Child & Youth Mental Health Service
Cairns and Hinterland Health Service District
chhhsed-linq@health.qld.gov.au
07 4226 2700

# THE ED-LINQ LINK

## TERM 3 2024

## DISORDERED EATING

Happy mid-term 3 y'all!

You may have noticed a change in our newsletters over the previous 2 terms ...

In response to the positive feedback we received about our 'School Attendance' issue, we have decided to provide a resource *disguised* as a newsletter each term & to disseminate PL opportunities as they arise. You can expect the arrival of your quarterly Ed-LinQ issue in the second half of each term.
Topic suggestions for future issues are more than welcomed!! Please send us an email with any requests.

This issue is all about disordered eating, and the importance of primary prevention in school communities. Inside this issue you'll find information about universal strategies, symptoms, risk & protective factors, links to information about different diagnoses, treatments, & more ...

Don't miss the Statewide Ed-LinQ online presentation **Eating Disorders in Young People: The School Context** with a **local Q&A** the following week (see pg 18 to register).

Have a wonderful rest of term, & don't hesitate to hit us up with any queries, questions, or concerns about students & their mental health.

*TOMA & AYU*

Ed-LinQ is a specialist program within the Child & Youth Mental Health Service (CYMHS). Established in 2009 to improve collaboration between the Education, Primary Care, Community, and Mental Health sectors, Ed-LinQ supports the early detection and collaborative care of school students at risk of, or experiencing, mental health difficulties.

READ MORE

# CONTENTS




resources collated by Ed-LinQ with thanks to the following organisations







CLICK TO SEE PAGE

# EDITORIAL


**Society consistently promotes harmful body stereotypes whilst gently whispering to us that we're not good enough.**

We're constantly bombarded with headlines about extreme weight loss or miniscule weight gain; influencers promote diet teas/supplements/meal replacements; 'glow-up' challenges saturate social media along with extreme dieting methods & anti-aging products for tweens … you get it. As of 2024, the global wellness and beauty industry is estimated to be worth over $1.5 trillion.

ED-LINQ
CAIRNS CYMHS

Research shows a significant correlation between the digital age and the rise in eating disorders, particularly among young people. Social media platforms, where users are frequently exposed to images promoting unrealistic body ideals (often perpetuated by the wellness and beauty industry) have been linked to increased body dissatisfaction and the onset of disordered eating behaviours. The constant promotion of idealised beauty standards through influencers and advertising exacerbates these issues.

While social media plays a critical role, offline media also contributes to the problem, sensationalising eating disorders through dramatic narratives that highlight the severe, often tragic, life-threatening consequences of eating disorders. Knowing how dangerous they can be the fear of getting it wrong is understandable.

No wonder eating disorders provoke such profound anxiety.

This presents a complex challenge: raising awareness without fuelling the anxiety that can delay appropriate intervention. Because fear can lead to inertia.

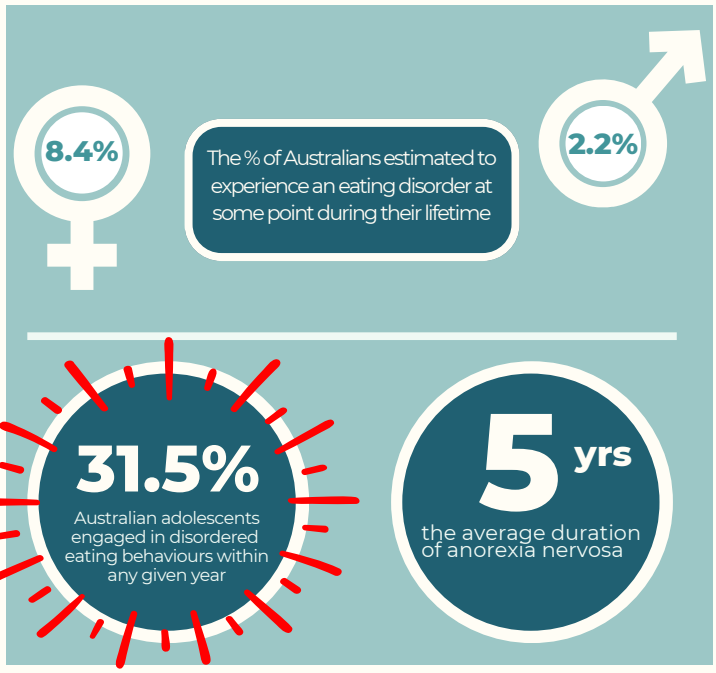
A "watch and wait" approach doesn't work for eating disorders. They're secretive & sneaky, & by the time they're physically evident, they're typically entrenched.

