Submission to 10 year preventive health strategy

Commonwealth Department of Health

Butterfly Foundation

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About us

Butterfly Foundation is the national charity for all Australians impacted by eating disorders and body image issues, and for the families, friends and communities who support them. Butterfly changes lives by providing innovative, evidence-based support services, treatment and resources, delivering prevention and early intervention programs and advocating for the needs of our community.

Butterfly highlights the realities for those seeking treatment for recovery, and advocates for improved access to effective, affordable care. Throughout its work Butterfly also emphasises the critical importance of prevention and early intervention strategies in limiting the development of, and suffering from, negative body image and eating disorders.

Butterfly operates a National Helpline that includes support over the phone, via email and online, reaching over 28,000 people each year. The Helpline is staffed by trained counsellors experienced in assisting with eating disorders and body image issues. We also provide a wide range of programs for service providers and recovery groups.

Because Butterfly recognises that eating disorders often arise from poor body image, we deliver a range of prevention programs including positive body image workshops to schools and workplaces. We use our strong social media presence to raise awareness, reduce stigma and increase help-seeking in relation to eating disorders and body image concerns.

Butterfly coordinates the National Eating Disorders Collaboration (NEDC) for the Commonwealth Government Department of Health.

As a founding member of the Eating Disorder Alliance of Australia (EDAA) we are committed to collaboration across the sector in pursuit of common goals and better outcomes for the community we serve.

Our vision

To live in a world that celebrates health, wellbeing and diversity.

Our mission

To bring about change to the culture, policy and practice in the prevention, treatment and support of those affected by eating disorders and body image issues.

Introduction

Butterfly Foundation welcomes the opportunity to provide a submission to the Commonwealth Department of Health's Consultation on the10 year preventive health strategy. We welcome the development of this strategy as an opportunity to bring the domains of physical and mental health together. In the case of eating disorders and body image issues, these domains are inextricably linked. As such, prevention efforts must take a holistic approach to ensure that initiatives targeting physical health do not inadvertently contribute to poor mental health. Most importantly, initiatives focused on physical health must not perpetuate harmful cultures that contribute to the development of body image issues or eating disorders.

Our submission addresses each question posed in the Consultation Paper, with a focus on the voices of those affected by eating disorders and negative body image and areas for policy and service improvement in the domain of prevention.

Eating disorders currently affect around 4 per cent of the Australian population – approximately one million people in any given year (Deloitte Access Economics, 2015). Left unaddressed, the medical, psychological and social consequences can be serious and long term.

A key challenge in the prevention of eating disorders is the ubiquity of diet culture and weight stigma, which are known social determinants of these conditions. Lack of lack of awareness of early signs and symptoms and high levels of stigma system are also key factors. Eating disorders are rarely considered as a priority in health prevention initiatives, which can result in missed opportunities, duplication of effort, and at worst the perpetration of harmful attitudes and behaviours.

Listening to the voices of people affected by eating disorders is essential to the development, implementation and review of health prevention policy. The eating disorder peer workforce is developing by drawing on this form of knowledge to meet the need for communities of recovery in the transition from treatment to self-directed recovery; this workforce could also be engaged to support preventive activity, particularly among cohorts most at risk of developing an eating disorder.

Children and young people repeatedly rank body dissatisfaction as one of their top issues, with body dissatisfaction reported by approximately 50 per cent of surveyed pre-adolescent girls, while pre-adolescent boys are increasingly reporting a desire for a more muscular body (Carlisle et al, 2019). Greater investment in primary prevention are required to prevent eating disorders from developing, including within primary school settings. This is an area of current focus for Butterfly, with the development of a whole of primary school body image program which we aim to implement across all Australian primary schools.

While eating disorders can affect anyone at any age, they remain more prevalent among adolescents and young people, with the average onset for eating disorders occurring during adolescence and young adulthood (Volpe et al, 2016). It is therefore critical that prevention programs target children and young people in setting where they live, study, work and play.

In addition to responding to Consultation Paper questions, in this submission we provide information on areas of challenge within health promotion such as weight stigma, and information on children and young peoples' body dissatisfaction.

Vision and aims of the strategy

Are the vision and aims appropriate for the next 10 years?

