Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

Eating disorders

Position statement

August 2021

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Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tangata
Tihei mauri ora
He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
Rau rangatira mā, ānei ngā whakaaro me ngā kōrero nā Te Tūāpapa Hauora Hinengaro

Executive summary

Eating disorders have devastating and life-threatening impacts on individuals, and their whānau and carers.

Delays in diagnosis and access to care exacerbate and prolong illness duration. Comorbidity with depression, anxiety and substance use disorders is common and the mortality rate for people with eating disorders is one of the highest of all psychiatric illnesses, with suicide contributing significantly to the high mortality rate.[i]

The estimates of the economic and social impact of eating disorders suggest a comparable disease burden for eating disorders as for anxiety and depression.[ii]

The Mental Health Foundation of New Zealand supports a Te Tiriti, equity and gaps analysis of eating disorder services and supports. Evidence-based treatment and support are necessary and current unmet need must be addressed.

We must also get ahead of the root causes of these potentially life-threatening disorders to reduce the pressure and reliance on overburdened services in the long-term.

Therefore, we support a shift towards a comprehensive approach to addressing eating disorders, including prioritising the need for investment in prevention, wellbeing promotion and early intervention for eating disorders, in line with the approach outlined in *He Ara Oranga*, the report from the Inquiry into Mental Health and Addiction.

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This position statement supports the work of the Eating Disorders Association of New Zealand and the commitments outlined in the Ministry of Health's 2008 policy document *Future Directions for Eating Disorders Services in New Zealand*.

About the Mental Health Foundation

The Mental Health Foundation of New Zealand (MHF) works towards creating a society free from discrimination, where all people enjoy positive mental wellbeing. We do this by helping people understand positive mental health and wellbeing and apply strategies to live well; and advocating for social and system changes to improve the determinants of mental wellbeing.

Specifically, we provide information about eating disorders and links to resources and support groups on our website.

More generally, much of our work overlaps with common goals of eating disorder prevention, which include improving general wellbeing, enhancing media literacy, and reducing bulling, prejudice, discrimination and self-stigma.[iii] For example the MHF:

- Developed Sparklers, in collaboration with the Canterbury DHB public health unit, which is a school-based mental wellbeing program with a focus on building resiliency, social and emotional wellbeing, inclusiveness and kind classrooms and relationships. Programmes such as these targeted at school communities may help promote protective factors (e.g., self-esteem and coping skills) for eating disorders.
- Provides media monitoring and guidance to help journalists and media outlets report on mental illness and mental health issues safely, accurately, and respectfully. This guidance contributes to guide best-practice reporting and portrayal of eating disorders.

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- Runs annual mental wellbeing campaigns – the anti-bullying campaign *Pink Shirt Day* aims to stop bullying by celebrating diversity and promoting positive social relationships and *Mental Health Awareness Week* aims to increase public participation in positive mental health and wellbeing programmes focused on workplaces and schools.
- Working to eliminate discrimination and prejudice against people with experience of severe mental distress as a partner in the Nōku te Ao: Like Minds programme, including through developing a lived experience-led social movement and community-based social action grants.

Eating disorders in Aotearoa New Zealand

There are no up-to-date estimates of the number of people affected by eating disorders in Aotearoa New Zealand, nor the social and economic impacts. Data collected in 2003/2004 suggests the lifetime prevalence estimate for any eating disorder is 1.7 percent.[iv] Given this data is nearly 20 years old, current prevalence of eating disorders may be higher, perhaps reflecting the findings of a more recent Australian study that found around 4 percent of the Australian population was suffering from an eating disorder.[v]

Anyone can have an eating disorder, at any age, and every person's experience of an eating problem is unique.

Women are more likely to experience an eating disorder than men, and Pasifika and Māori have higher prevalence rates for eating disorders.[vi] International research suggests people who identify with the rainbow community may also have higher prevalence rates.[vii]

There are reports of an increase in demand for mental health services for disordered eating in response to the COVID-19 noho rāhui/lock down.[viii]

Prejudice and self-stigma associated with having disordered eating prevents some people seeking help or support.

