Conceptualising a Preventative Approach to Eating Disorders in New Zealand

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Abstract—Eating disorders are taboo, stigmatised and silent. The combination of these three characteristics has influenced the status quo, whereby eating disorder sufferers only seek, or are able to obtain, help when their conditions are most visible and their lives are at risk. Over the past decade or so, many jurisdictions around the world have recognised the insidious impacts that eating disorders can have on both an individual and socioeconomic level. New Zealand's eating disorder policy mirrors an "ambulance at the bottom of the cliff" approach by focusing on treatment rather than prevention. This article argues that New Zealand ought to engage in eating disorder prevention, as similar prevention-focused public health initiatives have been successfully implemented in New Zealand. This article explores the multiplicity of international policy responses, as well as available evidence concerning the efficacy of these responses. Unfortunately, chronic underfunding of eating disorder research has resulted in policies being introduced without a sound evidential basis. As a result, this article argues first and foremost that the New Zealand government must follow Australia's lead in implementing a specific research strategy with sufficient funding. Although there is a lack of research into policy efficacy, three policies provide a strong foundation for the implementation of a preventative response in New Zealand: (i) integrating eating disorder education into the New Zealand health curriculum; (ii) a prohibition on the distortion of bodies in advertising; and (iii) alternatively, third party certification for companies which practice the portrayal of realistic body image and inclusive representation in advertising.

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I Introduction

This article argues that the socioeconomic costs of eating disorders warrant a drastic shift in policy from treatment to prevention-focused initiatives. Parts II and III provide an overview of eating disorders and their socioeconomic cost. Part IV examines the complex etiology of eating disorders, which encompasses social, psychological and biological factors. This article focuses its discussion of eating disorder prevention policy to those that address social causes, as these are the most amenable to government intervention. Part V examines New Zealand's eating disorder crisis, and Part VI makes the case for a preventative approach by considering the government's successful intervention into tobacco consumption.

Having argued in favour of preventative policy, Part VII discusses policy responses from various jurisdictions according to their respective categorisation: awareness and education around eating disorders; early intervention; and targeting the causes of body dissatisfaction.

Even in the absence of empirical evidence proving its efficacy, a prevention-based approach to eating disorders still has substantial merit; the status quo of worsening eating disorder outcomes will persist without government intervention. Part VIII argues that policymakers must allocate resources to understand how preventative approaches can target social causes of eating disorders. Furthermore, there are measures that can and should be adopted to initiate New Zealand's eating disorder prevention policy journey: (i) integrating eating disorder education into the New Zealand health curriculum; (ii) a prohibition on the distortion of bodies in advertising; and (iii) alternatively, third party certification for companies which practice the portrayal of realistic body image and inclusive representation in advertising.

II Background

An "eating disorder" refers to a complex range of medical conditions, with a core commonality being disturbances of eating behaviours and a hyperfocus on food, eating and body image.[1] The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) is widely used by healthcare professionals around the world as an authoritative guide to diagnosing mental

1 Phillipa Hay and others "Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders" (2014) 48 Aust N Z J Psychiatry 977 at 978.

illnesses.[2] The DSM-5 recognises three primary eating disorder diagnoses: anorexia nervosa (hereafter, anorexia), bulimia nervosa (hereafter, bulimia) and binge eating disorder. Anorexia involves an intense fear of weight gain leading to self-imposed or continual weight-loss, usually with a perception of oneself as overweight, despite emaciation.[3] Bulimia and binge eating disorder are characterised by regular binge eating episodes. People with bulimia compensate for binge eating with behaviours such as purging, excessive exercising or fasting. In contrast, those with binge eating disorder do not regularly engage in compensatory behaviour and are therefore likely to be overweight or obese. Eating disorder presentations which do not fit within these diagnoses, such as dietary restriction and fixation on one's weight, are classified under residual categories such as "other specified" and "unspecified" feeding and eating disorders.[4]

Persons with eating disorders are generally stereotyped as young, white, upper-class females.[5] However, a 2015 study found that eating disorder symptoms are distributed almost equally across levels of socioeconomic status.[6] The New Zealand Mental Health Survey, Te Rau Hinengaro, demonstrated that lifetime prevalence rates were 0.6 per cent for anorexia and 1.3 per cent for bulimia for the whole population.[7] For Māori, this increased to 0.7 per cent for anorexia and 2.4 per cent for bulimia. This study only assessed anorexia and bulimia, with the authors anticipating that the prevalence of other eating disorders such as binge eating disorder would also be higher among Māori.