The vision – to improve the health of all Australians at all stages of life, through early intervention, better information, targeting risk factors and addressing the broader causes of health and wellbeing – is sound, as are the aims outlined in the Consultation Paper. However, is not clear how mental health will be incorporated into any of the aims, as they are set out below:

1. Australians have the best start in life

   The Strategy will recognise the value of a life course approach, which emphasises the significance of prevention in the early years of life. We have heard the importance of preventing infectious disease and injuries in childhood and of supporting children at risk in order to create strong foundations to prevent of chronic conditions in later life.

2. Australians live as long as possible in good health

   A strong focus on preventive health and health promotion can extend the quality of life and life expectancy of Australians. We have heard that opportunities for prevention change as individuals' age and the Strategy should support action to prevent infectious disease, injuries and chronic conditions across the life-span.

3. Australians with more needs have greater gains

   The burden of ill health is not shared equally amongst Australians. We heard the Strategy should result in greater gains for parts of the Australian community who are burdened unfairly due to personal circumstances. Furthermore, there needs to be a focus in the Strategy on reducing inter-generational health disadvantage.

4. Investment in prevention is increased

   Our health dollars are spent primarily on the treatment of illness and disease. The consultations have indicated the need to significantly enhance investment in prevention in order to achieve a better balance between treatment and prevention in Australia, as outlined in Australia's Long Term National Health Plan.

The omission of mental health from the aims is particularly curious given the results from the Department of Health's 2019-20 national consumer survey "Living Well for Longer". As the Consultation Paper notes (p. 8), this survey canvassed over 4,000 people's views on their health priorities, including what was important to them in being or staying healthy and what would help them to take better care of their health. While the survey results do not appear to be in the public domain, the Consultation Paper notes that the survey respondents listed mental wellbeing as the most important health-related priority.

In light of this finding and drawing on evidence noting the high prevalence of mental health conditions throughout the Australia, we recommend that mental health be explicitly identified within the aims, and throughout the strategy.

The 10 year preventive strategy is an opportunity to bring the overlapping domains of physical and mental health together in a holistic way. For illnesses such as eating disorders, the traditional demarcation between mental and physical health is problematic given they are a set of mental health conditions associated with

high levels of psychological distress and significant physical health complications. Eating disorders are complex psychiatric disorders which involve a combination of biological, psychological and sociocultural factors. Left unaddressed, the medical, psychological and social consequences can be serious and long term. Once entrenched, eating disorders can impact on every aspect of an individual's life and for many, can be life-threatening.

Goals of the strategy

Are these the right goals to achieve the vision and aims of the strategy?

Butterfly supports the six goals and welcomes the prioritising effort for those with greater needs including in rural and remote locations.

Experiences in regional and remote Australia

Earlier this year Butterfly conducted a survey to understand the experiences of people with eating disorders who live in regional, remote and very remote areas (Butterfly Foundation, 2020b). Overall, our survey found that 99 per cent of respondents believe there needs to be more awareness around the eating disorders in regional and remote communities. People with in regional and rural areas were significantly more like to agree that where they live was an obstacle to accessing care compared with those living in metropolitan areas. We also found that respondents who lived in metropolitan areas had a significantly higher level of satisfaction with the knowledge of health care providers in relation to eating disorders than those in regional and remote areas: half the people residing in regional and remote areas (51 per cent) 'strongly agreed' that a greater level of knowledge was required, compared to 35 per cent in metropolitan areas. Respondents who lived in metropolitan areas had a significantly higher level of satisfaction with the empathy of the health care providers than those in regional and remote areas.

Survey respondent comments illustrate high levels of stigma among health care practitioners, and as in other areas of mental health care, discrimination was a feature.

The vast majority of respondents in both metropolitan and regional and remote areas reported experiences of stigma within the health care system - 67 per cent of those in metropolitan areas and 69 per cent of those in regional and remotes areas.

Of those who had sought help from a healthcare provider, 68 per cent of the overall sample reported experiences of stigma. These included health care workers minimising the seriousness of eating disorders and perceiving them to be lifestyle choices. Carers felt they were stigmatised as being controlling and neurotic. Several respondents also described being stigmatised due to their class, disability, ethnicity, sex or gender.

