacked or 'found out'. Additionally, some behaviours such as agitation or angry outbursts can be due to the physical effects of eating disorders.

- Stay calm.

- Do not persist with a conversation that isn't going well.

- Acknowledge the student's anger using an '*I*' statement and invite them to discuss it with you. This often helps to diffuse the anger as the student feels acknowledged and accepted regardless of their feelings. For example:

  I can see that you may be feeling angry with (or defensive about) me approaching you.

  I don't want to make things hard for you. I understand that you may be feeling angry. Would you like to talk about that?

- Refer to suggested strategies under *Denial or dismissiveness* in this chapter as these may also be useful.

What if I say the wrong thing and make it worse?

School staff express concern over saying the *wrong* thing and making the eating disorder worse.

The causal and maintaining factors of eating disorders are complicated. Just as it is unlikely that a person can say something to make the eating disorder significantly better, it is also unlikely that someone can say something to make the disorder worse. What may be more likely is that a comment may damage the trust and communication a teacher has developed with a student.

Although the points below have been covered elsewhere in this chapter, they are summarised here:

- Don't argue with the student about your concerns. Trying to convince them that they have a problem is unlikely to be effective and is likely to damage any trust or communication.

- Do not disagree with the student. Implying they are wrong is likely to damage current and/or future communication.

- Do not comment on their appearance, positively or negatively (e.g. telling someone they have lost weight or that they look fine just as they are). Although eating disorders are more complex than an appearance issue, comments about appearance can increase their focus on weight and body image.

- Avoid direct questions about their issues or behaviour. Rather, try and create an environment where the student feels safe talking openly.

  See also *Talking to the students* in this chapter.

- Do not do anything without the student's consent. Where this is not possible, let the student know what you are going to do and the reasons why. If possible, try to let them have some choice over who you tell and what you say.

- Avoid using labels (it may not be necessary to mention the term 'eating disorders' as this can often lead to a defensive reaction).

- Don't mention food or weight as these are symptoms rather than the problem, and are usually points of tension.

- Be aware of your role as a support person (do not diagnose or offer therapy).

- Don't agree to things you can't maintain, such as keeping it a secret.

- Maintain confidentiality unless a duty of care precludes this.

Making referrals

When to refer

Once student support services are involved, external referral will vary according to individual cases. As a general rule, referral is necessary whenever there is a suspected eating issue or disorder.

Left unattended, eating disorders (clinical and sub-clinical), can have long-term physical, psychological, emotional and social consequences for the young person and can be distressing for the people around them.

Referral can provide:

- assessment of the student's wellbeing (physically and psychologically)

- a diagnosis

- direction or guidance for the school, the young person and their family

- professional consultancy to the student welfare team

- early intervention, support and/or treatment.

Who to refer to

While it is usually the role of the parents/family to access treatment, at times the student welfare team may be required to assist in this process. Different health professionals may be involved in the diagnosis and/or treatment of an eating issue or disorder including:

- General practitioners

- Dietitians/nutritionists

- Counsellors

- Psychologists

- Psychiatrists.

Frequently, several different practitioners will be involved in the treatment of students with eating disorders, especially anorexia nervosa.

  See also **Chapter 2 – Current information about eating disorders** – *Treatment providers* and **Chapter 7 – Additional resources**.

How to refer

Suggested strategies

- Follow school policy when referring students and/or their families to external organisations (for example, who will make the referral, contact the parent/s and determine the communication protocols between the external agency and the school).

- Gain the student's consent to contact an external service on their behalf.

- Discuss with the student the reasons for accessing external services, for example, gaining specialist support.

- Effective referral depends on knowledge of local community services and the broader service system. Find out about services available in the local community.

- Wherever possible refer to a health professional or health service that is experienced in treating eating disorders.

- Try and maximize the chances of effective referral. For example:

  - refer the student to a health professional they are willing to go to. For example, sometimes young people are more willing initially to see a dietitian than a psychologist

  - if possible, give the student (and/or family) several options

  - discuss the process of finding someone to work with. It is normal to see a few people before finding a health professional/s that feels comfortable

  - match the student's needs with what the individual service offers (to improve the likelihood of the student being willing to seek support/treatment).

- Prior to suggesting a referral to a student and/or their family, make contact with external organisations to establish eligibility criteria, costs and availability of service (e.g. waiting lists).

- Protect the student's confidentiality and privacy.

- Advocate on behalf of the student.

- Review the referral with the student and their family.

Duty of care and confidentiality

> *"The school was helpful in maintaining confidentiality while making sure teachers were aware of the situation."*
>
> (Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)

Confidentiality is essential in creating a trusting relationship with students. Students can feel threatened when they perceive their privacy is at risk and teachers can find it difficult to balance protecting a student's confidentiality with their duty of care.

Confidentiality and privacy are particularly important when dealing with eating disorders as they may affect how a student seeks help. However, at times, ensuring confidentiality may not be possible when a duty of care precludes this.

Finding a balance between confidentiality and potential risk

Assessing risk and duty of care

Assessing risk is essential to maintaining duty of care. Risk assessment is important in the area of eating disorders, as they can have serious physical and psychological consequences.

Assessing risk can be complicated by:

- the overlap between some warning signs for eating disorders and normal adolescent developmental issues

- the secrecy sometimes associated with eating disorders (for example, a young person may conceal their weight loss by wearing baggy clothes or make frequent excuses not to eat).

Risk may be dependent on several factors, such as the:

- age of the student

- maturity of the student

- severity, frequency and duration of the symptoms

- family history

- other risk factors in the student's life

- support around the student.

Providing information to other people

When putting your duty of care before a student's confidentiality

Depending on your role within the school, there may be different situations where breaching a student's confidentiality is necessary. For example, to maintain duty of care, school welfare staff may have to tell managerial/leadership staff, or teachers may have to tell school welfare staff.

Suggested strategies

- At the outset of talking to a student, be upfront about confidentiality. Inform students of the confidentiality principles you are required to maintain and the reasons for this.

- When you make a decision to inform someone else, tell the student what you are going to do and why. Refer back to the initial conversation you had with the student about limitations of confidentiality.

- Where possible, obtain the student's consent to talk to someone else by discussing the need to access further support.

- **Allow the student to have as much control as possible over who knows what.** Talk to the student about who they would and wouldn't like to know. Talk to the student about what they are comfortable with people knowing.

- When telling others, work on the principle of a 'need to know basis'. Privacy should be respected even though complete confidentiality may not be possible. For example, the welfare staff may advise teachers that a student is experiencing some difficulties so that teachers can be supportive by being flexible with due dates and workloads.

- Regardless of the student's willingness for other people to know about their eating issues, maintaining confidentiality where possible will foster a sense of trust between the student and staff.

- Work towards a compromise with the student. Depending on your role and who the student does/does not want to know, you may suggest several options such as:

  - offering to talk to the student's parents/families

  - offering to talk to the School Counsellor or welfare staff (without using names if necessary).

- Ask the student how they would like you, as a support person, to respond if other people ask you about how they are.

- Talk to the student in a private space. If someone comes in during the conversation, stop the conversation and continue when that person has left. This will actively show the student that you value their privacy.

- When informing other staff members about a student, do so in an appropriately private space.

Providing ongoing support to students

The student support service/welfare team

> *"The school has been compassionate and understanding and ready to answer any questions and help solve any problems."*
>
> (Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)
>
> *"I wanted everyone to stop organising my life for me."*
>
> (Former student who experienced an eating disorder during high school, Eating Disorders Resource for Schools Consumer Consultation, 2003)

The student support service/welfare team can include any member of staff that has a counselling, support or welfare role, including Year Level Coordinators and School Health Nurses. As a member of the student welfare team, you may become aware of a student experiencing an eating issue or disorder through the course of your work. Alternatively, a teacher, student or family member may approach you.

When someone approaches you with information, it is important to give them some indication of how you will proceed and if anything is required of them.

Suggested strategies

Every situation is different and some strategies may be more useful than others.

- Identify who will work with the student. Because of the complex nature of eating disorders, the support of several staff members is optimal. The support team may include a trusted teacher, member/s of the welfare team, the Year Level Coordinator, the School Health Nurse or a school based Youth Worker.

  A support team will facilitate shared care and responsibility for the student and reduce potential pressure on individual staff members.

- Clearly define the roles of each member of the support team so that there are no gaps in support. For example, who is responsible for family liaison, for directly supporting the student, for communicating with teachers working with the student and for communication with the external treating health team.

- Designate one person to regularly check in with the student to see how they are coping. The presence of one consistent, concerned adult figure contributes to recovery.

- Develop a coordinated approach that recognises the individual needs of the student and their family. This may be in the form of a support plan. This may coincide with the case management plan that external professional/s or the treating health team develop.

- Ensure clear communication both within the welfare/support team, and between the team and the:
  - teachers working directly with the student
  - external treating professional/s or case manager (such as a psychologist, GP or medical specialist, dietitian)
  - student
  - student's family
  - student's friends.

- Establish and/or maintain peer support systems.

- Recognise that eating disorders have the potential to impact on the whole school community, both directly and indirectly. Parents/families, other students and teachers may all be affected when a student is dealing with an eating issue or disorder.

- Be flexible with school requirements.

- Chapter 3 of the *Framework for Student Support Services in Victorian Government Schools – Teacher Resource* (Education Victoria, 1999) specifies that effective intervention involves:

Clarifying referral procedures
This may involve identifying the need for referral and contacting appropriate services to assess suitability and availability and providing initial information to the service.

Linking the student to counselling services
This may involve providing ongoing information to the service, being involved in the development of a case management plan, being involved in support meetings with the treating team, the family and the student.

It is important to be aware of maintaining confidentiality unless a duty of care precludes this.

Ensure continuity of care *and* monitor and evaluate the student's progress
This may involve following up with the student after sessions with external professional/s or the treating health team, monitoring and addressing any issues the student is facing within the school and monitoring changes in the student's ability to cope, achievements, behaviour and social interaction.

Again, this may involve providing ongoing information to external professional/s or the treating health team and being involved in support meetings with the treating team, the family and the student.

Teachers identified as part of the support team

"The school is helpful by making sure I'm OK with everything at school."

(Student experiencing an eating disorder, Eating Disorders Resource for Schools Consumer Consultation, 2003)

"It is easy to feel inadequate, even though you are doing everything you can think of."

(Secondary School Nurse, Eating Disorders Resource for Schools School Staff Consultation, 2003)

"Everyone being 'nice' to me was unhelpful."

(Previous student who experienced an eating disorder during high school, Eating Disorders Resource for Schools Consumer Consultation, 2003)

The role of supportive teachers will vary according to the needs of the student. Although there are many strategies to facilitate ongoing support for students experiencing eating problems or disorders, it is important to adapt to the needs of each student.

Suggested strategies

- Keep doing what you are doing. If the student has sought you out, or accepted you as a support person, you have already made progress.

- Focus on developing and or maintaining a positive, supportive relationship with the student.

- Ask students what kind of support they would like from you as their teacher. (They may suggest things like being flexible with deadlines, helping their friends to understand).

- Separate the illness from the student. The student may behave in ways that are out of character and at times inappropriate, such as an angry outburst.

  See **Chapter 2 – Current information about eating disorders** – *Warning signs and consequences.*

- Don't monitor eating, weight gain/loss or trips to the toilet. This is likely to cause tension between the student and yourself and is the role of the external treating health team.

- Relate to the student as usual. Treating the student as unwell, or as a person with an eating disorder may reinforce the disorder and leave the student feeling isolated by their illness.

- Do not comment on their appearance, either positively or negatively. Although eating disorders are more complex than an appearance issue, comments about appearance can increase a student's focus on weight or body image.

- Focus on the student's strengths.

- Support the student's participation in activities as much as possible (although, at times, you may have to make adjustments for some activities the student may not be able to participate in). This may facilitate their sense of connectedness and support.

- Allow the student to have choice where appropriate. Eating disorders can be about gaining a sense of control.