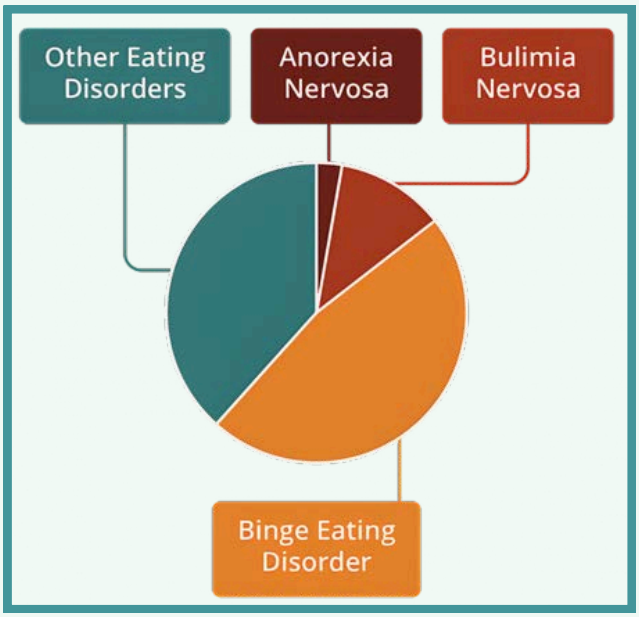
As a community, we need to build our confidence and capacity to address concerns about disordered eating promptly and appropriately. School-based educational programs and workshops that focus on mental health and self-worth, beyond just physical appearance, can help students develop healthier relationships with food and their bodies. Equally important is promoting a positive and inclusive school culture that challenges societal beauty standards and celebrates diversity in all its forms.