Eating disorders can arise at any age and within any socioeconomic group, ethnicity and gender.[8] Stereotypes have been identified as a barrier for accessing care.[9] Whether a sufferer is able to access care or not, eating disorders place a

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2 See American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (5th ed, Arlington (Va), 2013).

3 At 345 and 350.

4 Kristen M Culbert, Sarah E Racine and Kelly L Klump "Research Review: What we have learned about the causes of eating disorders – a synthesis of sociocultural, psychological, and biological research" (2015) 56 J Child Psychol Psychiatry 1141 at 1141.

5 Brittany Mulders-Jones and others "Socioeconomic Correlates of Eating Disorder Symptoms in an Australian Population-Based Sample" (2017) 12 PLoS One 1 at 1.

6 At 1.

7 Cameron Lacey and others "Eating disorders in New Zealand: Implications for Māori and health service delivery" (2020) 53 Int J Eat Disord 1974 at 1975.

8 The Butterfly Foundation *Paying the Price: The economic and social impact of eating disorders in Australia* (Deloitte Access Economics, Sydney, 2012) at 9.

9 Rachel Baffsky "Eating disorders in Australia: a commentary on the need to address stigma" (2020) 8 J Eat Disord at 1.

significant burden on not just the individual but also those around them and wider society.

III The Socioeconomic Burdens of Eating Disorders

The societal burdens created by eating disorders include financial and economic losses as well as significant strain on relationships and communities. Concerning financial burdens, the expense commonly associated with treating eating disorders often places immense financial pressure on parents and caregivers of adolescent patients.[10] In 2021, researchers undertook the first New Zealand study exploring the cost of caring for someone with an eating disorder.[11] The study found that, on average, the annual income for those caring for persons with anorexia was reduced by 27 per cent.[12]

To provide insight into the individual financial burden of caring for an individual with an eating disorder, various countries have undertaken studies to explore the wider economic cost. In Australia, the Butterfly Foundation's report estimated the full socioeconomic cost of eating disorders to the Australian economy to be AUD 69.7 billion in 2012. Of this amount, just AUD 99.9 million stemmed from direct healthcare costs, as the report's calculations included the costs of productivity loss and loss of life.[13] Another report found that out of all mental and neurological disorders, eating disorders were associated with the highest proportion of direct healthcare costs across 30 European countries in 2010.[14] Although there has not been a comprehensive socioeconomic study in New Zealand, the less visible costs of eating disorders, highlighted in these reports, underscore the urgency of policy intervention.

Adding to this impetus is the fact that an untreated eating disorder can significantly impact one's length and quality of life. The mortality rate for people with eating disorders is the highest of all mental illnesses.[15] The fact that there is no one-size-fits-all treatment reflects the complex etiology of eating disorders, which can involve many social, psychological and biological factors.

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10 See generally Davene R Wright and others "The Cost-Effectiveness of School-Based Eating Disorder Screening" (2014) 104 Am J Public Health 1774.

11 Kim Thomas "Eating disorders result in significant financial impact on carers" (3 February 2021) University of Otago <www.otago.ac.nz>.

12 Thomas, above n 11.

13 The Butterfly Foundation, above n 8.

14 Vanessa Wolter and others "Prevention of eating disorders—Efficacy and cost-benefit of a school-based program ('MaiStep') in a randomized controlled trial (RCT)" (2021) 54 Int J Eat Disord 1855 at 1856.