Overall, our findings support the importance of education and training for health care professionals, and ongoing efforts to reduce stigma within the health care system and the general community.

Mobilising a prevention system

Are these the right actions to mobilise a prevention system?

Butterfly supports the listed enablers. We particularly welcome the recognition of the need for: structured governance; a sustainable increase in funding, research, evaluation and research translation; and the inclusion of a health equity lens.

In relation to partnerships, Butterfly recommends that people with lived experience of poor health be considered key partners in the develop of all initiatives under the strategy.

Best practice program development requires genuine engagement and co-design with people who have lived experience expertise. Butterfly regards lived experience perspectives as critical to our work and the broader mental health sector. Storytelling, for example, not only provides a personal insight into the world of someone who has experienced a mental health condition, it sends a clear message of hope to those in in the community that recovery is very much possible. Contact with those who tell their story is at the forefront of changing public narratives, providing insights which cannot be replicated through other forms of knowledge generation.

A specific strategy that should be included under 'Information and literacy skills' is the development of guidance for public health and health care professionals to ensure that health promotion content does not reinforce weight stigma. More information on this issue is provided in the next section.

Boosting action in focus areas

Where should efforts be prioritised for the focus areas?

The Consultation Paper identifies six focus areas to boost prevention action in the first years of the strategy and to influence health outcomes across all stages of life:

- Reducing tobacco use
- Improving consumption of a healthy diet
- Increasing physical activity
- Increasing cancer screening
- Improving immunisation coverage
- Reducing alcohol and other drug-related harm.

Butterfly urges the consideration of mental health in the development of public health initiatives across all focus areas, noting the well-established links between poor physical health and poor mental health.

Eating disorders are frequently associated with other psychological and physical disorders such as depression, anxiety disorders, substance abuse and personality disorders (Butterfly Foundation, 2017).

People with bulimia nervosa, binge eating disorder and sub-threshold bulimia nervosa are more likely to be obese than people without an eating disorder (Hay, Girosi, & Mond, 2015).

In relation to the second and third focus areas, Butterfly recommends that any initiatives to promote healthy eating and physical activity avoid using stigmatising messages about body weight.

According to a recent Delphi study conducted by researchers collaborating under the Strategic Training Initiative for the Prevention of Eating Disorders (STRIPED) initiative at Harvard University, weight stigma, and the discrimination that it is commonly used to justify, are common. These messages are relayed through the media, educators, from peers in school settings in the form of appearance-based teasing, fitness professionals, prospective employers and others (Hart et al, 2020).

Weight stigma is also a feature of some public health campaigns and may be present in the attitudes of health care professionals (ibid). Weight stigma is of particular concern when it is a feature of health care and physical activity settings as this can lead people to avoid these settings.

Weight stigma is significant risk factor for the development of eating disorders, regardless of how much individuals weigh, and can contribute to other mental health conditions such as depression, anxiety, and suicidality (ibid).

As noted earlier, eating disorders are set of mental health conditions associated with high levels of psychological distress and significant physical health complications. Eating disorders involve a combination of biological, psychological and sociocultural factors.

While eating disorders can affect anyone at any age, they remain more prevalent among adolescents and young people, with the average onset for eating disorders between the ages of 12 and 25 years (Volpe et al., 2016).

Children and adolescents with eating disorders can experience interrupted physical, educational and social development and are at risk of significant medical complications in the long-term, along with other mental health issues.

Body dissatisfaction is common among children under 12. Nearly 50 per cent of girls aged 9 to 12 years old reported feeling dissatisfied with their body according to one study (Clark & Tiggemann, 2008). Another study found that found that 54.8 per cent of boys ages 12 to 18 expressed a desire to alter their body in some way Lawler and Nixon, 2011). In this context, it is critical that any healthy eating or physical activity initiatives targeting children and young people avoid messages that negatively affect body satisfaction.

To avoid causing harm, any new public health campaigns, early intervention programs or research initiatives should consider the risk of contributing to weight stigma and the development or exacerbation of eating disorders (Hart et al, 2020). Monitoring and evaluation of all physical health initiatives developed under the strategy should aim to capture unintended consequences related to weight stigma and eating disorder risk (ibid).