# STATS & FACTS

## #1 RISK FACTOR FOR DEVELOPING AN EATING DISORDER? DIETING

**THE AVERAGE AGE OF ONSET FOR EATING DISORDERS IS BETWEEN THE AGES OF 12 AND 25**



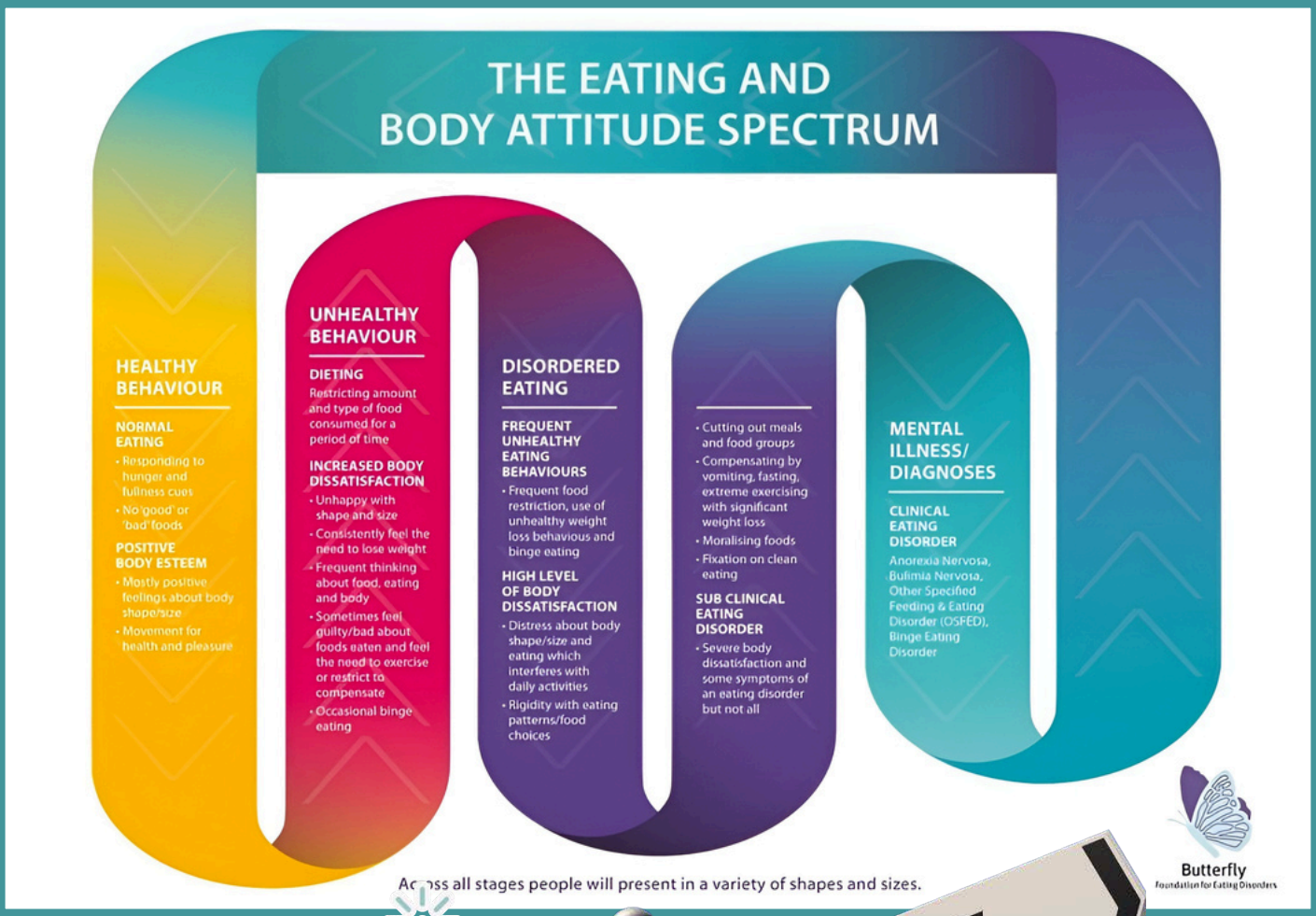




An estimated 1.1 million Australians, or 4.5% of the population, are currently living with an eating disorder, with 10.5% experiencing an eating disorder at some point in their lifetime


Eating disorders are the third most common chronic illness in young women

Around 50% of Australians aged 12 – 18 said their body image had stopped them to some extent from going to school, focusing on schoolwork and raising their hand in class

**27% OF AUSTRALIANS WITH AN EATING DISORDER WERE AGED UNDER 19 (UP FROM 15% IN 2012)**




CLICK PIC TO SEE PAGE


| MYTH | FACT |
|---|---|
| Dieting is a normal part of life. | Eating disorders almost invariably occur in people who have engaged in dieting or disordered eating. Dieting is also associated with other health concerns including depression, anxiety, nutritional and metabolic problems, and, contrary to expectation, with an increase in weight. |
| Eating disorders are not serious; they are a life style choice or about vanity | Eating disorders are serious and potentially life-threatening mental illnesses. A person with an eating disorder experiences severe disturbances in their behaviour around eating, exercising and related self-harm because of distortions in their thoughts and emotions |
| Eating disorders are a cry for attention or a person 'going through a phase'. | Due to the nature of an eating disorder a person may go to great lengths to hide behaviour, or may not recognise that there is anything wrong. Eating disorders are not a phase and will not be resolved without treatment and support. |
| Eating disorders only affect white, middle-class females, particularly adolescent girls. | Eating disorders can affect anyone. They occur across all cultural and socio-economic backgrounds, and can affect people of all ages, from children to the elderly, and all genders |
| Families, particularly parents, are to blame for eating disorders. | There is no evidence that a particular parenting style causes eating disorders. Although a person's genetics may predispose them to developing an eating disorder this is certainly not the fault of their family |

# PREVENTION

**UNIVERSAL** broad, inclusive, general

**SELECTIVE** specific, focused, criteria-based

**TARGETED** precise, deliberate, tailored

**EARLY INTERVENTION IS KEY TO IMPROVED HEALTH AND QUALITY OF LIFE OUTCOMES**

***It is never advised to 'watch and wait'***

*Early access to support and treatment is vital*

## PRIMARY PREVENTION

The 3 priority goals of primary prevention are:

- Improving general health, nutrition, and psychological well-being, such as boosting self-esteem and promoting a positive body image.
- Enhancing media literacy by educating people about the media's promotion of unrealistic standards. This helps individuals critically analyse media messages, reducing the risk of developing an eating disorder.
- Reducing teasing and bullying, including weight-based teasing.


CLICK ON PIC TO READ MORE

Care must be taken in promoting information about eating disorders in order to ensure positive outcomes, rather than accidental harm.

Research indicates that without due caution, **highlighting the symptoms or effects of eating disorders may increase the prevalence of the disorder**. The challenge is similar to that faced by health promotion and prevention campaigns for other health issues, such as illicit drug use and binge drinking.

It is recommended that **key messages are tailored and tested for audiences**, especially when those messages are specifically targeted at those at risk of developing an eating disorder. **There is a potential for harm in talking about eating disorders in a detailed way to people at risk.**

All communication about eating disorders should contribute to one or more of these three behavioural goals:

- **Recognition** – Broad community awareness and understanding of eating disorders as a priority mainstream health issue to increase support and reduce stigma
- **Resilience** – Ability to resist pressures of high-risk behaviours for eating disorders
- **Help seeking** – Early-stage identification of eating disorders and risk factors, leading to early intervention and reduction in the impact of the illness