15 Wright and others, above n 10.

IV Eating Disorder Causes

One research review and synthesis of the relevant academic literature identified the following main causes of eating disorders: idealisation of thinness, personality traits and genetics.[16] These causes are not isolated, but rather, they interact to influence the risk of eating disorder symptom presentation. The following section discusses the research review's findings for each of these main causes. Importantly, the review's authors noted that few factors have been studied in a male context, with most of the research focused on young adult women.[17]

A Idealisation of thinness

In Western societies, an increase in the idealisation of the "thin-ideal" (a slender physique with minimal body fat) for females and the "muscular-ideal" (a lean, muscular physique) for males has correlated with an increase in eating disorder incidence rates throughout the 20th century.[18] The media plays a significant role in forming these ideals.[19] A 2003 study found that greater media exposure among participants correlated with the incidence of an eating disorder by contributing to internalisation of these generally unattainable ideals.[20] Body dissatisfaction emerges due to discrepancies between what society portrays as an ideal body and a person's real body.[21]

In 1995, a significant study in Fiji, a country in which no eating disorders had previously been described, highlighted the role of the Western "thin-ideal" in causing eating disorders.[22] The introduction of Western television exposed Fijian adolescents to new body image values which differed to Fijian culture's emphasis on a fuller figure. Across the cohorts, the proportion of girls scoring poorly on the Eating Attitudes Test (EAT-26), a 26 question screening tool to determine if an individual may have an eating disorder that requires professional attention, more than doubled from 12.7 per cent to 29.2 per cent, and the proportion purging increased from zero per cent to 11.3 per cent.[23] Qualitative

16 Culbert, Racine and Klump, above n 4.

17 At 1143.

18 At 1145.

19 Pilar Aparicio-Martinez and others "Social Media, Thin-Ideal, Body Dissatisfaction and Disordered Eating Attitudes: An Exploratory Analysis" (2019) 16 Int J Environ Res Public Health 4177 at 1.

20 Culbert, Racine and Klump, above n 4, at 1145.

21 Aparicio-Martinez and others, above n 19, at 3.

22 Anne E Becker and others "Eating behaviours and attitudes following prolonged exposure to television among ethnic Fijian adolescent girls" (2002) 180 Br J Psychiatry 509.

23 At 510.

interviews revealed that 77 per cent of the girls noticed that watching television influenced their body image, with specific mention made to the slim figures of characters on shows such as *Beverly Hills, 90210*.[24] The study's author confirmed that exposure to Western media ultimately contributed to disordered eating.[25]

Social media is another significant factor promoting the idealisation and internalisation of thin and muscular ideals.[26] Studies show that users post images online that present themselves in line with current social ideals by selecting photographs that make the subject appear thinner and more attractive.[27] A 2019 study found that the frequency of disordered eating behaviours, such as over-evaluating weight and skipping meals, increased alongside the number of social media accounts that both girls and boys had.[28] These findings suggest that body dissatisfaction in association with social media occurs at a younger age than previously investigated—which is particularly concerning given these platforms have a minimum age of 13 years old.[29]

In sum, Western beauty ideals are no longer limited to the West. Globalisation, compounded by social media, has spread pressure to conform to these unattainable body types internationally.

B Personality traits

However, an eating disorder etiology discussion is incomplete without consideration of internal factors that can predispose an individual to an eating disorder. Certain personality traits increase eating disorder risk. According to one study, such traits may include perfectionism, jealousy and neuroticism (negative emotionality).[30] Interestingly, studies have found that those who share negative emotionality tend to be drawn towards one another.[31] This attraction creates a social environment where weight insecurity and value placed in achieving the "thin-ideal" are magnified. A study of college students found that exposure to

24 At 513.

25 At 512.

26 Aparicio-Martinez and others, above n 19.

27 Jaime E Sidani and others "The Association between Social Media Use and Eating Concerns among US Young Adults" (2016) 116 J Acad Nutr Diet 1465 at 1466.

28 Simon M Wilksch and others "The relationship between social media use and disordered eating in young adolescents" (2020) 53 Int J Eat Disord 96 at 96.

