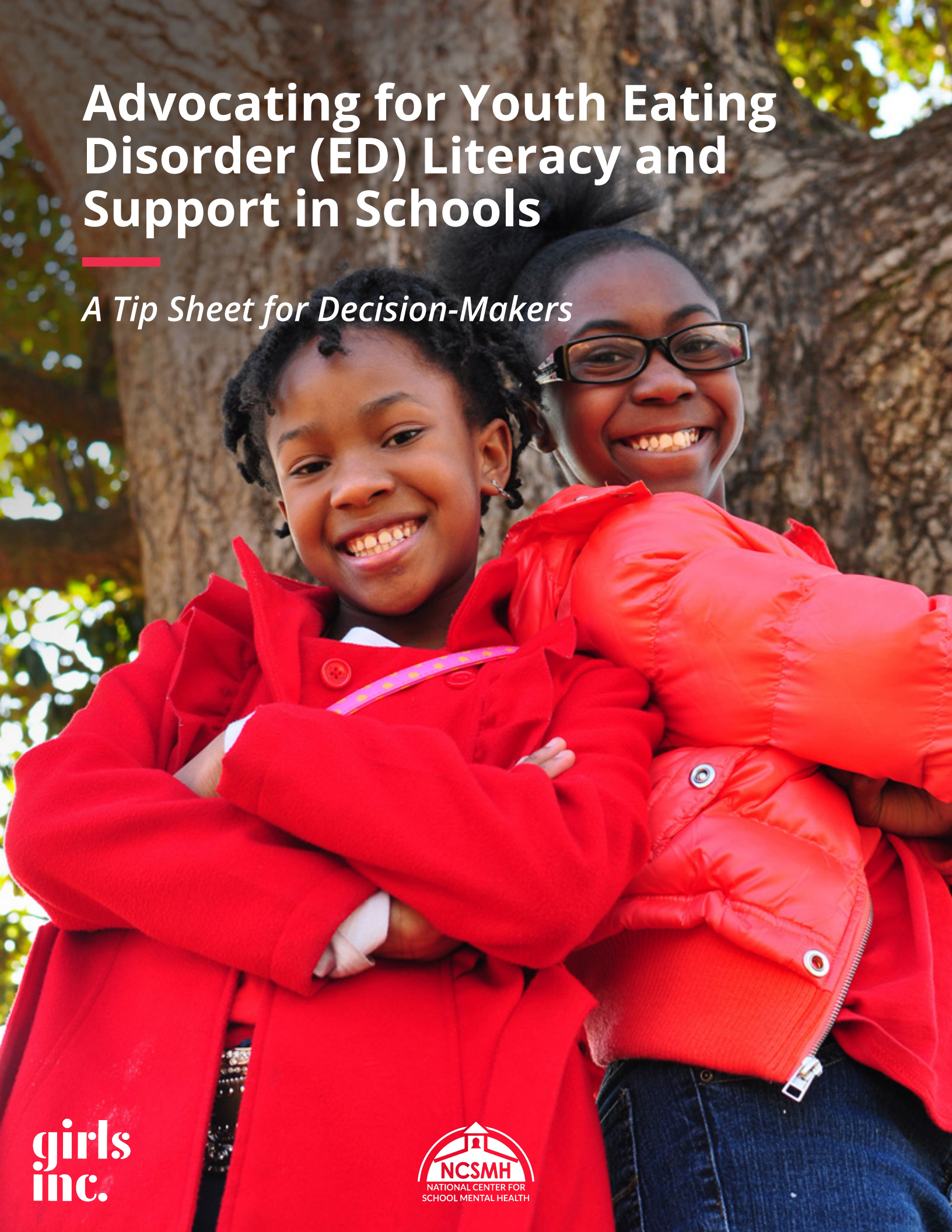
Advocating for Youth Eating Disorder (ED) Literacy and Support in Schools

A Tip Sheet for Decision-Makers



girls inc.

NCSMH
NATIONAL CENTER FOR SCHOOL MENTAL HEALTH

Intro: Eating Disorders and Educator Mental Health Literacy

Why should teachers be trained in eating disorder MH literacy?

As trusted adult figures who interact daily with students, teachers are uniquely positioned to identify, refer, and support youth struggling with eating disorders (EDs). They are valuable liaisons between students, their families, and services. School support is especially important for students of color[1], who are less likely to be approached about ED symptoms in primary care settings and more likely to use school-based MH services.

How do teachers feel about it?

Especially throughout the pandemic, teachers have recognized students' need for MH services, including for EDs. Studies show that while most teachers want to provide support, most feel unprepared and want more training[2].

What are the current problems with existing MH trainings?