## MEDIA LITERACY GUIDELINES

**CLICK HERE**

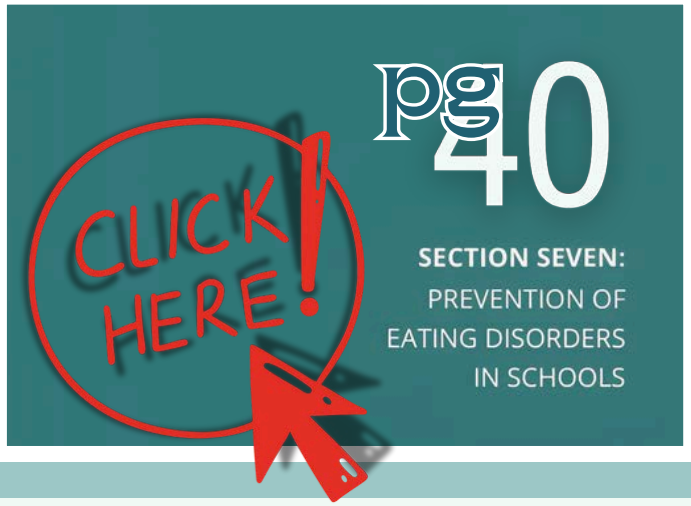
EVIDENCE-BASED PROGRAMS USED IN QLD

Flinders University Media Smart

Butterfly's Let's talk body image

Body Project Australia

CLICK TO LEARN MORE




# COMMUNICATING ABOUT EATING DISORDERS

*When addressing food, eating, and body image in schools ...*

## DO'S

- Ensure that information is developmentally appropriate
- Convey that eating disorders are serious mental illnesses, not lifestyle choices
- Acknowledge that anyone, at any stage, can experience an eating disorder
- Offer up-to-date, evidence-based information  Show respect for those with lived experience  Promote help-seeking behaviours
- Continuously monitor programs/resources/information and evaluate for safety and appropriateness

## DONT'S

- Describe details of specific eating disorder behaviours
- Use or provide information on measurements in relation to people who have experienced an eating disorder (e.g., weight, amount of exercise, number of hospital admissions)
- Normalise, glamorise or stigmatise eating disorder behaviours
- Use judgemental language
- Encourage behaviours motivated by fear or stigma (e.g., social exclusion, bullying)
- Use imagery that shows stereotypical presentations of eating disorders including people of low weight

# UNIVERSAL PREVENTION

**UNIVERSAL PREVENTION IS BROAD BUT FOCUSED ON SPECIFIC POPULATIONS, AIMING TO IMPROVE GENERAL WELL-BEING.**

To promote health and prevent problems across an entire population or community, regardless of individual risk factors

whole of school community

School programs that teach all students about the importance of a positive body image and healthy eating behaviours

## UNIVERSAL PREVENTION FOR CHILDREN AND YOUNG PEOPLE

Universal prevention efforts focus on entire communities - national, local, community, or classroom - with the goal of enhancing overall health and well-being. These programs aim to build resilience and lower the risk of eating disorders among people who haven't shown symptoms. By increasing resilience and reducing risk factors, these programs are expected to lead to fewer eating problems and cases of eating disorders in the long run.

## UNIVERSAL PREVENTION APPROACHES ARE DESIGNED TO:

- Support everyone: These programs not only assist those at high risk of developing eating disorders but also promote the overall health and well-being of those at minimal risk.
- Teach children to manage societal and cultural pressures that contribute to negative body image and dissatisfaction.
- Focus on young adolescents (ages 12-15), recognizing this developmental stage as a critical time when many personal and environmental risk factors for eating disorders can emerge.

***Those with lived experience consistently say that we need to change how society discusses health, food, mental well-being, and bodies, emphasising the importance of safe messaging across all sectors.***

Using consistent, safe language in how we talk about bodies, teach nutrition, and develop health policies can help reduce the risks of eating disorders, disordered eating, and body image distress.

NEDC, in collaboration with La Trobe University, has developed a set of principles that will guide the ways that information about health, food, minds and body are provided to people across a wide range of settings. This is a key eating disorder prevention and harm minimisation initiative, arising from the National Eating Disorders Strategy 2023-33.


**CLICK ON PICS TO READ MORE**

chhhsed-linq@health.qld.gov.au 07 4226 2700

*it takes a village ...*

# BUTTERFLY & PREVENTION

Butterfly
LET'S TALK eating disorders

Butterfly Foundation offers a range of professional development programs to help schools support students experiencing body image concerns and eating disorders:

- Implement awareness and prevention strategies
- Provide basic early intervention support
- Inform you of appropriate referral support for students experiencing body image concerns and eating disorders

**Click on the butterfly to learn more**

Want to learn more from the experts?? Butterfly Foundation holds webinars that look at understanding & implementing universal strategies within a school community. A somewhat inconvenient time for most educators, (& not free) but you can totally rely on Butterfly for up-to-date, evidenced based information .