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Where we can go further

The MHF supports calls for urgent investment in services, including specialist services, for eating disorders, and increased options for early intervention. The Mental Health and Addiction Inquiry heard concerns about the limited availability of, and options for, treatment, and gaps and regional variability of specialist services for eating disorders. A recent petition called for urgent boosts to our mental health services to address unmet need.[ix] There is recent evidence of barriers to access for Māori with eating disorders.[x]

At the same time, we must prioritise and invest in prevention and positive mental wellbeing promotion. This means addressing the drivers of eating disorders, enhancing protective factors and reducing risk factors, and empowering individuals and communities (such as schools) to uplift their physical and mental wellbeing.

1. *Support research and innovations in prevention and wellbeing promotion*

Although no single cause of eating disorders has been identified, there are many risk factors that increase the likelihood that a person will experience an eating disorder at some point in their life. There is limited but promising evidence to suggest some particular types of prevention programs are effective in preventing eating disorders. Some prevention programmes have yielded a small to moderate effect in the reduction of risk factors, such as those that boost media literacy, and a mixture of psycho-education and cognitive-behavioural exercises.[xi] There is no evidence that such programmes prime participants and increase risk factors for eating disorders.[xii]

We support:

- The establishment of the Ministry of Health's proposed eating disorder forum to encourage national discussion of aspects of prevention, early intervention, and education.

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- The Ministry of Health's 2008 commitment to a research agenda for eating disorders**,** including investigating, developing and establishing effective, evidence-based eating disorder prevention and awareness initiatives in schools.
- Exploration of how drivers of other mental health conditions and disparities in prevalence rates between ethnic groups might also influence eating disorders, including determinants such as poverty, racism and education.

2. *Invest in early intervention innovations*

Budget 2021 funding of the continuation of the *Mana Ake* initiative and the co-design of mental wellbeing support in primary and intermediate schools is a positive step towards early intervention and service access for young people, including those with disordered eating. Boosts to integrate primary mental health support, such as the Health Improvement Practitioners and Health Coaches, may also provide early intervention and support.

We also support:

- Fulfilling the Government's commitment for an eating disorder forum to support local leadership, supports and innovations.
- Empowering primary health professionals to understand and recognise symptoms of eating disorders and available referral pathways and dispel misconceptions that may be barriers to referral or support access.
- Resourcing of early intervention pathways through primary and secondary services.
- Explore innovations for those with mild-moderate thresholds who are not eligible to access specialist services or are on a waitlist. For example, a systematic review into self-help and guided self-help techniques found comparable outcomes to formal therapist-delivered psychological therapies.[xiii] The University of Auckland is currently undertaking a feasibility study of a self-help workbook treatment designed for people with an early form of anorexia nervosa.[xiv]

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3. Ensure services and supports are fit for purpose

We recommend:

- Commissioning a gaps analysis to identify and address unmet need in primary, secondary and specialist services, access to integrated services and continuum of care, inequity of access and workforce development (including a culturally safe and diverse workforce). This should be undertaken alongside those with lived experience, their whānau and support groups.

- A review of the Ministry of Health's current policy *Future Directions for Eating Disorders Services in New Zealand (2008)* to assess whether the recommended actions and the tiered service model is still fit for purpose. Where it is fit for purpose, we recommend the Ministry report on progress made against actions and implementation of service improvements.

We also support:

- investment in peer models and innovations (e.g., NZ's first Peer-to-peer support service)
- facilitating the involvement of whānau and families in recovery
- including people with lived experience, Māori and Pasifika in eating disorder treatment planning and delivery
- additional support to kaupapa Māori services, and
- a recovery-oriented framework for treatment and support.

4. Research and data

We recommend:

- The next comprehensive mental health and addiction survey (see *He Ara Oranga* recommendation 11, 'agreed in principle' by the Government) include data about eating disorder prevalence, health service use data, and social and economic costs.
- Routine collection of data on the number of admissions, the length or type of treatment being undertaken by these services, recovery rates, and relapse/readmission rates.

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