Educator training on mental health typically excludes content on EDs. Trainings tend to focus on depression, anxiety, and ADHD. They prioritize suicide risk and disorders that could interrupt a classroom environment. Given the severity of EDs, their impact on academic engagement and success, and their rise during COVID-19, it is essential for educator mental health training to include ED content.

Why is it important to include EDs?

EDs, some of the most severe and deadly mental illnesses among youth, have seen a marked rise during COVID-19[3]. These disorders are highly stigmatized- many associate EDs exclusively with thin, white, affluent young girls[4]. However, EDs affect youth of all genders, races, body sizes, and income levels. The absence of comprehensive and inclusive ED education perpetuates the existing biases of otherwise well-meaning educators, leaving behind behind students who don't fit the stereotype.

Important Definitions

Mental Health

the social, emotional, and behavioral well-being of students, including substance use.[5]

Mental Health Literacy

an individuals' knowledge and beliefs about mental disorders that aid their recognition, management, and prevention.[6]

Eating disorders

any of a range of psychological disorders characterized by abnormal or disturbed eating habits.[7]
Examples: anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED)

Youth mental health in 2022
Impact of the COVID-19 Pandemic

Youth MH is a national emergency.
In October of 2021, the American Academy of Pediatrics (AAP), Academy of Child and Adolescent Psychiatry (AACAP), and the Children's Hospital Association (CHA) declared children's mental health as a national state of emergency[8].

45 % increase in self-injury and suicide cases in 5-17 year- olds[8,9]

51% rise in emergency department visits for attempted suicide among adolescent girls.[8,9]

Suicide is the 2nd leading cause of death in youth ages 10-24.[9]

Children who experienced lockdown are 5x more likely to require mental health services and experience higher levels of posttraumatic stress.[10]

Eating disorders have skyrocketed during the pandemic.

A study at C.S. Mott Children's Hospital in Michigan reported that ED-related hospital admissions increased by **123%** during the first year of the pandemic.[3]

In 2020, incidences of first diagnosis were **15.3%** higher than in previous years. In the same study, a higher proportion of patients with EDs in 2020 had suicidal ideation than in past years.[11, 12]

EDs are prevalent and severe.

Eating disorders are the **2nd** most deadly mental illness, right behind opioid overdose.[13] **9%** of the US population, or **28.8 million** Americans, will have an eating disorder in their lifetime.[14]

According to the Eating Disorders Coalition, every **62 minutes**, at least one person loses their life as a direct result of an eating disorder.[15]

Culturally relevant and de-stigmatizing ED training for educators

EDs affect individuals of all genders, races, body sizes, and income levels. The absence of comprehensive, inclusive ED literacy perpetuates existing biases of otherwise well-meaning educators, leaving behind students who don't fit into the stereotype.

Myth #1: Eating disorders only happen to white people.

- Black teenagers are 50% more likely than white peers to exhibit bulimic behavior *and* significantly less likely to receive help.[13]
- Hispanic adolescents are significantly more likely to suffer from bulimia than non-Hispanic peers.[13]
- Asian Americans have a higher internalization of the 'thin body ideal' than white peers, a high incidence of anorexia, and a tendency to deny or minimize symptoms.[4]
- 48.1% Native American adolescents are attempting weight loss, higher than every other racial/ethnic group of that age.[16]
- All racial/ethnic minority groups report higher rates of binge-eating disorder than white counterparts.[13]

Myth #2: Only heterosexual girls have EDs.

- About 1 in 3 people with an ED is male.[17]
- Gay males are 7 times more likely to report binging & 12 times more likely to report purging than straight peers.[13]
- Lesbian and bisexual women were about twice as likely to report binge-eating in the last year.[13]
- Trans children have a greater risk of developing bulimia and anorexia than cis peers.[18]
- Compared to cis female peers, trans college students were over 4x more likely to report anorexia or bulimia diagnoses and twice as likely to report purging.[19]

Myth #3: All people who have EDs appear thin.

- Most people with EDs are not underweight. Those who are extremely ill may still look healthy.[19]
- EDs are present in all BMI categories.[20,21,22]
- Even if a previously emaciated ED sufferer has gained weight, they may not be recovered.[23]
- Although restrictive disorders are characterized by weight loss, many with EDs do not lose weight and can even gain weight as a symptom.[23]

Myth #4: EDs are a personal choice made by affluent individuals.