Guidance from Butterfly and other experts in eating disorders and body image – including people with lived experience of eating disorders - should therefore be sought when priority actions under focus areas two and three are developed.

Continuing strong foundations

How do we enhance current prevention action?

There are several examples of excellence among existing prevention activities in Australia. The strategy should build on health campaigns that have been independently assessed as having positive attitudinal and behavioural impact, and which are suitable for adaptation to local environments.

One example of a successful, weight-inclusive physical activity campaign is VicHealth's 'This Girl Can'. In contrast to ubiquitous 'fitspiration' images on social media, This Girl Can features real women and encourages women and girls across Victoria to get active – whatever their age, size, background or ability. The campaign was designed in response to research that showed a key barrier to not trying new activities or getting involved in sport is a fear of being judged, or not being fit enough to start. Twice as many women than

men put off getting active because they are worried about what other people think of them (VicHealth, 2020a). In its first two years the campaign has inspired more than 400,000 Victorian women to get active as a result of seeing the campaign (VicHealth, 2020b).

Butterfly holds significant expertise in eating disorder prevention initiatives across school, community and home settings, and is a partner in the international Dove Self-Esteem initiative.

Our Prevention Services operate across several school and community settings to change beliefs at behaviours at the individual and population level. Our programs with young people, parents, teachers and community professionals delivering education, strategies and tools have now reached over 880,000 young people and over 7,600 professionals and parents Australia-wide (Butterfly Foundation, 2020a). Our aim is twofold: increase the proportion of students who report that they have positive body esteem or a healthy relationship with food or exercise; and bring about an increase in weight-neutral health policies and an integration of the no-diet approach into health policy.

The evidence base for investing in programs for children and adolescents is clear. Research highlights that body dissatisfaction is an important risk factor for negative physical, mental and social outcomes including unhealthy dieting and muscle building behaviours, depression, anxiety, higher weight and eating disorders (Paxton & Damiano, 2016).

Body dissatisfaction is repeatedly one of the top ranked issues for young Australians with body dissatisfaction reported by approximately 50 per cent of pre-adolescent girls, while pre-adolescent boys are increasingly reporting a desire for a more muscular body (Carlisle et al, 2019). Stigmatising weight attitudes are forming from very early in childhood, and are related to appearance-based teasing, which are linked to the development of body dissatisfaction and unhealthy behaviours. Importantly, greater body concerns from ages 5 and 7 have been shown to predict dieting by age 9 (Evans et al., 2013; Dohnt & Tiggemann, 2006). By the time they reach adolescence, 1 in 6 girls have already employed at least one potentially dangerous method of weight reduction.

An example of one of our programs is 'RESET – a conversation about boys' body image'. This program is Australia's first digital body image program for adolescent boys, providing the opportunity to talk about pressures and concerns relating to body image. This program helps educators raise awareness, reduce stigma and encourage help-seeking in boys and young men, and is available to all schools to download.

Another example is our Butterfly Body Bright program for Australian primary schools, which is currently in development phase. Butterfly Body Bright is a new whole of school approach to consistent and long-term promotion of positive body image and healthy behaviours for Australian primary schools, including healthy attitudes and behaviours towards the body, food, and physical activity within in an appearance-inclusive environment. It is a strengths-based, evidence-informed universal prevention program to foster a positive foundation for children's developing body image by equipping students with skills to be confident in their body. It also aims to build resilience to sociocultural risk factors that underpin the development of body dissatisfaction and disordered eating. The program is being developed with the input of an Expert Advisory Group, and Educator Reference Group and a Parent Advisory Group.

Butterfly would welcome the opportunity to provide advice and to embed elements of our programs into new healthy eating and physical activity campaigns and other initiatives developed under the strategy.

Conclusion

Butterfly welcomes the development of this strategy as an opportunity to address the disjuncture between the domains of physical and mental health. In the case of eating disorders and body image issues, these domains are clearly linked yet they are routinely ignored in public health campaigns addressing healthy eating and physical activity. The strategy has the potential to address healthy attitudes and behaviours towards the body, food, and physical activity within in an appearance-inclusive environment which fosters body confidence and resilience to environmental drivers of poor health.

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