- Convey to the student that you believe in their ability to overcome the eating issue or disorder. Actively promote the message that recovery is possible.

- Be clear about your responsibility to them (e.g. duty of care) and what you can and can't offer.

- Maintain your professional boundaries. Remind yourself that it is not the school's role to 'fix' the eating disorder. Recovery is often a complex, multi-layered process. Recognise the value of being present and enquiring about the student's overall wellbeing.

- Focus on developing a trusting relationship. This involves respecting confidentiality and privacy. For example, you may ask the student how they would like you to respond if another class member asks you how the student is.

- Do not do anything without the student's consent. Where this is not possible, let the student know what you are going to do and the reasons why.

Protecting yourself from over-involvement

When supporting someone with an eating disorder, it can at times be difficult to balance being interested and supportive with being too involved. Over-involvement may lead to difficulties, such as increased pressure on the supporting teacher, tension between school staff, decreased reliance on other support options and confusion over personal and professional boundaries.

Potential indicators of over involvement

- When the student singles you out, for example, by saying *"You are the only one that understands"* or *"You are the only one I can talk to."*

- When you reveal more about yourself than you would to other students.

- When you put yourself out more than you usually would, for example, giving a student your home phone number or having unusually frequent or long meetings with the student.

- When you disagree frequently with other professionals working with the young person.

- When you believe your opinion or approach is the only option.

- When you find it difficult to stop worrying about the student out of school hours.

- When you feel a sense of helplessness or failure in your professional role.

- When you feel individually responsible for the process and/or outcomes.

- When you find yourself reacting to the situation rather than acting in a considered way.

Suggested strategies

It is important to protect yourself and the supportive relationship you have developed with the student, while still maintaining your professional boundaries.

- Debrief with the welfare team. Get support for yourself.

- Specify boundaries around the time you spend with the student. It can be useful to do this at the start of meetings so the student knows what to expect. For example, you may welcome the student in and let them know that you have a spare 20 minutes.

- Structure and contain what you discuss. For example, you may ask the student what they would like to focus on in this meeting.

- Focus on listening. Avoid getting into the role of a therapist by discussing issues in a therapeutic manner. For example, avoid asking too many exploratory questions and encourage them to talk to their treating health team about counselling issues.

- Focus on issues related to school and support rather than their family or the eating disorder.

- Ask the student about the support and/or treatment they are getting from others. When they mention something positive about treatment or their support network, reinforce this by reflecting it back to them.

- Encourage the student to use their wider support network such as friends.

- Encourage the student to talk to external professional/s or the treating health team about any issues they are not happy with in relation to their treatment or support, rather than trying to fix it yourself.

- If the student has stopped going to appointments with other members of the support or external treating health team, offer to arrange someone to accompany them to their next session.

- Consult with external professional/s or the treating health team about what it is useful to focus on when supporting the young person (if confidentiality permits).

Communication with parents or family members

> *"The school was helpful by discussing the problem with my parents."*
>
> (Previous student experiencing an eating disorder, Eating Disorders Resource for Schools Consumer Consultation, 2003)

Ideally, the family should be informed. However, the timing of this will depend on the following factors:

- The student's wish for their parent/s to know. Sometimes students will appreciate the school's support in involving and communicating with their parent/s. At other times this will be threatening for them.

- If the student has talked or tried to talk to their parent/s or a carer about the issue.

- The relationship with the student (if building open communication and trust with the student has taken time, and they don't want their parent/s to know, you may consider alternatives like going to a local GP).

- The age of the student, for example, different approaches may be taken for a 12 year old and 17 year old student.

- The severity and/or immediacy of the issues, such as whether the student is endangering themselves physically or psychologically.

Approaching parents or family members

> *"The school was helpful in providing a key teacher to liaise with on a daily or weekly basis."*
>
> (Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)
>
> *"My daughter wished the matter to remain personal so I had not contacted the school. It was a relief to have them 'break the ice' regarding the matter."*
>
> (Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)

Suggested strategies

- The School Counsellor, or equivalent, is generally the most appropriate person to inform parents/families.

- Negotiate an agreement with the student to enable open communication with parents/families.

- If appropriate, involve the student in conversations with their parents/families.

- Specify a family liaison–person so that the family has the opportunity to develop a supportive relationship with a school staff member.

- When approaching parents/families, ask them if it is convenient to talk, otherwise make a time that is suitable.

- Aim to establish/maintain a positive, open and supportive relationship with parents/families. Be mindful that parents may feel blamed or responsible for the eating issue or disorder.

- Focus on the general wellbeing of the student, rather than concerns about an eating disorder if the topic appears to be sensitive.

- Offer a few specific observations about the student's behaviour to illustrate why you are concerned.

- Do not make a diagnosis.

- Begin by telling the parents/families that you are concerned about the student they parent or care for. For example:

  I am concerned about (student's name) at the moment. I have noticed that s/he seems to be preoccupied (or distant, agitated, fidgety, unhappy). I was wondering if you had noticed anything?

- Aim to show empathy and support. Listen to what the family member is saying without interrupting, making judgments or promises.

- Ask the family member what kind of support they would like. This may provide useful information about how to proceed, but it may also facilitate a sense of trust and safety with the family.

- Be clear about the support the school can offer and the services available through the school.

- Try and decide collaboratively on the next step with the family member.

- Consider the family dynamics and any cultural or social issues that may make it difficult for the parents/families to discuss the issue.

- Encourage the family to access support, information or treatment from external agencies.

- Notify parents/families both verbally and in writing of your concerns, what the school can offer and the school's approach.

- Consider action in relation to duty of care if a student requests that parent/s are not informed.

- Consider action if parents/families deny there is a problem.

- Do not persist with a conversation that isn't going well. This may damage future communication. To end a conversation that isn't going well:

  - acknowledge that they don't want to talk about it (affirm their choice)

  - reiterate your concern for their son or daughter

  - leave the door open by reassuring them that you are available to talk anytime

  - let them know that you will contact them again soon

  - you may also talk about your duty of care as a school.

Providing ongoing support to the wider family

The school support service/welfare team may be involved in providing support to parents and/or other family members. This will vary between individual families. Schools may also be involved in supporting siblings who attend the same school.

The support of families can be valuable for students overcoming eating disorders. Families often need support for themselves in order to do this.

Suggested strategies

- Phone the family on a regular basis to reaffirm that support is available.

- Listen. Providing an opportunity for parent/s to talk can be very supportive.

- Encourage parents/families to consider counselling for themselves, or family therapy if appropriate.

- Provide information about the role of the school and how the school may be of assistance.

- Be clear about your professional boundaries and your role as a support person. Encourage family members to discuss counselling issues with the external professional/s or the treating heath team.

- If appropriate, acknowledge some of the short and long-term effects eating disorders can have on the family unit.

- When appropriate, remind family members that some changes (such as depression or agitation) can be due to the physical effects of eating disorders, rather than a change in their loved one.

- Provide information about local family support groups or telephone support lines that may be able to offer information to family members about handling eating disorders within the family.

 See **Chapter 7 – Additional resources** – *Support, referral, education and information services.*

- Encourage family members to:

  - focus on the student's personal qualities rather than the eating disorder

  - maintain usual family activities

  - allow the student to have as much choice and autonomy as possible, within the boundaries outlined by the treating health team, as this will facilitate independence

  - provide opportunities for the student to maintain/increase their social networks

  - support the role of external professional/s or the treating health team

  - discuss any concerns about treatment with the external professional/s or the treating health team.

Supporting siblings

A student with an eating disorder may also have a sibling/s attending the same school. Siblings often report difficulties as they come to terms with the effects of the eating disorder on their brother or sister and their family unit.

Suggested strategies

- Decide on a support person who will be responsible for making regular contact with the sibling/s to see how they are.

- Openly acknowledge that eating disorders can be difficult for the whole family. Sometimes siblings feel guilty about their own feelings of anger or fear about the disorder.

- The sibling may feel extra responsibility for supporting their sister or brother during school when other members of the family are not around. Support them in this if appropriate.

- Provide opportunities for the sibling to talk about how they are feeling, rather than how their brother or sister is.

- Recognise that eating disorders often impact on the whole family and can lead to feelings of resentment. For example, the family may experience increased stress because of:

  - financial pressure as a result of paying for treatment

  - decreased family time as a result of frequent medical appointments

  - decreased support for other family members.

- Recognise that the sibling may be concerned that they are at an increased risk of developing an eating disorder themselves.

- Be flexible with workloads and deadlines if necessary.

- Ask the student what kind of support they would like.

- If appropriate, connect the sibling with an organisation that supports carers.

Supporting friends

> *"The school is helpful by letting my friends always know how I am."*
>
> (Year 12 student experiencing an eating disorder, Eating Disorders Resource for Schools Consumer Consultation, 2003)

The effects on a student's friends and fellow classmates can be difficult. It is the role of the school to balance supporting friends with maintaining the student's confidentiality and privacy.

See also *Finding a balance between confidentiality and potential risk* and *Providing information to other people* in this chapter.

The effects of the eating disorder on other students may vary according to:

- the size of the student population (smaller schools may be more aware of changes within particular individuals)

- the school's response to the eating issue or disorder

- previous experiences of eating issues or disorders within the school

- if there is/are sibling/s of the student with the eating disorder attending the school

- the effects of the disorder on the young person (for example, has it prevented the young person from attending school completely or partially)

- the age of the student with the eating issue or disorder

- the severity of the issue

- the prognosis for the young person

- the duration of the illness and recovery process.

People around the young person with the eating issue or disorder may experience:

- confusion over what is happening and why

- a sense of responsibility

- anger, resentment or frustration

- feeling confronted (with issues of morbidity or mortality, perhaps for the first time)

- fear (of the consequences or that it may happen to them).

Suggested strategies

> *"I would have liked the school to teach friends/classmates about how eating disorders affect people and maybe learn how to talk to sufferers so they can get help."*
>
> (Former student experiencing an eating disorder, Eating Disorders Resource for Schools Consumer Consultation, 2003)

- When supporting the student's friends, protect the confidentiality and privacy of the student with the eating disorder.

- Provide generic information to friends and fellow students about how to be supportive to a friend who is experiencing difficulties, regardless of the issue (for example, caring, continuing to invite them places and being there for them).

- Encourage friends to continue to do usual activities with the person experiencing the eating disorder.

- Encourage friends not to take responsibility for their friend's eating disorder or recovery.

- Consider the needs of the student's immediate friendship group. They may be feeling a loss in their friendship circle or confusion over how to relate to their friend.

- Ask the student with the eating disorder how they would like teachers (and others) to respond when asked how the student is.

- Be mindful of other students reactions to the eating disorder, for example, provide age appropriate and selected information.

- Support friends and fellow students by providing information and opportunities to talk about:

  - emotions they may be experiencing

  - coping with the changes in their friend (for example, behavioural and social changes such as increased agitation or social isolation)

  - strategies to support their friend

  - strategies to support themselves (taking time-out)

  - their responsibility as a friend (to provide friendship rather than to 'fix' their friend)

  - the ineffectiveness of focusing on food, weight or appearance with their friend.

- Provide basic information about eating disorders.

Dealing with rumours

"Rumours of eating disorders spread across the school."

(Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)

"So many rumours went around about me when I was sick, it was awful…I feel a lot of pressure now about what I eat, I feel like everyone is watching me."

(Student with an eating disorder, Bendigo Health Care Group, 2000, pp. 24)

When a student is suspected or diagnosed with an eating disorder, fellow students may have different reactions. Sometimes rumours develop, which can further isolate the student experiencing the eating disorder.

Rumours can be a form of bullying.

For more information about dealing with bullying, see also **Chapter 3 – Prevention** – *Reducing risk factors – Bullying, teasing and discrimination.*

Suggested strategies

- Assess the role of the rumours. Sometimes rumours indicate students' feelings of discomfort or fear.

See also *Supporting friends* in this chapter.

- Demystify the illness. Eating disorders can sometimes become glamorised or mysterious. Provide factual, age-appropriate information that focuses on several aspects of the illness such as the causes as well as the social and psychological consequences (rather than just the extreme physical consequences).