## THURS 29TH AUG 10AM

### BODY KIND SCHOOL CULTURE

This session focuses on creating a positive and inclusive Body Kind school environment to support young people's body image. Designed for all staff, it explores how by challenging some of the strong cultural beliefs around eating, weight and health we can better support young people, ourselves and the people around us.

**Platform:** Live via Zoom, no recording available

**Length:** 1hr, plus 15 mins question time

$90

- Learn about the do's and don'ts of:Talking about appearance, bodies, weight and food
- Educating around body image
- Selecting learning activities and resources, particularly in relation to food/eating
- Responding to students' body image concerns
- Role modeling to students, colleagues, everyone!

**CLICK TO ENROL**


Butterfly Foundation is excited to be launching an exciting new e-Learning program for Australian secondary schools, later this year. Click on pic to learn more.


In late 2022, with support from nib Foundation, Butterfly invited all young people in Australia aged 12 to 18 yrs to take part in the first annual Body Kind Youth Survey and to share their experiences and ideas around body image.

Find out what we learned from their first survey by clicking on the image.

Studies show that weight-centric health approaches can worsen body dissatisfaction, shame, and the risk of developing or maintaining disordered eating or eating disorders. They also increase the likelihood of relapse in those recovering from these conditions.

BODY IMAGE

**LEARN MORE HERE**

# RISK FACTORS

## BIOLOGICAL & GENETIC RISK FACTORS

- family history of eating disorders & other mental health conditions
- high body weight in childhood
- early menstruation (<12yrs)
- transitional developmental stages - adolescence, pregnancy etc
- family history of eating disorders & other mental health conditions
- higher parental body weight
- genetic predisposition towards specific traits such as perfectionism

## SOCIO-CULTURAL RISK FACTORS

- adopting and aspiring to cultural ideals of thinness, muscularity and leanness
- pressure to achieve and succeed
- peer pressure
- teasing or bullying, especially when focused on weight or body shape
- troubled family or personal relationships
- family dieting

## PSYCHOLOGICAL & BEHAVIOURAL RISK FACTORS

- dieting
- perfectionistic traits
- obsessive-compulsive traits or disorder
- neurodivergent individuals
- depression or depressive features
- anxiety, including social anxiety and avoidance of social interaction
- substance misuse
- overvaluing body image in defining self-worth
- dissatisfaction with body weight and shape
- low self-esteem or feelings of inadequacy
- harm avoidance or traits such as excessive worrying, anxiety, fear, doubt and pessimism
- individuals who have experienced trauma, abuse, neglect or post-traumatic stress disorder (PTSD)

# PROTECTIVE FACTORS

## SOCIO-CULTURAL PROTECTIVE FACTORS

- Belonging to a culture that accepts a range of body shapes and sizes
- Involvement with sport or industry where there is no emphasis on physical attractiveness or thinness
- Peer or social support structures and relationships where weight and physical appearance are not of high concern

## INDIVIDUAL

- High self-esteem
- Positive body image
- Critical processing of media images
- Emotional well-being
- School achievement
- Being self-directed and assertive
- Good social skills with success at performing multiple social roles
- Problem solving and coping skills


## FAMILY

- Belonging to a family that doesn't over-emphasise weight & physical attractiveness
- Eating regular meals with family

# HIGH RISK COHORTS

**Females**, especially during biological and social transition periods (e.g., onset of puberty, change in relationship status, pregnancy and postpartum, menopause, change in social role)

**Children and adolescents**; although eating disorders can develop at any age, risk is highest between 13 and 17 years of age

**Competitive occupations**, sports, performing arts and activities that emphasise thin body shape/weight requirements (e.g., modelling, gymnastics, horse riding, dancing, athletics, wrestling, boxing)

**LGBTQIA+ communities**

# SYMPTOMS


## PSYCHOLOGICAL

- Preoccupation with eating, food, body shape and weight
- Feeling anxious and or irritable around meal times
- Feeling 'out of control' around food
- 'Black and white' thinking (e.g. rigid thoughts about food being 'good' or 'bad')
- A distorted body image
- Using food as a source of comfort (e.g. eating as a way to deal with boredom, stress or depression)
- Using food as self-punishment (e.g. refusing to eat due to depression, stress or other emotional reasons)

## PHYSICAL

- Rapid weight loss or frequent weight changes
- Loss or disturbance of menstruation
- Decreased libido
- Fainting or dizziness
- Feeling tired and not sleeping well
- Lethargy and low energy
- Signs of damage due to vomiting including swelling around the cheeks or jaw, calluses on knuckles, damage to teeth and bad breath
- Feeling cold most of the time, even in warm weather