- While social pressures are a risk factor, they are typically not the sole or even primary cause. Many EDs have a strong genetic and biological component.[19]
- There is no consistent association between socioeconomic status and ED risk.[4]

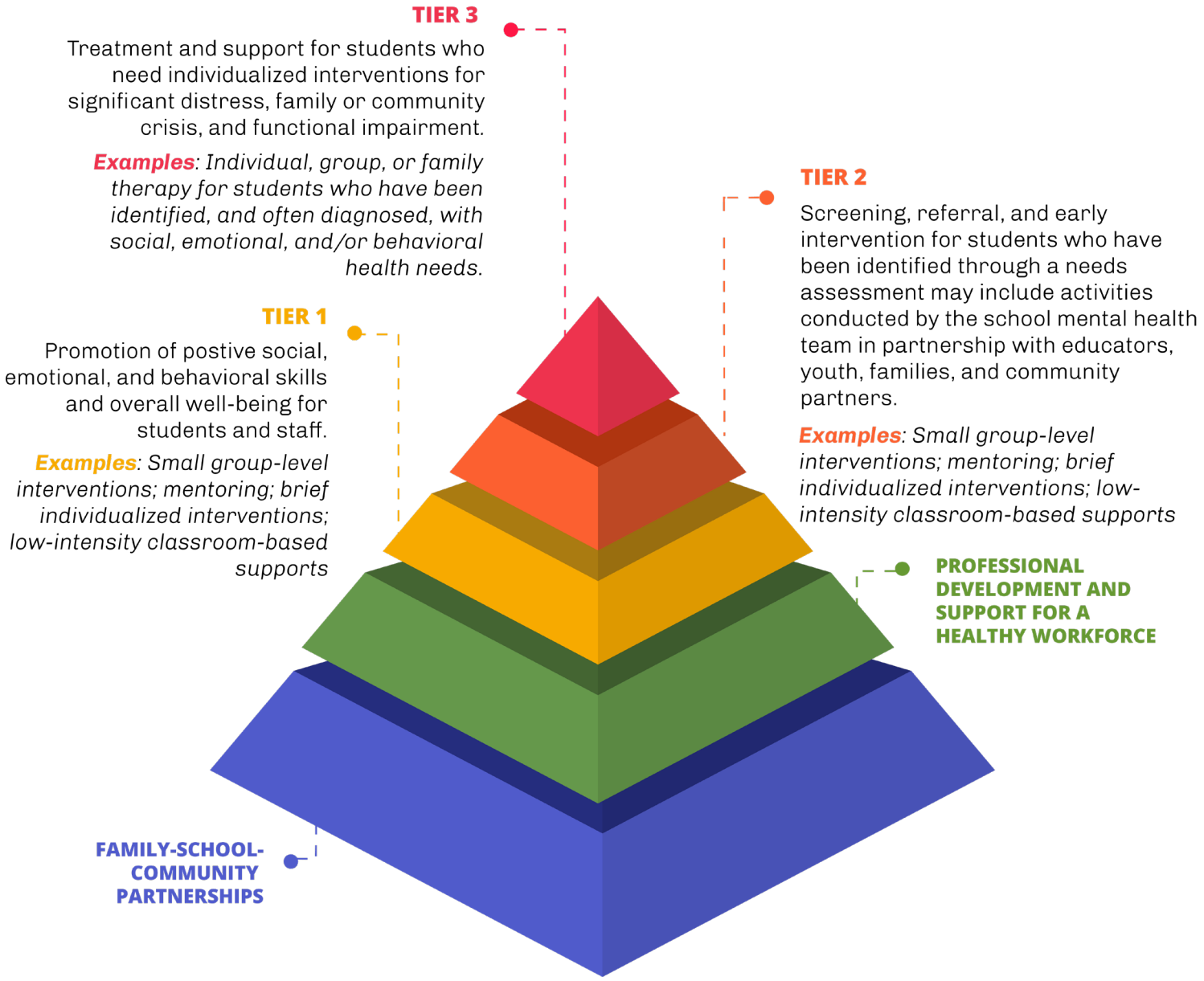
Myth #5: EDs are solely caused by the pressures of social media.

- While social pressures are a risk factor,
- they are typically not the sole or even primary cause. Many EDs have a strong genetic and biological component.[19]

Comprehensive, inclusive ED literacy equips educators to identify, refer, and support *all* students struggling with EDs.

Addressing Eating Disorders through Comprehensive School MH Systems

Comprehensive school MH systems support students and staff through a tiered approach. A multi-tiered system of support (MTSS) promotes MH for all students and facilitates the referral of students who may benefit from a higher level of intervention. In order to properly address youth eating disorders when they show up in the school environment, supports must exist at all levels. Professional development for educators, including ED MH literacy, is integral to effective MTSS for students with EDs.