- Work with students who are instigating and/or perpetuating the rumours:

  - talk about confidentiality and its value. For example, promoting the idea that if this is true, it is no-one's business

  - without identifying the students as instigators of the rumours, encourage them to come up with ways of dealing with the rumours by establishing a sense of shared concern and responsibility. For example *"Can you help me work out a way of stopping rumours about (student's name), as s/he is finding them very upsetting?"*

Copycat behaviour and co-dieting

"My daughter's school is an all girls school. It appears to me that there is a very real subculture of anorexic and bulimic students. These students seem to compete with each other…e.g. how much weight they have lost, how little they ate."

(Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)

Seeing a friend develop an eating issue or disorder can sometimes lead to confusion, fear and self-doubt. It can lead to student's questioning their own values around thinness, healthy eating, weight loss dieting and body image. At times students may imitate the behaviour of their friend. This may be the student's way of:

- dealing with their own fear

- trying to relate to their friend

- trying to understand the illness

- feeling special or unusual.

In other cases, a group of students may diet together, which can create competition around weight loss. If dieting is part of the accepted norm of the peer group it can be difficult for any young person who is anxious for peer acceptance to resist joining the behaviour.

Suggested strategies

Approaching a student who is imitating the behaviour of a friend with an eating disorder should be similar to approaching a student with a suspected eating problem.

See *Approaching a student* in this chapter and **Chapter 4 – Early Intervention** – *Identifying students at risk*.

- Focus on developing protective factors in students (such as life skills).

See **Chapter 3 – Prevention** – *Promoting protective factors*.

- Create opportunities for students to work collaboratively on various shared projects to reduce levels of competition and promote cooperation.

- Assess the culture around weight loss dieting and body image in the wider school community. Be aware of comments, posters and literature that may promote one type of body shape and size.

See **Chapter 3 – Prevention** – *Creating a supportive school environment – A whole school approach*.

- Deal appropriately with any comments from student to student about appearance.

See **Chapter 3 – Prevention** – *Reducing risk factors – Bullying, teasing and discrimination*.

- Assess the culture around physical education and sports in the school.

See **Chapter 3 – Prevention** – *Promoting protective factors – Physical education*.

- If appropriate, invite a professional to deliver a supported program to students.

- Assign a teacher or group of teachers who have regular contact with the student/s to monitor any early warning signs of eating disorders.

- Work with the student welfare team about strategies to reduce copycat behaviour and co-dieting for the purpose of weight loss.

Rural schools

Schools in rural regions often face additional barriers when referring or supporting a student with an eating disorder, such as:

- Increased pressure on school staff (particularly welfare staff) to provide an active role in support/treatment due to:
  - isolation from health services, resources and external support
  - limited/no availability of health professionals that specialise in eating disorders
  - limited/no choice of health practitioners
  - waiting lists for health practitioners

- Increased stress on families due to:
  - lack of treatment options, support and information
  - travel time to medical appointments
  - lack of community knowledge around eating disorders which sometimes leads to increased stigma
  - financial pressures that precludes families from accessing private practitioners.

- Some schools are supported by mobile mental health workers (for example, CAMHS) however, there is great demand for this service.

Suggested strategies

- Identify statewide organisations that provide support to families using telephone or email.

See **Chapter 7 – Additional resources** – *Support, referral, education and information services*.

- Consult with the nearest Community Health Centre, Community Mental Health Service and Hospital about additional support they may be able to offer to families or students.

See **Chapter 2 – Current information about eating disorders** – *Treatment providers*.

- Establish a support network for families who would like to talk to other families in similar situations. For example, the school may create and update a list of email addresses and phone numbers to distribute to families who would like to be part of the network.

- Provide support for parents in their role. For example, the school may work with parents to acknowledge the importance of enhancing protective factors and reducing risk factors in the home environment. This may be done formally or informally.

- Obtain specific information about families and eating disorders (such as books and websites). Pass this onto parents/families.

See **Chapter 7 – Additional resources** – *Support, referral, education and information services*.

- Provide opportunities for parents/families to interact socially. For example, designate a parent meeting room within the school or host parent morning teas.

- Establish a library for families as obtaining literature can be more difficult in rural areas. Actively promote the library.

• Establish a *Family Interactive Centre*.

> *"The school is creating community. Consider the Family Interactive Centre…As you walk into this fairly large room, you see couches…fresh tea and coffee…computers, work areas, the parent's library. Parents with infants… exchange parenting tips. Workshops are held on nutrition, the social services…The Family Interactive Centre helps families to…understand the practices that support their children's education…In the Centre, informal relationships develop that are powerful and meaningful."*
>
> (Hernandez, 1999, pp. 49)

• Provide specific programs for parents aimed at increasing their knowledge around eating disorders and their parenting skills. It may be useful to include information/discussion about:

  - normal adolescent changes (physical, emotional and social)

  - effective, supportive parenting (a young person's need for stability, boundaries, support, parental confirmation and trust)

  - risk factors in the development of eating disorders (addressing factors across different domains, such as cultural, social, familial, psychological)

  - protective factors against the development of an eating disorder (such as opportunities to participate)

  - parental attitudes around weight, healthy eating, weight loss dieting, body image and eating behaviours and the impact these have on the young people they parent

  - practical skill development such as effective communication, conflict resolution and relaxation skills.

Chapter summary

Schools can be actively involved in supporting a student and their family through an eating disorder. The school may be involved in identifying an eating issue, notifying parent/s and/or the welfare team, referral, supporting friends and family members of the student, liaising with the external treating health team and being flexible with the student and their academic requirements and attendance.

Restoring wellbeing

Who in the school is this information relevant for?

The information presented in this chapter and the corresponding supporting resources offers strategies and suggestions to support school staff in their role after a traumatic incident. Although different members of the staff team may have different roles, the information is of particular relevance to anyone within the school who has a welfare/support or managerial/leadership role.

> *"Provide appropriate support to students, their families and other members of the school affected by emergency situations or potentially traumatic incidents."*
>
> (Education Victoria, 1999, pp. 52)

Why focus on restoring wellbeing in schools?

Schools have a role in protecting students from traumatic incidents and facilitating wellbeing after such events. Some of these events may take place in the school environment, while others may occur externally but have an impact on the school, its students and staff.

Traumatic incidents may occur in relation to eating issues or disorders. Schools may be involved in:

- minimising the impact on the school community and its members when a student has an eating disorder, especially if they require hospitalisation

- referral for students who experience ongoing adverse effects as a result of fellow students with eating disorders

- referral for other members of the school community, such as teachers, who may experience ongoing adverse effects as a result of students with eating disorders

- developing and implementing supportive activities for groups within the school

- supporting a student returning to school

- reducing risk factors or enhancing protective factors within the school as a means of preventing relapse.

Traumatic incidents within schools

> *"Traumatic incidents are those which are extraordinary and are beyond people's normal coping abilities."*
>
> (Education Victoria, 1999, pp. 52)

> *"Any situation faced by members of the school community causing them to experience unusually strong emotional reactions, which have the potential to interfere with their ability to function either at the time the situation arises, or later."*
>
> (Cahill, 2000, pp. 31)

In relation to eating disorders, trauma may occur when a fellow student (or teacher):

- is diagnosed with an eating disorder

- collapses or faints at school (as a result of an eating disorder)

- experiences obvious physical consequences associated with eating disorders (such as extreme weight loss, loss of hair)

- experiences psychological complications as a result of an eating disorder (such as depression or anxiety)

- is observed engaging in some behaviours associated with an eating disorder (self-induced vomiting, use of laxatives, decreased socialisation)

- takes regular time off school to attend medical appointments

- is hospitalised with an eating disorder

- returns to school after hospitalisation and/or treatment

- has a prolonged recovery

- dies as a result of an eating disorder.

Dealing with traumatic incidents within schools

The way in which a traumatic incident is dealt with can affect the impact it has on individual people. Schools have a responsibility to minimise potential harm and reduce the likelihood of further harm.

Schools may address traumatic incidents that occur at school and incidents that have occurred externally but impact on members of the school community. The action that schools take following a traumatic incident may be influenced by:

- the age of people involved

- if the incident was public or has become public (e.g. covered by the local media)

- the nature of the incident

- special requests made by the affected student's family (e.g. for information to be concealed or revealed)

- where the incident happened (during school or out of school)

- if anyone involved was directly responsible for the incident

- if the incident could have been avoided.

For information and practical strategies to respond to traumatic incidents within schools see **Supporting resource 8.**

Supporting students returning to school

"The school was helpful by arranging a meeting after my daughter came out of hospital, allowing her to return to school with less stress and being contactable at any time."

(Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)

"The school helped my daughter believe that it was OK to take 2½ months off."

(Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)

The treatment of eating disorders varies from person to person.

See also **Chapter 2 – Current information about eating disorders** –*Treatment.*

However, in the majority of cases, recovery is long-term and requires both medical and psychological intervention. Consequently, a student with an eating disorder may regularly miss days or part days, and in more severe cases, months, school terms or a school year.

When a student returns to school, either partially or fully, the school has a role in supporting the student, their family, friends and teachers.

Suggested strategies

- Ask the student how they would like to be supported.

- Develop a support team. The support team may include a trusted teacher, member/s of the welfare team, the Year Level Coordinator, the School Health Nurse or a school based Youth Worker. A support team will facilitate shared care and responsibility for the student and reduce potential pressure on individual staff members.

- Determine roles and responsibilities within the team, for example:

  - designate a key support person for the student (such as the Student Welfare Coordinator)

  - designate a key family-liaison person for the family (such as the Year-Level Coordinator)

  - designate a person to liaise with the external case manager or treating health professional/s (for example, the key support person for the student or the Student Welfare Coordinator).

- Meet with the student, their parents/families and the support team before the student returns to school to:

  - discuss the needs of the student and their family

  - develop strategies to support the student (in relation to their needs)

  - develop a realistic educational program for the student

  - develop communication protocols between all members of the support team, the student, the family and the external professionals or treating health team

  - set dates for continued meetings with the student, their family and the support team (if appropriate).

- Support any treatment plan developed by the external professional/s or treating health team.

- Consider the timing of potentially stressful decisions, such as whether a student needs to repeat a year, drop one of their favourite subjects (such as sport) or take longer to do VCE.

- Make decisions based on both the short and long term needs of the student. Where possible try to minimise jeopardising the student's future career and/or study options. For example, if they need a certain VCE score to study their chosen career, repeating VCE may be more viable.

"The school have also helped us by providing the opportunity for my daughter to extend her VCE study by providing a program that is flexible…she will spread her VCE over three years."

(Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)

See also *Teaching students with eating disorders* in this chapter.

Facilitating social and academic re-integration back into the school

"My daughter was always welcomed when she would attend school….the fact that teachers made comments about how glad they were to see her really had a huge impact on her and particularly reduced her…anxiety."

(Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)

- Be flexible with workloads and deadlines. Students with eating disorders are often coping with physical and psychological consequences (such as impaired concentration or depression) that make it difficult for them to complete academic tasks.

- Recognise that the student may not have seen fellow classmates, friends and/or teachers for some time.

- Recognise the stress associated with re-engaging with a group of friends that may have changed or developed in different ways.

- Develop strategies with the student to facilitate them feeling more comfortable with seeing people again. For example:

  - consider assigning a fellow student or group of students to support the returning student for a limited period (this may involve meeting the student during lunch breaks, travelling with the student to school, making sure the student has someone to sit with in each class)

  - if appropriate, reintegrate the student into previous activities they were involved in, for example, drama or music groups

  - be flexible with participation levels. For example, a group may meet twice a week, however the student may not be able to sustain this physically or emotionally.

- Be aware of any factors that have the potential to trigger or sustain the eating problem. For example, increased stress due to academic pressure, bullying or social isolation.

- If necessary and possible, offer financial assistance to the family for out-of-school activities such as camps and excursions.