## BEHAVIOURAL

- Dieting behaviour
- Eating in private and avoiding meals with other people
- Evidence of binge eating (e.g. disappearance and/or hoarding of food)
- Frequent trips to the bathroom during or shortly after meals
- Vomiting or using laxatives, enemas, appetite suppressants or diuretics
- Changes in clothing style (e.g. wearing baggy clothes)
- Compulsive or excessive exercising (e.g. exercising in bad weather, continuing to exercise when sick or injured, and experiencing distress if exercise is not possible)
- Changes in food preferences
- Obsessive rituals around food preparation and eating
- Extreme sensitivity to comments about body shape, weight, eating and exercise habits
- Secretive or deceptive behaviour around food

# ANOREXIA NERVOSA

*"ANOREXIA" IS A MEDICAL TERM TO DESCRIBE "LOSS OF APPETITE ESPECIALLY WHEN PROLONGED."*
*"NERVOSA" IS A LATIN TERM TRANSLATING TO "NERVOUS" OR "PERTAINING TO THE NERVES."*

Anorexia, short for anorexia nervosa, is an eating disorder characterised by an intense fear of gaining weight and a distorted body image, leading to restricted food intake and excessive weight loss. People with anorexia often see themselves as overweight, even when they are dangerously underweight. They may go to great lengths to avoid eating and may engage in extreme exercise, use of diet aids, or purging behaviours (like vomiting or using laxatives) to lose weight.

Anorexia can have severe health consequences, including heart problems, bone loss, and, in extreme cases, death. Treatment typically involves a combination of medical care, nutritional counselling, and therapy to address underlying emotional and psychological issues.

**Access to evidence-based treatment has been shown to reduce the severity, duration and impact of anorexia nervosa.**

*Evidence-based psychological therapies to consider for the treatment of anorexia nervosa in children and adolescents include:*

- Family-based treatment (FBT) or family therapy for anorexia nervosa (parent-focused and multi-family group also acceptable)
- Eating disorder-focused CBT (CBT-ED) enhanced with family involvement
- Adolescent-focused psychotherapy

**CLICK HERE TO READ MORE ON TREATMENTS**

***Atypical Anorexia Nervosa*** *is a subtype of OSFED (Other Specified Feeding or Eating Disorders). Individuals with atypical anorexia nervosa exhibit all the symptoms of anorexia nervosa but maintain a weight within or above the normal BMI range despite significant weight loss. This condition is serious and potentially life-threatening, with similar impacts and complications as anorexia nervosa.*

*NB: the additive "Atypical" can be experienced as pejorative & unhelpful for those with the disorder.*

# BULIMIA NERVOSA

Bulimia nervosa involves recurring episodes of binge eating followed by compensatory behaviors like vomiting or excessive exercise to prevent weight gain. Individuals with bulimia nervosa may become trapped in a cycle of uncontrolled eating followed by attempts to counteract it, leading to feelings of shame, guilt, and disgust. Over time, these behaviors can become more compulsive and uncontrollable, resulting in an obsession with food, eating, weight loss, dieting, and body image.

## WARNING SIGNS

- Repetitive dieting behaviours, such as counting calories, skipping meals, fasting, or avoiding specific foods
- Evidence of binge eating such as disappearance or hoarding of food
- Evidence of vomiting or misuse of laxatives, appetite suppressants, enemas, and diuretics.
- Frequent trips to the bathroom during or shortly after meals
- Patterns or obsessive rituals around food, food preparation and eating
- Avoidance of, or change in behaviour in social situations involving food
- Secretive behaviour around eating
- Compulsive or excessive exercising
- Signs of vomiting-related damage: cheek/jaw swelling, knuckle calluses, tooth damage, and bad breath.
- Feeling bloated, constipated or developing intolerances to food
- Loss of or disturbance to menstruation
- Fainting or dizziness
- Fatigue or lethargy
- Sleep disturbances
- Compromised immune system (e.g., getting sick more often)
- Sudden weight loss, gain or fluctuation

Preoccupation with eating, food, body shape and weight

- Intense fear of gaining weight
- Preoccupation with food or activities relating to food
- Heightened anxiety or irritability around mealtimes
- Heightened sensitivity to comments about body, weight, eating, or exercise
- Low self-esteem and feelings of shame, self-loathing or guilt
- Body dissatisfaction and negative body image
- Depression, anxiety, self-harm or suicidality
- Obsession with food and need for control

National Eating Disorders Collaboration

Evidence | Experience | Expertise

**EVIDENCE BASED TREATMENT FOR CHILDREN & ADOLESCENTS:**

- Eating disorder-focused CBT (CBT-ED) with family involvement

**LEARN MORE HERE**

# BINGE EATING DISORDER

BED is a serious mental illness marked by recurrent binge eating episodes without compensatory behaviors. A person with BED often feels a loss of control, consuming large amounts of food quickly, often in secret. This can lead to feelings of guilt and shame. The causes of BED vary, including genetic, environmental, social, and cultural factors. It affects people of all ages, genders, and backgrounds, with studies suggesting similar rates in both males and females.