general mental health

Talking Points

Data Points

Talking Points	Data Points
Young people have been uniquely impacted by the challenges of COVID-19 and ontinue to suffer the consequences of heightened stress, isolation, loss of routine, grief, etc.	Children who experienced lockdown were five times more likely to require mental health services and experienced higher levels of posttraumatic stress.[10]
The state of youth mental health was dire before the pandemic. Now, it's a national emergency.	• In 2020, suicide was the second leading cause of death for youth ages 10-14.[9] • In early 2021, children's hospitals across the country saw a 45% increase in self-injury and suicide cases in 5-17 year olds.[8,9]
While teachers want to support their students' mental health, many do not feel prepared to do so.	A recent study found that, while 93% of teachers are concerned about mental health needs, 85% expressed the need for further mental health training.[2]
Offering mental health services in schools increases access and treatment completion.	Of children and adolescents who receive mental health services, most receive them in school. Youth are 6 times more likely to complete evidence-based treatment when offered in schools than in other community settings.[24]
Mental health concerns threaten academic performance.	Mental, behavioral, social, and emotional health issues are a leading contributor to chronic absenteeism. Chronic absence, or missing 10% or more of school days, is an early warning sign of academic risk and school dropout.[25]

Eating disorder rates increased exponentially throughout the pandemic.

A children's hospital in Michigan reported a 123% increase in ED-releated admissions during the first year of the pandemic alone.[3] Many inpatient and outpatient facilities reached full capacity, further limiting access to care.

EDs are not a choice. They are serious and often deadly medical conditions caused by biological, psychological, and social factors.

28-74% of risk for eating disorders is through genetic heritability.[19]

The stereotype that EDs only impact thin, affluent, white, American young girls is both false and harmful. EDs impact youth of all genders, races/ethnicities, sexual orientations, income levels, etc.

- Less than 6% of people suffering from EDs are medically "underweight".[19]
- Black, Indigenous, and people of color (BIPOC) are significantly less likely than their white counterparts to have been asked by a doctor about ED symptoms, to be diagnosed, or to receive treatment.[19]
- Black teens are 50% more likely than white teens to exhibit bulimic behavior.[4,19]
- Asian American students report higher rates of restriction, purging, muscle building, and cognitive restraint.[4,19]
- Trans college students report EDs at about 4x the rate of their cisgender classmates.[19]

Short-Term Improvements

1. Provide information to educators and other school staff about disordered eating.

Schools can take the first step by providing basic information to their staff, including ED prevalence, severity, and tips for identification.

2. Conduct awareness campaigns

Engage the community through social media or in-person presentations, observance of ED awareness week/month, flyering, or PSAs.

3. Review and update accommodations for students with EDs.

Students struggling with EDs have specific needs that may go beyond a standard 504 plan. Those returning from or undergoing treatment may require meal monitoring or support, home-school coordination with a treatment team, or alternatives to exercise requirements.

4. Establish partnerships with community behavioral health providers to provide school-based services and referral pathways to community care.

Though the school environment provides a unique opportunity to identify and support students at risk of EDs, it is not a replacement for professional treatment. Creating relationships with providers allows school staff to better refer students to the services they need.

5. Engage youth in school decision-making processes.

Student perspectives are critical to inform school efforts to address eating disorders. Staff can learn from accounts of students' experiences during COVID-19. Schools could conduct focus groups, invite students to research and provide input on MH trainings, and co-develop school-wide initiatives that align with student priorities.

Long-Term Asks

1. Expand mental health literacy training for educators to include EDs.

Trainings that exclude EDs can be supplemented with other ED-focused resources or co-created with experts and students. The latter invites students voices and helps schools to tailor training content relevant to the distinct needs of their student body. This might also include providing information through awareness campaigns, PSAs, or observation of ED awareness week/month. Advocating for legislation that mandates teacher mental health training can support this strategy.

2. Invest in school-based nutrition and mental health education for students.

ED literacy training is best conducted in schools where, simultaneously, students are learning about EDs. This includes healthy nutrition and suport-seeking strategies.

3. Expand coverage for psychological and nutrition counseling in schools.

Low student-to-school personnel ratios decreases school capacity to provide adequate support.[27] Recent federal and state investments in school MH provide opportunities to hire more school counselors, psychologists, nutritionists, and other school-based health professionals.[28]

4. Allow excused mental health absences.

Some school districts and states have implemented or are considering additional supports for all students, including mental health days[26]. Excused absences are important for students struggling with EDs, who often need to miss school for treatment or extended recovery time.

The EPIC Model for Advocacy

How to connect with, educate, and motivate your audience.[29]

Engage

Get your listener's attention with your story. Think about key messages you want others to remember and focus on those as you share your story.

State the Problem

Present key talking points about pediatric eating disorders and the specific need for ED-inclusive mental health literacy in schools.

Inform About Solutions

Educate the listener about and benefits of comprehensive school mental health systems for children's well-being and improved school climate and teacher support.

Call to Action

Now that you've engaged your listener, presented the problem, and informed them of a solution, state what you want the listener to do. Use the "example asks" in this tip sheet.

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