- Address any ongoing issues that may be a result of the student's behaviour or condition prior to them taking time off school. For example, alienation of previous friendship groups or angry outbursts.

- Inform teachers directly involved with the student about what they can do to support the student while maintaining confidentiality. For example, being flexible with workloads and deadlines.

Teaching students with eating disorders

"Recovery is the priority, education has to be secondary."

(Secondary School Nurse, Eating Disorders Resource for Schools School Staff Consultation, 2003)

The role of supportive teachers will vary according to the needs of the student.

See also **Chapter 4 – Intervention –** *Providing ongoing support to students – The student support service/welfare team* and *The role of teachers identified as part of the support team.*

Suggested strategies

- Be aware of the stress associated with returning to school.

- Focus on maintaining a safe, supportive classroom environment.

- Deal appropriately with harassment or personal comments about appearance towards anyone in the class.

- Avoid exposing the student to activities that may draw attention to their eating disorder or weight.

- Encourage participation by running small group classroom activities, especially if the student is isolating themselves by sitting alone, not talking or not participating.

- Allow the student to have as much choice as possible. Allow them to decline participation in an activity.

- Recognise signs of increasing stress. Diffuse any stressful situations as usual. For example:

  - consider negotiating a subtle signal from the student (such as a hand gesture), prior to their return to class, so that they can let you know they are becoming distressed without drawing undue attention to themselves

  - encourage the student to take care of themselves by having a break, going for a walk or going to the School Counsellor.

- When issues related to eating disorders such as food, weight or mental health come up in class discussion, use language that normalises these issues and reduces any associated stigma.

See also **Chapter 3 – Prevention** – *Guidelines for talking about eating disorders in the classroom.*

- Be flexible with workloads, deadlines and assessment.

- Work with the student to find a balance between realistic workloads and deadlines and your responsibility to ensure the student has met key learning indicators. Modify assessment if necessary.

- Maintain expectations of behaviour. While it is important to be flexible academically, it is not helpful to make exceptions for unacceptable behaviour (such as angry outbursts). Unacceptable classroom behaviour should be dealt with in the usual way.

- Inform yourself of the effects of eating disorders, such as impaired concentration, so that you have some idea of what to expect.

- Provide or arrange extra tutoring if the student is experiencing stress due to missed work.

- Remember that academic learning may not be a priority for the student (attending school, seeing friends and recovery may take precedence).

- Report any changes or concerns about the student to the support/welfare team.

- Access support for yourself from the support/welfare team.

Chapter summary

Schools have a role in facilitating wellbeing after traumatic events. In relation to eating issues or disorders, potentially traumatic incidents may occur, for example, when a fellow student (or teacher) is diagnosed or hospitalised with an eating disorder.

Schools may be involved in minimising the impact of traumatic events on the school community by providing support to those directly involved, developing and implementing support plans for students and supporting students returning to school after an event.

Additional resources

Libraries

General libraries may stock some books on eating disorders. The following libraries specialise in eating issues, women's health and/or related issues.

The Eating Disorders Foundation of Victoria

Library and Resource Centre
1513 High Street
Glen Iris, Victoria

Phone   9885 0318
                     1300 350 236 Non-metropolitan number

Opening hours: 9.30am-5.00pm, Monday to Friday, except public holidays.

A postal library service is available for people living in rural Victoria. EDFV members may borrow material. Any person may use the library resources on site and photocopy materials.

Women's Health Victoria

Women's Health Victoria Library
Level 1, 123 Lonsdale Street
Melbourne, Victoria

Phone   9662 3755
Internet site   **www.whv.org.au/services.htm**

Opening hours: 9am-1pm, Monday to Friday, except public holidays.

The library is attended by qualified librarians skilled in handling reference enquiries and online searching.

On-line resources

The Victorian Centre of Excellence in Eating Disorders
www.ceed.org.au

The Eating Disorders Foundation of Victoria
www.eatingdisorders.org.au

Eating Disorders Association Resource Centre (QLD)
www.uq.net.au/eda

ISIS – Centre for Women's Action on Eating Issues
www.isis.org.au

Eating Disorders Association of South Australia
www.communitywebs.org.edasa

Eating Disorders Foundation of New South Wales
www.edf.org.au

New South Wales Centre for Eating and Dieting Disorders (CEDD)
www.cedd.org.au

National Eating Disorders Association (NEDA) of the USA
www.nationaleatingdisorders.org

The Eating Disorders Association of the United Kingdom
www.edauk.com

Curriculum based resources/guides for teachers

Eating disorders and body image programs

Friedman, S. S. (2000). *Nurturing Girlpower. Integrating eating disorder prevention/intervention into your practice.* Salal Books, Vancouver.

Boulden, K. & Ireland, L. (2000). *Risky Business. Professional Development Package for School Communities about Body Image, Gender, Eating and Exercise Issues.* Equity Programs Unit, Education Queensland, Australia.

NSW Department of School Education (1997). *No Body is Perfect. Teaching and learning about body image and gender.* NSW Department of School Education, Australia.

*Victorian Government Department of Human Services (2002). *Shapes: Body Image Program Planning Guide*. Rural and Regional and Aged Care Services Division, Department of Human Services, Victorian State Government.

*Victorian Government Department of Human Services (2002). *Best Bets: Body Image Programs Overview*. Rural and Regional and Aged Care Services Division, Department of Human Services, Victorian State Government.

*Available at
www.health.vic.gov.au/healthpromotion/quality/ body_image.htm

Health promotion

There are many general mental health and health promotion programs and resources available to teachers, a few of which are listed below.

Integrated health promotion: A practice guide for service providers

Integrated health promotion: A practice guide for service providers is a resource kit produced by the Primary and Community Health Branch in partnership with the Public Health Branch (Rural and Regional Health and Aged Care Services Division). This guide is a practical resource to support agencies and organisations to plan, deliver and evaluate effective integrated health promotion programs.

It is available on the Department of Human Services website, **www.dhs.vic.gov.au**. Select 'primary health knowledge base' from the options presented and then *Integrated Health Promotion: A guide for service providers*.

The Advocacy Project

The Advocacy Project was developed in response to the disconnection and alienation expressed by youth engaging in damaging social behaviours who have increased rates of non-participation in education, training and work. The project's objectives are to:

• increase retention and participation in education, training and employment

• improve educational outcomes.

One of the most important aspects of the model is advocacy. Advocating strongly for an individual is a powerful way to demonstrate support for that person. Within this model teachers become advocates for students. After enrolment the advocate/teacher takes responsibility for the development of the student's educational program and monitoring of their progress, utilising the teacher's professional role to the fullest.

Evaluations of the project have shown an increase in retention of students and significant improvements in results.

Internet site **www.advocacy.gsat.edu.au**

Mental health promotion

MindMatters

MindMatters is a mental health promotion program for secondary schools. The program includes:

• a resource for schools

• a national professional development and training strategy

• a dedicated website

• an evaluation process

• a quarterly newsletter.

MindMatters outlines a whole school approach to mental health promotion and suicide prevention. The program aims to enhance the development of school environments where young people feel safe, valued, engaged and purposeful. Social and emotional wellbeing have been linked to young people's schooling outcomes, their social development, their capacity to contribute to the workforce and the community and to reducing the rate of youth suicide.

Internet site **www.curriculum.edu.au/mindmatters**

Festival for Healthy Living

The *Festival for Healthy Living* is a school-based health promotion project. Through the use of drama and performing arts, the project aims to support schools in maintaining a whole school approach to mental health and wellbeing. A step by step guide has been developed for schools and provides information about the initiative, implementing a *Festival for Healthy Living* and information about additional resources.

Reference

Cahir, S. (2002). *Festival for Healthy Living: A Mental Health Promotion Strategy. A Step by Step Guide for Schools.* The Royal Children's Hospital Mental Health Service, Victoria, Australia.

School Focused Youth Services (SFYS)

The School Focused Youth Service (SFYS) is a statewide initiative, which commenced in 1998 as part of the Victorian Government's response to the recommendations of the Suicide Prevention Task Force (1997). It is a joint initiative of the Departments of Education, Employment and Training (DEET) and Human Services (DHS) in partnership with the Association of Independent Schools of Victoria (AISV) and the Catholic Education Office (CEO).

The SFYS is an innovative service targeting young people between 10 and 18 years of age. The service works with the education, health and welfare sectors to enhance the physical, mental and social-emotional well being of children and adolescents at primary and secondary levels of Government, Catholic and Independent schools.

Internet site **www.sfys.infoxchange.net.au/**

Inclusive physical education and sport programs

Give it a go. Including people with disabilities in sport and physical activity.

This resource offers school based strategies to support teachers in the inclusion of young people with disabilities in regular physical activity programs. It provides information and strategies for different age groups and students experiencing different issues, including eating disorders and obesity.

Reference

Australian Sports Commission and Active Australia. (2001). *Give it a go. Including people with disabilities in sport and physical activity.* Australian Sports Commission, Australia.

SEPEP Sport Education in Physical Education Program

SEPEP is an international model (developed in the 1960's by Daryl Siedentop), aimed to develop additional skills in young people through physical activity. Through methods such as providing opportunities for students to take responsibility for leading activities, students take on greater responsibility for their own learning while also developing social, cognitive and sports skills. The *SEPEP* model offers opportunities for all students to experience positive rewards through physical education programs.

Reference

Alexander, K. & Taggart, A. (1995) *SEPEP. Sport Education in Physical Education Program.* Australian Sports Commission, Australia.

Game Sense. 30 games to develop thinking players

Game Sense. 30 games to develop thinking players offers a series of practical session plans within the area of physical education. The Game Sense approach aims to promote an enjoyable and challenging environment for all students that fosters the development of life skills including teamwork, communication and decision-making skills while developing technical skills.

Reference

Australian Sports Commission (1999). *Game Sense. 30 Games to develop thinking players.* Australian Sports Commission, Australia.

Effective communication texts

Bolton, R. (1987). *People Skills. How to assert yourself, listen to others, and resolve conflicts.* Simon & Schuster, Australia.

Eating Disorders Foundation of Victoria. (2000). *Information on Eating Disorders for families, partners & friends.* Eating Disorders Foundation of Victoria, Australia.

Related organisations

Support, referral, education and information services

The Victorian Centre of Excellence in Eating Disorders (CEED)

CEED aims to reduce the risk, duration and impact of eating disorders in people of all ages by building Victoria's capacity to undertake effective prevention, early intervention and clinical care.

CEED offers several services including:

* a list of eating disorder services across Victoria (including public and private hospitals and support groups)

* information

* professional resources

* professional development.

Phone   (03) 9342 7507

Email   ceed@mh.org.au

Internet site **www.ceed.org.au**

The Eating Disorders Foundation of Victoria (EDFV)

The EDFV is a non-profit incorporated association that supports those whose lives are affected by eating disorders, and informs the community about these disorders.

The EDFV offers the following services:

* support groups for people with an eating disorder and for families and friends

* a telephone and email support, referral and information service

* general education including a library/resource centre, bi-monthly newsletter and seminars

* list of referral services and health practitioners in Victoria

* professional development.

Telephone Support Line (03) 9885 0318 or 1300 550 236 (non-metro callers in Victoria)

Email   edfv@eatingdisorders.org.au

Internet site **www.eatingdisorders.org.au**

Community Health Services and Women's Health Services

To find a local Community Health Service and Women's Health Service:

* see Community Health Centres in the A-K White Pages telephone directory

* check your local government entry in the white pages or contact their offices

* visit **www.betterhealth.vic.gov.au** and select 'Service directories'.

Community Mental Health Services

To find local adult (ages 18+) and child and adolescent (ages 0-18 years) Community Mental Health Services:

* phone (03) 9616 7578 or (03) 9616 7571

* visit **www.health.vic.gov.au** and select 'Directories of services'.