BED can lead to serious medical complications, including cardiovascular disease, type 2 diabetes, high blood pressure, high cholesterol, and an increased risk of stroke, diabetes, and heart disease. It can also result in osteoarthritis, chronic kidney problems, or kidney failure. Additionally, BED often causes extreme body dissatisfaction, social withdrawal, and intense feelings of shame and guilt. These physical and emotional impacts can contribute to mental health challenges such as depression, anxiety, self-harm, or suicidality.

## Behavioural warning signs include:

- Evidence of binge eating such as disappearance or hoarding of food
- Secretive behaviour around food such as not wanting to eat around others
- Evading questions about eating and weight
- Increased isolation and withdrawal from activities previously enjoyed
- Erratic behaviour such as shoplifting/overspending

## Impacts and complications include:

- Extreme body dissatisfaction/distorted body image
- Social withdrawal or isolation
- Feelings of shame, guilt and self-loathing
- Depressive or anxious symptoms and behaviours
- Self-harm or suicidality

CLICK ON PIC FOR FACT SHEET


Of people with eating disorders, 47% have binge eating disorder compared to 3% with anorexia nervosa, 12% with bulimia nervosa and 38% with other eating disorders

## EVIDENCE BASED TREATMENT FOR CHILDREN & ADOLESCENTS:

- Cognitive Behaviour Therapy Enhanced (CBT-E)
- Cognitive Behaviour Therapy – Guided Self Help (CBT-GSH)
- Interpersonal Therapy (IPT)

**43%**

OF PEOPLE WITH BED ARE MALE

# AND THE OTHERS ...

## ARFID

AVOIDANT/RESTRICIVE FOOD INTAKE DISORDER

ARFID is marked by a lack of interest in food, avoidance, and aversion to eating. This restriction **isn't due to body image issues** but rather **anxiety** or a food-related phobia, heightened sensitivity to food textures, tastes, or smells, or simply a lack of interest in eating. ARFID can lead to significant weight loss, nutritional deficiencies, reliance on tube feeding or supplements, and major disruptions in social functioning.ARFID is a relatively new diagnosis (10 years is 'brand-spanking' in Psychiatry!), so research on effective treatments is still growing. Current evidence suggests Cognitive Behaviour Therapy (CBT) may help. CBT may include gradually introducing feared foods, relaxation training, and support for changing eating habits. Responsive Feeding Therapy (RFT) is also used to treat ARFID in children, and its principles can be applied to adolescents and adults. RFT involves creating pleasant mealtime routines with few distractions, modelling good eating behaviours, and allowing the child to follow their hunger cues.

## OSFED

OTHER SPECIFIED FEEDING OR EATING DISORDERS

A person with OSFED may show many symptoms of other eating disorders like anorexia nervosa, bulimia nervosa, or binge eating disorder but doesn't meet the full criteria for these diagnoses. However, this doesn't make OSFED any less serious or dangerous. The medical complications and disordered thoughts and behaviors associated with OSFED are just as severe as those in other eating disorders.

## UFED

UNSPECIFIED FOOD OR EATING DISORDER

Unspecified Feeding or Eating Disorder (UFED) causes significant distress and impairment in social, work, or other important areas of functioning, but does not meet the full criteria for other feeding and eating disorders. This category is used when a clinician chooses not to specify why the criteria for a specific disorder are not met, often due to insufficient information, such as in emergency room settings.

# RECOVERY

The concept of ‘recovery’ can vary from person to person. For some, recovery means that they no longer experience any thoughts related to an eating disorder. For others, while those thoughts may persist, they are able to control how much attention they give them, ensuring they don't interfere with their daily life.

Relapse can be seen as a stage of change, where old patterns of thoughts or behaviours resurface. It can play a crucial role in recovery by highlighting what strategies are effective for the individual and what triggers may exist. Although relapse can be stressful, it is a common experience and can provide valuable insights into the patterns of the eating disorder, aiding in future recovery efforts.


READ MORE ABOUT THE STAGES OF CHANGE HERE

## UNDERSTANDING THE SCHOOL’S ROLE IN RECOVERY AND SUPPORT

Schools play a crucial role in supporting students with eating disorders. Here are some key actions schools can take:

Be Flexible and Understanding: Schools should accommodate students' absences due to treatment and maintain clear communication with the student and their family.

Support Transitions: Liaise with CYMHS Clinicians to ease transitions between hospital and home, ensuring the student receives consistent support.