Contacting private practitioners

Individual details of private health practitioners (psychologists, psychiatrists, GPs, counsellors, dietitians) who have an interest in eating disorders may be obtained through:

* The EDFV Information, Support and Referral Line (03) 9885 0318 or 1300 550 236 (for non-metro callers) or email edfv@eatingdisoders.org.au

* The Australian Psychological Society on (03) 8662 3300 or 1800 333 497 (for non–metro callers) or email referral@psychsociety.com.au

* The Dietitians Association of Australia at **www.daa.asn.au**

Special interest organisations

Active Approach Australia - Disability Education Program

Active Approach Australia delivers the Australian Sports Commission's Disability Education Program, which provides interactive and fun training for coaches, teachers, sports administrators, leisure centre staff and others and gives the skills, confidence and knowledge to better include people with disabilities (including mental health issues) in sport and physical activity.

Phone   (03) 9378 3471

Address   483 Buckley Street
               Essendon Victoria 3040

Internet sites **www.ausport.gov.au**
               www.vis.org.au/sported

ACHPER

The Australian Council for Health, Physical Education and Recreation (ACHPER) is a national professional association representing people who work in the areas of Health Education, Physical Education, Recreation, Sport, Dance, Community Fitness or Movement Science. The Mission of the Council is to promote healthy lifestyles for all Australians and particularly to study and promote its areas of focus.

ACHPER Victorian branch offers the following:

- Comprehensive professional development program (workshops, conferences, forums)

- Consultancy services (metropolitan and country)

- Resource development and publications

- Physical and Sport Education (PASE) professional development for primary, secondary and special education teachers fully or partly funded by the Department of Education & Training for government teachers. Non-government teachers are able to attend PASE professional development on a fee for service basis

- Special projects such as the Active Australia Schools Network and the Healthy Families Program

- Extensive sub-committee and reference group structure to maintain strong industry links in all areas of focus

- Representation on appropriate industry committees to ensure a voice for Victorian members.

Phone   (03) 9354 5311

Address   Level 2, Building B
                 Moreland City College
                 Alva Grove,
                 Coburg Victoria 3058

Internet site   **www.achper.vic.edu.au/**

Email   enquiries@achper.vic.edu.au

Victorian Department of Education & Training - SOFWeb

SOFWeb is an initiative of the Victorian Department of Education & Training.

Using information technology, *SOFWeb* aims to enhance teaching and learning by offering comprehensive information about local, national and international resources and projects as well as peer support and professional development opportunities.

SOFWeb provides information for:

- teachers

- parents and the community

- students

- leadership and management.

Internet site   **www.sofweb.vic.edu.au**

VicHealth - The Together We Do Better Website

The *Together We Do Better* website provides ideas and information for people interested in their own, and the community's mental health and wellbeing. *Together We Do Better* seeks to increase community awareness of the benefits of strong, connected and supportive communities. It provides information on mental health issues, news, case studies, and access to campaign resources, as well as tips for taking action to help strengthen the social fabric of our community.

Internet site   **www.togetherwedobetter.vic.gov.au/**

Models of intervention

Creating conversations

Through an interactive curriculum and providing information about drugs and drug related issues, the *Creating Conversations* program provides an opportunity for students to learn communication and problem solving skills. A significant feature of the program is the interactive parent event (usually an evening held at the school) that is facilitated by the students. This event provides an opportunity for students to talk openly with parents about issues that are real and relevant for them.

More recently, the program has been used for other issues relevant to adolescent wellbeing such as sexual identity, bullying and cross-cultural issues.

Internet site   **www.sofweb.vic.edu.au\wellbeing\ druged\parent.htm**

The walking school bus

The *walking school bus* is a practical concept that is being used nationally and internationally. The concept involves trained community members (sometimes parents) acting as the 'bus driver' and 'conductor'. The bus follows a set route to and from the school.

A step by step guide **Walking School Bus: A guide for parents and teachers** is available from the VicHealth website.

Internet site   **www.vichealth.vic.gov.au**

Best start

Best Start is a government prevention and early intervention project that aims to improve the health, development, learning and wellbeing of all Victorian children from pregnancy through transition to school (usually eight years of age).

Best Start is focused on reducing the impact of disadvantage (from any cause) and enhancing the life chances of all children, particularly those who are vulnerable and not currently accessing services.

The project involves parents, communities, providers and the three tiers of government in the design, use and evaluation of universal services at the local level. Exploring how ante-natal, maternity and maternal and child health services, child care, pre-school, and primary schools can best work together with other community resources on the ground to improve outcomes for children is the priority.

Internet site   **www.beststart.vic.gov.au**

Creating a positive school environment
- a whole school approach

Effective prevention requires a coordinated approach across multiple domains. Risk and protective factors exist within the individual, the family system, the school environment, peer relationships, other relationships and the wider community. Multiple intervention strategies that aim to concurrently address risk factors and promote protective factors require a coordinated whole school approach.

Issues to consider in creating a positive school environment include:

• managerial/leadership support

• parent involvement

• wider community programs and support

• the support needs of students and their families

• the support needs of teachers and other school staff

• the curriculum

• consultation and communication within the school community

• staff training and professional development needs.

The School Audit Checklist –
A practical checklist for schools

Adapted from: Allen, K. (2001). *Selected Notes*. Community Nutrition Unit, Department of Health and Human Services, Tasmania, 2001. Checklists originally adapted from the resources *Risky Business*. (Equity Programs Unit of Education Queensland, 2000) and *MindMatters*, (Commonwealth Department of Health and Aged Care, 2000).

Who in the school is this information relevant for?

The school audit checklists are a tool to examine current practices within the school and any areas that need to be addressed in whole school change. The checklists are of particular relevance to school staff who are involved in planning and instigating changes in policies and procedures, for example, managerial/leadership staff and committees designed to address particular issues.

School Audit - promotion of positive body image and eating behaviours

Answering the following questions will give you a snapshot of your school's policies, culture, curriculum and practices with regard to nutrition and body image promotion. It will hopefully stimulate discussion and thinking about how your school can integrate ways to promote healthy body image and eating behaviours, and the early detection of eating problems into your school's activities and programs.

School health policies and practices

Please tick the appropriate box. If *yes*, please indicate if a review of policy is needed.

Does your school have a:	Yes	No	Needs review
Anti-harassment and anti-discrimination policy?	☐	☐	☐
Does the policy include harassment and discrimination based on physical appearance and body size?	☐	☐	☐
Racism and cultural sensitivity policy?	☐	☐	☐
School canteen policy that links canteen practices with the curriculum?	☐	☐	☐
Protocol for approaching and referring students with possible eating problems?	☐	☐	☐
Protocol for liaising with parents and health professionals regarding students with eating problems?	☐	☐	☐
Protocol for supporting teachers and friends of a student with an eating problem?	☐	☐	☐
Gender equity policy?	☐	☐	☐

Practice

Please tick how often the following practices occur in your school.

Occurrence	Always			Never
Opportunities for teachers, students and parents to discuss school policies regarding teasing, bullying, sexual harassment, gender role constraints	☐	☐	☐	☐
Staff members act as role-models by their positive interactions with students, other staff and parents	☐	☐	☐	☐
Staff members are not discriminatory towards students, staff and parents on the basis of diverse physical appearance and body size	☐	☐	☐	☐
Staff members role-model healthy behaviours and attitudes towards their own eating, body image and activity (e.g. they do not discuss their dieting with students or colleagues)	☐	☐	☐	☐
Students have equitable access to school resources, such as teacher time, counsellors, leadership opportunities and safe places	☐	☐	☐	☐
Staff members role-model healthy expectations of themselves and other staff (e.g. seek assistance when over-committed or stressed, and support other staff when stressed)	☐	☐	☐	☐

Curriculum teaching and learning

Please tick the box that indicates how satisfied you are with the current practice in your school.

Practice	Very satisfied			Very dissatisfied
The school has a comprehensive health curriculum (including mental health) offered to all students (either as a subject or integrated into other subjects)	☐	☐	☐	☐
The curriculum offers opportunities for students to learn about diversity (including size and appearance)	☐	☐	☐	☐
Teachers are supported by receiving information about the availability and use of resources addressing nutrition, eating and body image issues	☐	☐	☐	☐
The school encourages teachers to attend programs on nutrition, eating and body image issues or offers opportunities for guest speakers	☐	☐	☐	☐
Parents are given the opportunity to participate in and learn about the content of the health curriculum (including nutrition, eating and body image issues)	☐	☐	☐	☐
Health and physical education programs promote positive messages such as *PE is for everyone*, that healthy and fit bodies come in a wide variety of shapes and sizes and that body size and shape are largely determined by genetics	☐	☐	☐	☐
Sport and recreation programs are 'size friendly' – for example, inclusive of students with different abilities, uniforms and sports equipment suit diverse body sizes, body weight is not included in fitness assessments	☐	☐	☐	☐
Health programs recognise the social context of young people's lives and explore the individual, social and environmental influences on students' values and behaviour (e.g. eating behaviours)	☐	☐	☐	☐
The curriculum and school program provide positive food experiences/programs (e.g. cooking, social occasions with food, multicultural events)	☐	☐	☐	☐
The curriculum provides positive food and eating messages e.g. that food is for nourishment, pleasure and social health (not 'good' and 'bad' foods)	☐	☐	☐	☐
The school canteen offers a range of affordable, fresh foods	☐	☐	☐	☐

Body image

Please tick the box that indicates how satisfied you are with the current practice in your school.

Students gain an understanding, relevant to their age and culture of:	Very satisfied			Very dissatisfied	Not covered
Healthy nutrition and eating habits/attitudes	☐	☐	☐	☐	☐
Healthy activity habits/attitudes	☐	☐	☐	☐	☐
The nature and dangers of dieting	☐	☐	☐	☐	☐
Weight and body changes with age, especially during puberty	☐	☐	☐	☐	☐
Gender stereotyping	☐	☐	☐	☐	☐
Personal and cultural identity	☐	☐	☐	☐	☐
Victimisation	☐	☐	☐	☐	☐
The impact interactions within some friendship groups can have on an individual's body image and self-esteem	☐	☐	☐	☐	☐
Community health resources and services available to students	☐	☐	☐	☐	☐

Personal and social skills

Please tick the box which indicates how satisfied you are with the opportunities provided for students to acquire personal and social skills that contribute to positive mental health and wellbeing.

Students have an opportunity to develop:	Very satisfied			Very dissatisfied	Not covered
Communication/assertiveness skills	☐	☐	☐	☐	☐
Decision making/problem solving skills	☐	☐	☐	☐	☐
Help-seeking skills	☐	☐	☐	☐	☐
Conflict resolution skills	☐	☐	☐	☐	☐
Stress management/relaxation skills	☐	☐	☐	☐	☐
Social skills	☐	☐	☐	☐	☐
Self esteem	☐	☐	☐	☐	☐
Skills to set achievable, healthy goals	☐	☐	☐	☐	☐
The ability to identify and express emotions and needs	☐	☐	☐	☐	☐
Critical thinking and reflection	☐	☐	☐	☐	☐
Media literacy skills	☐	☐	☐	☐	☐

School organisation, ethos and environment

Please tick the box that indicates how satisfied you are with the current practice in your school.

Practice	Very satisfied			Very dissatisfied
Opportunities are provided for students and staff to develop positive and meaningful relationships	☐	☐	☐	☐
Teachers and students are supportive of, and respectful towards each other	☐	☐	☐	☐
The school actively discourages physical and verbal harassment and violence between students and/or staff (including harassment based on size and appearance)	☐	☐	☐	☐
Opportunities are provided for all students to experience success in a variety of ways (across social, creative, academic and sporting areas)	☐	☐	☐	☐
Students of diverse body size and appearance are chosen as role models for a variety of tasks and roles such as team captains or lead roles in school productions	☐	☐	☐	☐
Learning resources (e.g. posters, books, videos, activities) reflect the diversity of body shapes, sizes and appearances	☐	☐	☐	☐
Furniture, equipment (e.g. sporting) and uniforms cater for a diversity of body sizes and shapes (small, large and tall)	☐	☐	☐	☐
Competition within the school community is structured to support the personal and social growth of students	☐	☐	☐	☐
The school offers opportunities for students to make healthy food choices via:				
- school canteen	☐	☐	☐	☐
- fundraisers	☐	☐	☐	☐
- other school functions (e.g. Eisteddfords, socials, parent/teacher events)	☐	☐	☐	☐

Partnerships and services

Please tick the box that indicates how satisfied you are with the current practice in your school.

Practice	Very satisfied			Very dissatisfied
Opportunities are provided for parent education on nutrition, healthy eating behaviours and body image	☐	☐	☐	☐
Opportunities are provided for staff to work with community organisations with experrise in nutrition, eating and body image issues (for example, integrating issues into the curriculum and developing prevention and intervention strategies)	☐	☐	☐	☐
The school is aware of, and has access to, external counselling and support services for students with eating and body image issues	☐	☐	☐	☐
Teachers are provided with information about the signs and symptoms of disordered eating issues	☐	☐	☐	☐

Please indicate whether referral procedures are in place for the following and, if so, whether a review is needed.

The school has procedures in place for the identification and referral of students at risk of eating problems, e.g. those:	Yes	No	Needs review
who experience low self esteem, anxiety, depression, obsessive – compulsiveness, perfectionism	☐	☐	☐
with a family history of eating disorders, drug abuse or mental health problems	☐	☐	☐
with a history of physical or sexual abuse	☐	☐	☐
who are large or who say they are fat	☐	☐	☐
who are engaging in weight loss dieting or frequent and/or extreme dieting	☐	☐	☐
who have or are experiencing teasing, bullying, sex based harassment or weight related teasing	☐	☐	☐
who are involved in high level competitive sports	☐	☐	☐
who are involved in activities such as drama and dance, where weight and body shape are considered a factor affecting performance	☐	☐	☐
who are experiencing high periods of stress	☐	☐	☐
who experience difficult peer relationships	☐	☐	☐
who experience conflicting pressures from different cultures	☐	☐	☐

Please tick the box that indicates how satisfied you are with the current practice in your school.

Practice	Very satisfied			Very dissatisfied	Not offered
Peer support programs	☐	☐	☐	☐	☐
Mentoring programs	☐	☐	☐	☐	☐
Student equity groups	☐	☐	☐	☐	☐

If these programs are offered, can eating and body image issues be integrated into them?

☐ Yes, please specify

_____

_____

_____

_____

☐ No

Are there any other programs within the school into which these issues can be integrated into (e.g. lifeskills, religious education)?

☐ Yes, please specify

_____

_____

_____

☐ No

Health promotion models for whole school change

Several health promotion models have been created to guide whole school change. A number of these models utilise principles from the World Health Organisation's *Health Promoting Schools Framework*. There is consequently considerable overlap between the models.

Some of these models primarily address general adolescent wellbeing, while others have been developed with a specific focus on eating disorder and body dissatisfaction prevention. These models generally provide a conceptual framework for

instigating and maintaining change within schools. The range of models available allows schools to choose a model/s that is suitable for their individual needs.

For a practical resource to support agencies and organisations to plan, deliver and evaluate effective integrated health promotion programs see *Integrated health promotion: A practice guide for service providers* on the DHS website.

See **Chapter 7 – Additional resources** – *Health Promotion*.

Resource

General adolescent wellbeing models	Authors/Publisher
Framework for Student Support Services	Education Victoria (1999)
The Gatehouse Project	Glover, Patton, Butler, Di Pietro, Begg & Cahir (2002)
SchoolMatters	Cahill (2000)
Comer Process for Change in Education	Comer, Ben-Avie, Haynes, & Joyner (1999)
Eating disorder specific models	
Preventing eating and body image problems in children and adolescents using the health promoting schools framework.	O'Dea & Maloney (2000)
School-based programs for preventing eating disturbances.	Neumark-Sztainer (1996)
On the move from Tertiary to Secondary and Primary Prevention: Working with an Elite Dance School.	Piran (1999)

References for these models are listed in the *References and resources consulted* section.

Purpose of school policies

Developing policies can be an effective way of initiating change within the whole school environment. Enacted policies can provide and/or facilitate:

- a shared understanding of school priorities and values

- a school environment and philosophy that promotes wellbeing

- the reduction/prevention of factors that may contribute to disordered eating such as bullying and weight–related teasing

- the promotion of protective factors or resilience in young people

- early detection and intervention of eating disorders and other adolescent health issues

- best practice models based on current knowledge of prevention

- consistent responses to incidents, including critical incidents

- legal protection.

For suggested strategies to support the implementation of school policies, see **Supporting resource 4** – *Facilitating change at a whole school level.*

Guidelines for writing school policies

Polices will vary from school to school based on their individual needs and may include:

- a clear statement about the issue

- school goals

- aims of the policy

- definitions of the issue or behaviours

- consequences of non-compliance to school policies

- grievance procedures.

Suggestions for writing school policies

- Use a *School Audit Checklist*. Checklists are useful to stimulate discussion, acknowledge what is already happening in the school, identify areas that need to be addressed and to prioritise issues.

  See **Supporting resource 1**.

- A policy doesn't need to be detailed. Ideally, a policy is concise and easily accessible. Charts, bullet points and clear headings can facilitate easy access to information.

- Tailor policies to the needs of the school and its members.

- Consider updating existing policies to encompass eating disorders.

- Survey parents/families, students and teachers about issues they would like to see addressed in school policies. For example *The School Safety Survey* (Fuller, 1998).

- Hold discussion groups with students, teachers and/or parents/families. This can help to develop a shared sense of responsibility about school safety, provide valuable information about bullying, teasing and harassment issues and create support for school policies.

- Develop a *School Policy Working Group* that includes people from the whole school community including students, teachers, welfare staff, school management and parents. Alternatively, an existing action group may take on this task. This group may administer surveys, collate survey results, develop draft policies, promote the use of school policies and develop strategies to support policy implementation.

- Obtain support (including financial and resource support) from managerial/leadership staff for both policy development and implementation.

- Implement the school policy. Evaluate implementation strategies.

Facilitating change at a whole school level

For a practical resource to support agencies and organisations to plan, deliver and evaluate effective integrated health promotion programs see *Integrated health promotion: A practice guide for service providers at the DHS website*.

For further information, see **Chapter 7 – Additional resources** – *Health promotion*.

Making changes

Making changes within any organisation requires a range of tasks including planning, consultation, problem-solving, dealing with resistance and obtaining resources.

In order to make changes within a school community, it is necessary to review the issues or problems (a needs analysis) and plan strategies to address the identified issues.

Potential challenges

It is important to consider potential challenges when developing the overall plan, including strategies of how to deal with issues as they arise. Challenges may include:

- resistance from staff, students and/or families
- resource issues (for example, lack of time or financial resources)
- tension between different groups within the school
- evaluation procedures indicating a lack of success with new policies or procedures
- unforeseen barriers.

Dealing with challenges

Some suggestions for dealing with, and reducing the likelihood of challenges include:

- creating as much ownership over the changes as possible within the school community, e.g. involving people in the decision-making and planning process. *The more people see their ideas in action, the more likely they are to support change*
- educating members of the school community about the planned changes and the reasons for them
- consulting with groups and individuals who will be affected by the change
- creating realistic short, medium and long-term plans that include clear goals and corresponding strategies
- prioritising issues and allocation of resources
- generating support from the wider community (external organisations may be able to provide consultation, professional and/or financial resources)

- being flexible, adjust and re-prioritise plans during the implementation stage
- celebrating any successes
- recognising that change is a process that requires individuals to recognise an existing problem and the need for proposed changes before they will adopt strategies
- consulting specialist literature about organisational theory and change. Several models provide a linear framework to guide change at a whole school level, for example, *The Gatehouse Project* and the *Shapes* program.

The Gatehouse Project - Stages of the whole school strategy

1. Establishment – e.g. establish an adolescent health team
2. Review – examine current policies, programs and practices
3. Planning – plan implementation of evidence based strategies to enhance security, communication and positive regard
4. Training and implementation – provide training/support for teachers
5. Evaluate – monitor, evaluate and communicate progress

Source: Glover, Patton, Butler, Di Pietro, Begg, & Cahir. (2002). *The Gatehouse Project – Promoting emotional wellbeing: Team guidelines for whole school change*. Centre for Adolescent Health, Melbourne, Victoria.

Shapes: Body Image Program Planning Guide - Eight strategies for effectiveness

1. Build credibility
2. Take time to plan
3. Match resources to goals – have you the resources to achieve the goal/s?
4. Build support networks
5. Look at ways to expand resources
6. Nurture alliances
7. Learn from your and other's experiences
8. Spread the word

Source: Victorian Government Department of Human Services. (2002). *Shapes: Body Image Program Planning Guide*. Rural and Regional and Aged Care Services Division, Victoria.

For a practical resource to support agencies and
organisations to plan, deliver and evaluate effective integrated
health promotion programs see *Integrated health promotion:
A practice guide for service providers* on the DHS website.

For further information, see **Chapter 7 – Additional resources** –
Health promotion.

Monitoring and evaluating policies and practices

Evaluation is an important part of school change. Evaluation
provides valuable information that can be used to:

- identify progress

- distinguish effective from ineffective strategies

- improve practices/strategies

- re-evaluate objectives

- develop new recommendations for school change

- counter a lack of commitment to change in the school
community

- generate new resources to support/maintain school change

- provide an opportunity to celebrate success.

In relation to eating disorders, prevention programs are in
their infancy; evaluation can increase the body of knowledge
around effective and ineffective methods.

Monitoring change

Suggested strategies

- Obtain comparison (or baseline) data if possible. For
example, in relation to developing policy and practices
around creating a safer school environment, survey
students about their level of safety prior to, and after the
strategies have been implemented.

- Develop realistic and appropriate evaluation techniques
based on the objectives of change, for example:

  - qualitative evaluations such as verbal and written reports
including discussion groups, student, parent and/or staff
surveys

  - quantitative evaluations including the number of reported
bullying incidents, number of people involved in a training
program.

- Change can be slow, especially in its initial phases. Monitor
short, medium and long-term changes. Monitor small
changes.

- For more specialist information, consult literature about
evaluating organisational change.

Implementing bullying, teasing and discrimination policies

Implementing school policies requires a coordinated effort
across the school community.

Suggested strategies
Policy and procedures

- Encourage teachers to develop their own classroom
agreements with students. Display these agreements.

- Survey students and parents/families about:

  - bullying issues and experiences within the school (such
as problem areas and times)

  - other risk factors they are aware of (this may be specific
to eating disorders and include factors such as weight
loss dieting culture within the school, weight-related
teasing or sex-based harassment)

  - students' sense of safety within the school

  - what they would like to see changed/improved

  - what they find useful or effective.

- Address the 'anti-dobbing' ethos within the school.
Talk about the anti-dobbing code with the whole school
and within groups.

- Promote acceptance of diversity (such as different cultures,
religions and body shapes and sizes) by including different
images in the school through posters, videos, artwork and
literature.

- Encourage teachers to choose students with varied
shapes and sizes to represent the school (such as school
captains, sports captains, major roles in drama and
musical productions).

- Provide both formal and informal avenues for students
to report any incidents of bullying, teasing and harassment.

- Consider levels of reporting, for example, anonymous
versus confidential.

- Develop a sensitive Grievance Procedure for all staff
members to follow when dealing with complaints from
students regarding bullying, teasing and harassment
(this may be part of the policy itself). Documented
procedures can facilitate a consistent response to bullying
within the school.

- Encourage and facilitate opportunities for students to
challenge prejudice in the wider community or media
(such as, discrimination based on appearance, size, race
and sport). For example, students may write collective
letters to advertising companies and Government
regulatory bodies about damaging media images or
policies.

- Evaluate school uniforms so that students feel comfortable physically and psychologically. For example, be flexible with ways students may attempt to cover up, (for example, wearing bike pants under skirts). Offer a range of clothing options such as pants and skirts of different styles.

- Evaluate the suitability of school furniture and equipment. Are they adequately sized for students of different sizes and heights?