Adjust Curriculum: Modify or remove certain curriculum materials that may be triggering, and consider excusing students from specific activities like physical education, food technology, or health classes.

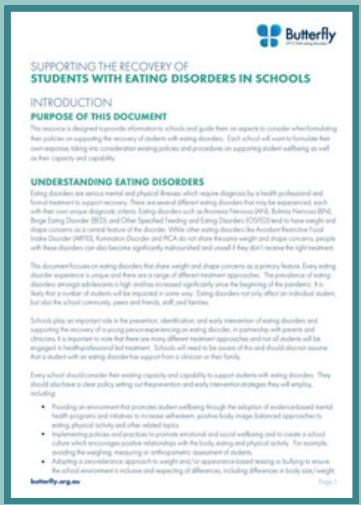
Monitor Physical Activity: Keep an eye on students' physical activity during break times to ensure it aligns with their recovery needs.

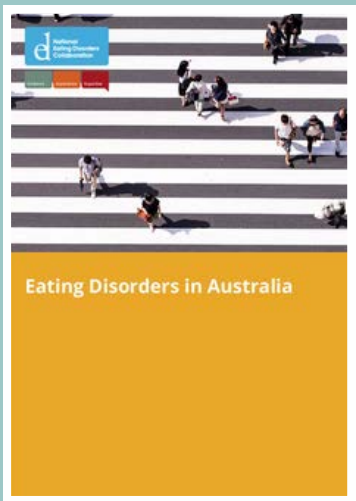
Provide Support for Peers: Schools can recommend support services for the siblings and friends of the affected student, such as sessions with a the wellbeing team or referrals to external support.

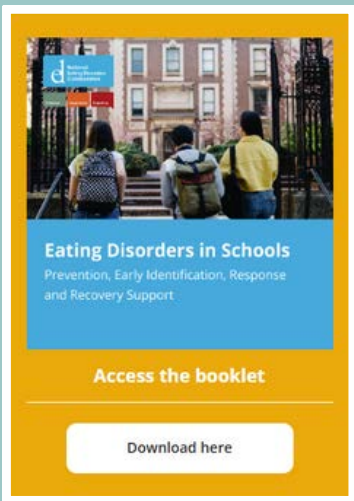
Develop a Recovery Support Plan: Create an eating disorder recovery support plan to guide staff in supporting students returning to school after hospital treatment or extended absences.
The Butterfly Foundation offers a resource called **Supporting the Recovery of Students with Eating Disorders in Schools**, which includes a section on **Considerations for an Eating Disorder Recovery Support Plan**. This plan can be used for students diagnosed with an eating disorder or integrated into the school's existing wellbeing strategies.

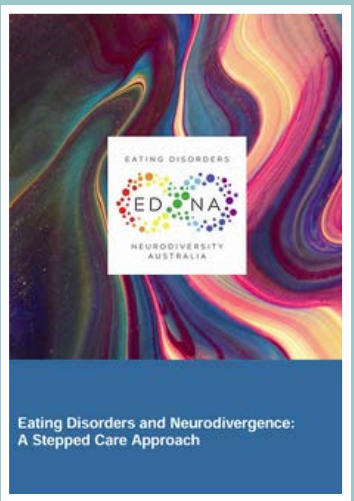
SEE THE RESOURCE HERE

# RESOURCES

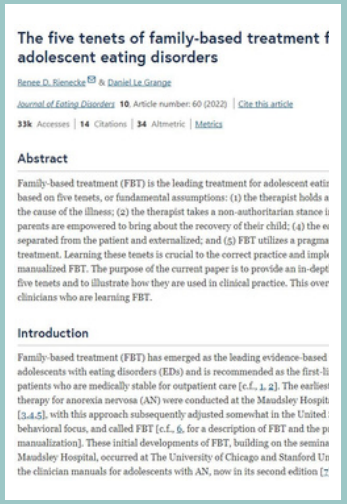


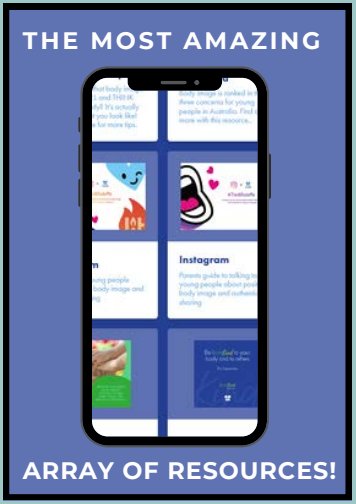










LIVED EXPERIENCE STORIES

PREVENTION FOR YOUNG PEOPLE


## REQUESTING PL FROM ED-LINQ

please click HERE to access our request form. If you would like to discuss your training needs with us prior to completing the form, drop us an email on:
chhsed-linq@health.qld.gov.au