- Consider the physical layout and design of the school. Are there changes that can be made to reduce the opportunity for bullying, teasing and harassment? For example, enclosed spaces, locker areas.

- Consider the power of role modelling in the school. Encourage staff to model acceptance of both their own body image and diverse body shapes, sizes and appearance.

- Create a protocol of appropriate and acceptable language and topics of discussion. For example, it is not appropriate for teachers to comment on each other's weight or weight loss or discuss their personal dieting techniques.

- Encourage staff to examine their own feelings and/or concerns with body image, weight, dieting and exercise.

- Establish a team or committee to address existing risk factors within the school. To create a sense of shared ownership, include parents/families, students, school staff and a relevant community member on the team.

- Prioritise which risk factors to address. For example, directly address risk factors that are present in the school environment (such as weight related teasing).

Encouraging change

- Reward and support students and teachers who facilitate reporting of bullying, teasing or harassment.

- Reward and support students and teachers who act to intervene when bullying, teasing or harassment is occurring within the school.

- Encourage all teachers to have a consistent response to bullying, for example, following the same Grievance Procedure.

- Create shared responsibility across the school community for bullying. For example, consult students involved in bullying and harassment (including students who may perpetuate bullying) when developing problem solving strategies.

Support

- Develop ways to explore and address why some people feel the need to put others down through teasing, bullying or harassment. Consider ways of supporting students who are involved in bullying others.

- Develop and foster organised student support systems such as:
  - buddy systems
  - peer support systems
  - student support networks or support groups for students who feel bullied.

- Create and maintain a wider support network around students who feel bullied. For example, hold a discussion group with parent/s, a staff member and a local community youth worker.

- Develop and facilitate peer mediation programs. This creates an opportunity for young people to:
  - contribute to their environment
  - take shared responsibility for the implementation of school policies
  - introduce positive peer influence.

Creating a supportive school environment

Policies relating to a supportive school environment may address:

- positive relationships between staff and students

- positive relationships between students

- a confiding relationship with at least one adult

- positive communication between all members of the school community

- opportunities to participate

- opportunities for rewards for a range of activities and achievements

- collaborative decision-making within the school

- structured support networks

- shared care/responsibility within the school for wellbeing

- acceptance and promotion of diversity

- a sense of physical, emotional and social safety

- role modelling of communication and acceptance.

Suggested strategies

Fostering a sense of support

- Develop and foster organised student support systems such as:

  - buddy systems

  - peer support systems

  - student support networks or support groups for students around relevant issues.

- Develop a *Student and Staff Support Team* that is responsible for school prevention initiatives and the support needs of students and staff. This team may work collaboratively with other committees or teams within the school. Alternatively, designate this responsibility to an existing committee.

- Consider continuity in student-teacher and family relationships. For example, a sense of connectedness can be fostered in students and families when their Year Level Coordinator progresses through the school years with the student. This facilitates longer-term relationships within the school community.

- Develop a reward point system for positive actions or words as well as caring, understanding or supportive gestures.

- Review and monitor formal student support systems. Consider the match between student needs and the services offered. For example, survey students about what they value about student support services and any unmet needs they may have.

- Consider access to formal student support services. Are there any barriers for particular groups of students, e.g. language issues?

- Consider the needs of socially and emotionally isolated students who may be at risk of health and wellbeing issues. Develop a system where one adult takes the time to connect with that student formally or informally at least once a week, as a confiding relationship with one adult is a protective factor against many adolescent issues.

- Consistently reward students for *all* kinds of achievements and individual qualities. Find things to reward *all* students for.

- Consider high-risk times for stress, such as before exams and the initial transition into high school. Develop programs that facilitate support at these times.

- Develop formal support networks for students who are struggling with academic work. For example, student peer tutoring systems.

- Monitor changes in absenteeism. Follow up students and provide support.

- Find ways to promote and encourage help-seeking behaviour in schools. For example:

  - talking openly about adolescent wellbeing and mental health issues

  - holding discussion groups

  - distributing posters and literature

  - integrating student welfare into curriculum through different subjects, for example:

    - English (literature about mental health and wellbeing)

    - History (historical context of mental health and wellbeing)

    - Social studies (different cultural values and perceptions of mental health)

    - Art (history of body size and beauty).

- Consider the support needs of all staff. For example, areas in which staff would like more training or professional development opportunities.

Activities and Special Events – Creating opportunities to participate

- Find creative ways to engage with isolated students and provide opportunities for them to participate in the school community.

> *"A young, isolated boy, who liked his dog, wrote a manual about pet care and took care of the animals at school."*
>
> (Brooks, 1994, pp. 550)

- Promote classroom and school activities that facilitate acknowledgement of each student's qualities. For example, anonymous compliment sheets.

- Facilitate self and peer responsibility for learning in the class environment. For example, run class activities with different pairs of students taking it in turns to lead the activity.

- Form *School Teams* for all kinds of activities (perhaps across year levels). Create opportunities for teams to work together. For example, a fundraising committee or a health promotion group. This will facilitate shared interests and positive relationships within the student body.

- Organise and promote *Theme Weeks* (or months). For example, a health promotion group within the school may focus on different aspects of physical, emotional, psychological and social health. This group may develop information displays, organise guest speakers, activities or special events that promote awareness and discussion of the issue.

- Organise special events within the school that facilitate a sense of school community. These events can facilitate relationships by creating shared interests. For example, cross year level plays where year 10 students write plays based around a theme, such as friendship, and students from all year levels take on different roles such as director, actor, costume designer, sound and lighting.

These plays may be performed during lunch times, as a special evening event for the whole school community, for local primary schools or for special interest groups. This may also facilitate connections with the wider community. For example, *The Royal Children's Hospital – Festival for Healthy Living*.

For more information about the Festival, see **Chapter 7 – Additional resources** – *Mental health promotion*.

- Develop strategies that create and strengthen a sense of community and relationships within the school, particularly for young people who may not be linked into a social group. For example:

  - create a lunchtime walking group. This can promote the importance of an active, healthy life style rather than focusing on obtaining a certain body size or shape

  - organise lunchtime outings for students who want to participate. For example, students may be invited to walk to a near by park/recreation area. This may provide an opportunity for students to use recreational equipment they may not otherwise use at school

  - create a gardening group. This offers an opportunity for young people to actively participate in their environment and receive positive rewards.

- The *Walking School Bus*. This is a new concept being used nationally and internationally. It has many benefits for the wider school community. For example:

  - relieves parents/families of transporting students to school

  - provides a safe travelling alternative for young people who may not otherwise travel with anyone

  - actively engages other community agencies (e.g. the local Council may fund the project, community members may act as 'bus driver')

  - promotes an active/healthy life style rather than weight loss exercise

  - provides an opportunity to create and strengthen a sense of community and relationships within the school, particularly for young people who may not be linked into a social group

  - lessens traffic congestion around school zones

  - reduces environmental pollution by reducing car travel

For more information about *The Walking School Bus*, see **Chapter 7 – Additional Resources –** *Models of Intervention*.

School environment and space

- Evaluate the physical school environment. For example, are there posters or literature that promote negative or unrealistic images? We suggest height/weight charts be removed.

- Home rooms can create opportunities for informal support/discussion among students. Students may take responsibility for furnishing the room. For example, students may work together to raise money for a cappuccino machine and then develop a roster for maintaining the machine.

Facilitating communication

- Encourage students (in groups) to actively voice their objections to TV and media that promote unrealistic/unhealthy images.

- Facilitate communication within the school between all members of the school community. For example:

  - hold information evenings for parents/families

  - hold discussion groups. This may be between teachers and students, students and students, teachers and teachers, members of the wider community sector and students. This can be useful when a particular school issue comes up or when there is a major school change.

    See the *Creating Conversations Model*, **Chapter 7 – Additional resources** – *Models of intervention.*

  - create opportunities for all students to voice their concerns about any school issue, for example, an anonymous suggestion box

  - hold regular staff, student and parent meetings

  - school newsletters.

- Create and maintain a collaborative decision-making process within the school, particularly for issues that directly affect the students. Collaborative decision-making can create a sense of shared responsibility and ownership within the school. For example, voting for new school uniforms, or priorities for spending money within the school, e.g. would students prefer to spend more money on library resources or sporting resources?

- Teach social skills training.

- Teach and affirm individual coping and problem-solving skills.

- Examine potential opportunities for health promotion and prevention in the curriculum. For example:

  - teaching life skills such as decision-making and stress management skills

  - critically examining why diets don't work.

> *"Up until adolescence, decisions are always something other people did. The daunting decision of what am I going to do for the rest of my life?"*
>
> (Comment from someone who experienced an eating disorder during her school years, Hunwick, 2002, pp. 10-11)

- Examine areas of the curriculum that may need addressing, for example:

  - does the curriculum promote dominant cultural messages about the human body being a metaphor for success, health, self-discipline and self-worth? For example, slimness does not indicate a person's health, attractiveness, success or worth

  - is the curriculum based on notions or stereotypes of gender?

- Consider teaching methods and styles. For example, does the teaching style promote collaborative learning or accommodate the different learning styles of students? Are there opportunities for students to discuss their views?

- Facilitate positive and professional interactions between staff members.

Wider community involvement

- Consider other immediate influences in a young person's life, such as the neighbourhood. The school is part of the wider local community.

- Engage with organisations or services that have a significant impact on student's lives.

- Facilitate students' involvement in community organisations. Invite members of the wider local community to be actively involved in the school. For example:

  - local community groups may provide information, activities, workshops

  - local sporting groups may offer school based programs

  - a local restaurant may offer cooking classes

  - the local supermarket may offer work experience for students

  - students may take on voluntary work in the local community

  - associations representing diverse groups in the wider community may come and offer entertainment or information sessions

  - the local police may come to the school for informal activities

  - the local youth service may come for special school activities.

- Identify strengths and resources within the local community, for example, an active residents group or a local voluntary organisation.

- Identify issues of concern to the school community (including parents/families, students and the school council) and work with services that offer specialist support in that area. For example if drug availability and use is a concern within the school community, approach a local service that works in the area of alcohol and other drug intervention.

- Involve local businesses, community services and media to promote positive messages.

Case examples

A school invited a local drama group to develop a play that addressed the areas of self-esteem, body image and eating concerns. The group performed the play for different year groups. The play was followed by discussion groups.

Year Level Coordinator, Eating Disorders Resource for Schools School Staff Consultation, 2003

A group of students walked dogs at the local animal shelter on a weekly basis.

A school periodically invites a local yoga teacher to come and run relaxation classes during lunch times and class free periods.

Student Welfare Coordinator, Eating Disorders Resource for Schools School Staff Consultation, 2003

A local bank developed a program with a school aimed at career development and developing life skills. The bank supported and sponsored the development of a 'school bank'. The external bank ran educational sessions about the different roles in the bank. Students 'applied' for the positions in their school bank. The external bank held interviews and employed people, and helped in establishing a room at the school that looked and felt like a bank. The school bank was open three mornings a week. Students could open personal accounts there, and in turn the external bank invested their money.

Loseth et al, 1999

A local artist was employed to work with students to paint a mural in the school. Murals can also be used to promote awareness of issues.

Increasing student participation-
Physical education

Policies relating to physical education and sports within the school may address:

- availability of varied physical education and sports activities

- the balance of competitive and non-competitive physical education and sports activities offered

- the rewards offered to students around physical education and sporting activities

- the relationship between body image and involvement/ enjoyment in physical activity

- conversations around potentially sensitive issues (e.g. weight, body shape and size, competitive performance)

- staff attitudes around health, fitness, body shape and size

- staff encouraging or suggesting dieting to students

- measuring student performance and achievement (e.g. the use of scales, calliper tests, ranking students against each other rather than themselves)

- the culture around, and participation levels at sports days and carnivals

- imbalances in the level of participation, for example, gender, age groups, social groups

- the relationship between Health and Physical Education in the school curriculum

- the relationship between competitive sports and the development of clinical eating disorders

- the different roles of people within the school around policy implementation.

Increasing students' enjoyment and motivation levels

"We need to teach our students that coming top is not the same thing as being happy."

(Comment from someone who experienced an eating disorder during her school years, Hunwick, 2002, pp. 10-11)

- Survey students about the types of physical activities they would like available.

- Some students prefer not to participate in competitive sports. Consider the availability of competitive and non-competitive physical education and sports activities.

"We offer yoga and tai chi to try and involve all students in PE."

(Physical Education Teacher, Eating Disorders Resource for Schools School Staff Consultation, 2003)

- Consider the focus and culture of the physical education and sport program. Is it promoting 'healthism' (a focus on weight, low-fat foods, weight loss dieting and weight-loss exercising) rather than a balanced, active life style and diversity in shape and size.

- Consider any imbalances in levels of participation, for example, imbalances based on gender, size or ability level. Offer activities that engage these students without drawing attention to them. For example, students who are larger may be more likely to engage in physical movement rather than physical activity. This may also reduce their sense of failure in the area of PE.

- Refer to documents which have been developed to support PE teachers in creating inclusive physical education programs such as *Give it a Go. Including people with disabilities in sport and physical activity*.

  See **Chapter 7 – Additional resources** – *Inclusive physical education and sport programs*.

- Refer to resources that support teachers in developing physical education programs that provide opportunities for students to learn different skills and experience positive rewards regardless of their physical ability or skills. For example the *SEPEP* model.

  See **Chapter 7 – Additional resources** – *Inclusive physical education and sport programs*.

- Consider promoting physical activity as a form of stress management rather than body control or weight reduction. For example, physical activity does not have to be confined to physical education classes.

- Introduce a five to ten minute break from the classroom (or first thing in the morning) that involves some form of activity (e.g. tunnel ball, follow the leader).

- Promote physical activity as a personal challenge. For example, take the focus off winning or beating someone else as a measure of how good students are at physical activity.

- Offer mixed sports. Encourage the formation and continuation of mixed teams.

Consider the messages being promoted through the physical education program

"I used to think girls couldn't play football. But we've been playing in the field just now and we've been letting the girls play. It's been more fun…I thought they'd be rubbish. But they're really good."

(13-year-old male student, Salisbury & Jackson, cited in Boulden & Ireland, 2000, pp. 86)

- Does the school promote a *'PE is for everyone'* message?

- There is a documented relationship between competitive sports and the development of clinical eating disorders. Provide education and literature to physical education teachers and sport coaches around early warning signs for eating disorders.

  See also **Chapter 2 – Current Information about Eating Disorders –** *Warning signs and consequences* and **Chapter 4** *– Early Intervention – Identifying students at risk.*

- Consider messages promoted through both formal (e.g. public acknowledgement) and informal rewards (e.g. praising and encouraging students). For example, acknowledging students at a whole school assembly for winning an inter-school competition, while not acknowledging other teams that may not have won, but put in a good effort.

- Promote a message that even small amounts of activity are good for physical and emotional wellbeing.

- Reward students for varied achievements and benefits associated with physical education, not just winning. For example, offer encouragement when students use exercise as a form of stress or anger management.

- Replace language that may perpetuate damaging messages such as 'weight loss', 'fat', 'unhealthy' and 'overweight' with terms such as '*physical wellbeing*' and '*active lifestyle*'.

- Monitor language, comments and attitudes around health, fitness, body shape and size from teaching staff and students. Particularly monitor attitudes and comments towards students who are overweight.

- Monitor discrepancies in messages promoted to students. For example, some teachers may put down sports in favour of academic pursuits. Female students in particular who are involved in sport can feel devalued and this can create confusion about the importance of a healthy lifestyle and body image.

"The school had a particular sports teacher whose attitude was not helpful, even a factor in the development of the eating disorder."

(Parent, Eating Disorders Resource for Schools Carer Consultation, 2003)

- Consider how students are graded in physical education. For example, are they graded against each other or against themselves, e.g. their 'personal best'?

- Measure student performance and achievement in a way that does not over emphasise weight. For example, we suggest not using scales and calliper tests.

- Do not weigh students.

- Consider the culture around sports days and carnivals. For example, are there opportunities for team sports? Are there opportunities for non-competitive sports?

- Review images promoted within the physical education and sporting programs. Are they unrealistic or unhealthy images that promote a one-dimensional image of health and beauty? Consider posters, literature and videos.

- Consider any preferential treatment based on gender, intentional or unintentional, for example, teachers relating differently to males.

"A year 8 basketball lesson is about to start. Many of the boys are energetically and boisterously moving around the gym, dribbling, yelling out for passes, unsuccessfully shooting baskets despite their comportment having all the trademarks of their National Basketball League (NBL) heroes. While a couple of the girls are peripheral to this pre-lesson activity, many are sitting court-side, while others are still putting on their onion-like Physical Education attire – bike pants under shorts, under skirts, under baggy T-shirts… The Physical Education Teacher arrives, pleased to exchange opinions about the NBL final with a group of boys. Two sheepish students…are selected as referees and the games begin. Apparent skill levels vary greatly as does student's participation. Some boys throw themselves freely at the ball and around the court, other boys and girls negotiate a safe path through the game, and the remainder are bystanders."

(MacDonald cited in Boulden & Ireland 2000, pp. 78)

- Consider the expectations placed on males regarding being 'tough'. Is school sport used as a way of promoting the dominant male culture without considering the needs of individual students?

Case example

A school provided a modern dance program designed for male students who weren't interested in competitive sports such as football.

Secondary School Teacher, Eating Disorders Resource for Schools School Staff Consultation, 2003

Developing partnerships with the local community

For a practical resource to support agencies and organisations to plan, deliver and evaluate effective integrated health promotion programs see *Integrated health promotion: A practice guide for service providers* at the DHS website.

For further information, see **Chapter 7 – Additional resources** – *Health promotion*.

Suggested strategies

Effective partnerships are based on open communication and collaboration (or shared responsibility).

• Identify organisations within the local community that may have shared interests with the school, such as providing services to young people, or to families in need.

  For example, sporting clubs, local youth services, local drug and alcohol support services, services offering financial support (e.g. The Salvation Army).

  Many local governments or councils have lists of community, government and non-government organisations.

• Establish a committee that is responsible for developing and maintaining partnerships with the wider community. The committee may:

  - include parents/families, school staff, students and a community member

  - consider areas of need or interest in the school community

  - develop a list of objectives based on these needs or interests

  - develop strategies to create positive partnerships

  - designate responsibility according to the skills of committee members

  - evaluate strategies and their effectiveness

  - use knowledge gained from evaluations to inform future planning.

• Access organisations that offer treatment/support to young people with mental health issues. These organisations may also support the school welfare staff in their role.

• Facilitate collective responsibility for wider social or cultural issues that affect students, for example, a dieting culture. Members of the community who have expertise or an interest in the area may generate and implement strategies for change.

Interested groups may include:

- child/youth services

- other local schools

- activist groups

- local business

- artists

- fitness centres

- cultural groups

- special need groups

- local or state Government representatives

- women's/men's groups

- religious groups

- community support groups

- adult befriending programs (e.g. *Big Sisters*)

- recreation clubs.

• Facilitate the provision of services in the school environment, for example, invite and provide space for external health professionals to provide services on site.

• When developing additional programs for parents/families and/or students (for example, a *self-esteem wellbeing* program), consult with specialists from the community and/or involve community members in the delivery of the program.

• Consult with specialist organisations when dealing with minority groups, for example, students from diverse religious backgrounds or same-sex attracted students.

• Invite health professionals to provide programs to meet identified needs of students. For example, a psychologist from the local community may come and talk about looking after yourself physically and emotionally during exam periods.

• Encourage and facilitate opportunities for students to challenge prejudice in the wider community or media (for example, discrimination based on appearance, size, race or sports). Students may write letters to relevant organisations such as advertising companies and Government regulatory bodies.

See also **Supporting resource 5** – *Wider community involvement*.

Dealing with traumatic incidents within schools

Suggested strategies

Short term

- If the incident occurs at school, follow the critical incident policy. Critical incident policies ideally provide direction around:

  - immediate handling of the incident – crisis management

  - addressing the incident with students

  - identifying and monitoring students and staff in need of direct support

  - informing parents/families and addressing their concerns

  - informing the media or outside community members.

- Provide a coordinated response to the incident.

- Clearly define who is responsible for tasks identified in the coordinated response.

- Facilitate or maintain regular and effective communication protocols between school staff.

- Hold update meetings for staff each morning immediately after the incident.

- Hold debriefing meetings each afternoon following the incident.

- Designate one or more people to deal with enquiries from the wider school community. This will ensure a consistent response to enquiries and reduce misinformation.

- Decide who is the best person to tell students and the method of doing this, for example, consider age appropriate information.

- Inform students in smaller groups (e.g. home groups), to facilitate discussion and support.

- Develop a written statement for staff to assist them in informing students.

- Designate one or more people to offer support to students.

- Inform students of who they can go to if they wish to access support and/or counselling.

- Access trained professionals to provide further support and/or debriefing if necessary.

- Develop appropriate strategies to support students and staff who were directly involved in the incident such as:

  - providing individual debriefing within a few hours of the incident

  - providing group debriefing within a few days of the incident

  - providing further opportunities to speak about the incident.

- Deal with any individual reactions that require further support, for example, people directly involved may feel they should have done more, or didn't act quickly enough. Refer people to specialist trauma counselling if necessary.

- Develop appropriate strategies to support students, staff, parents and families who are affected by the incident such as:

  - providing relevant information about the incident

  - providing guidance about how they can support those directly involved if they request to do something

  - providing opportunities to speak about the incident.

- If appropriate prepare an information sheet about the incident for the school community. Information can help to reduce anxiety about the unknown and reduce misinformation.

- Consider both the physical and psychological wellbeing of individuals and the school community.

- Provide informal opportunities for members of the school community to support each other, for example, hold a morning tea for parents/families.

- Be prepared for intense reactions of grief and/or anger.

- Provide information, support and/or programs that facilitate students' use of individual coping responses, for example, information about getting enough sleep or the benefits of talking to someone.

- Hold an information session with school staff and/or parents/families about signs of trauma to assist in identifying people who need extra support.

- Consider encouraging staff to take a day off if they need to have some time out.

- Activities that foster a sense of school community are pertinent during stressful times.

See **Chapter 3 – Prevention** – *Promoting protective factors – A supportive school environment.*

Medium to long term

- Monitor potentially vulnerable people who may include:

  - students and/or staff who were involved, directly or indirectly

  - students who are/were close to the person/people involved in the incident

  - students and/or staff who have experienced something similar

  - students and/or staff who are vulnerable due to other factors in their life.

- Look out for signs of depression, anxiety or anger in those affected. Strong emotional responses can be a contributing factor in the development of mental health concerns such as depression and anxiety.

- Refer students and/or staff who experience ongoing effects associated with the incident to specialist support/counselling.

- Develop and/or maintain student support systems (or informal support systems) such as buddy systems or peer support programs.

- Provide professional development for staff around the issue.

- Hold a staff meeting some time later with the purpose of checking for any residual issues with staff, students or the school community.

- Review the handling of the incident. If necessary, make changes to the critical incident policy.

- Prioritise promoting protective factors (resilience) in students.

See **Chapter 3 – Prevention** – *Promoting protective factors – A supportive school environment.*

- Consider the most appropriate ways of acknowledging or addressing events that trigger recollection of the incident such as anniversary dates.

- Recovery from traumatic incidents, both individually and as a school community can take time.

Enquiries from parents/families and the wider school community

- Provide basic, factual information about the incident/situation while maintaining confidentiality.

- Inform parents/families of what the school is doing to support students.

- Provide information about signs of stress to look out for in the student they parent.

- Provide information about how they can help, if they request to.

See *Managing school emergencies: Minimising the impact of trauma on staff and students*
www.sofweb.vic.edu.au/safety/emergency.pdf

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