29 At 97.

30 Culbert, Racine and Klump, above n 4, at 1147.

31 Pamela K Keel and K Jean Forney "Psychosocial Risk Factors for Eating Disorders" (2013) 46 Int J Eat Disord 433 at 437.

friends dieting is a significant predictor for higher body dissatisfaction, extreme weight control behaviours and binge eating five to ten years on.[32]

C Genetics

While certain personality traits are an internal factor where environment can have a degree of influence, the second internal factor—genetics—does not. Various studies emphasise that genetics can substantially contribute to the risk of disordered eating, which can develop into an eating disorder diagnosis.[33] However, despite significant advances in the study of genetic associations over the past two decades, relatively little is known about the genes which predispose a person to eating disorders.[34] Difficulties in identifying genetic precursors to eating disorders also arise because eating disorder etiology results from a combination of genetic and environmental factors. Nevertheless, up to 50 per cent of disordered eating has been described as being hereditarily transmitted, and researchers have suggested that neurotransmitters in the brain are involved in disordered eating behaviours.[35] A family history with leanness can also be associated with anorexia, and a family history of obesity with bulimia.[36] Previous studies have also found that children have a higher risk of eating disorder diagnosis if their mother has disordered eating or self-esteem problems.[37] In sum, the science so far suggests that genetics play a complex role in the development of eating disorders, but its specific role is yet to be fully understood.

D Failure to obtain early intervention

Understanding the causes and symptoms of eating disorders leads to the question of diagnosis and treatment. Unfortunately, it is estimated that while 79‑88 per cent of adolescents with eating disorders have contact with a health provider, only 3–28 per cent receive treatment for their eating disorder.[38] A systematic literature review on the perceived barriers to seeking help as an eating

32 At 437.

33 Culbert, Racine and Klump, above n 4, at 1150.

34 Emily Davis "Unlocking the Genetics of Eating Disorders" (18 August 2020) University of North Carolina Research <www.endeavors.unc.edu>.

35 Aparicio-Martinez and others, above n 19, at 2.

36 Hay and others, above n 1, at 979.

37 Aparicio-Martinez and others, above n 19, at 2.

38 Sonja Swanson and others "Prevalence and Correlates of Eating Disorders in Adolescents. Results from the National Comorbidity Survey Replication Adolescent Supplement" (2011) 68 Arch Gen Psychiatry 714 at 718.

disorder sufferer found that shame and stigma were identified more frequently as barriers than practical factors such as costs and transportation.[39]

The discrepancy between those suffering from eating disorders and those seeking medical treatment is alarming given the significance early identification of eating disorders has as a critical contributor to better outcomes.[40] Research has emphasised that it is appropriate to commence medical management of a patient, even prior to them fulfilling all of the diagnostic criteria of a particular disorder, in order to limit and reverse symptom progression as quickly as possible.[41]

According to the National Eating Disorders Collaboration, an initiative of the Australian Government Department of Health, recovery rates are between 74–90 per cent in those who have had a history of disordered eating for less than one year.[42] This finding contrasts significantly with the recovery rate of 21 per cent in those who have had a history of an eating disorder for four years or more. However, lack of symptom awareness frustrates the possibility of early detection by family, friends or teachers.[43] Adolescents are the highest-risk group for eating disorders, but teachers have iterated that they feel uncomfortable when faced with students' eating disorders and lack the knowledge and confidence to respond appropriately.[44] The cumulative impact of stigma and lack of symptom awareness has contributed to poor diagnosis and treatment outcomes, which were exacerbated by the restrictions brought about by the COVID-19 pandemic from 2020–2021.

V New Zealand's Eating Disorder Crisis

This part considers the extent to which the COVID-19 pandemic exacerbated poor outcomes in eating disorder diagnosis and treatment in New Zealand by analysing the government's response preceding and following the pandemic. Though the government is aware of the worsening situation, the policy focus has remained on treatment rather than prevention.

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39 Baffsky, above n 9, at 1.

40 Elizabeth Rowe "Early detection of eating disorders in general practice" (2017) 46 AFP 833 at 833.

41 Susan Strongman "Dying for help: Eating disorder treatment waiting lists months long" (22 March 2021) RNZ <www.rnz.co.nz>.

42 The National Eating Disorders Collaboration *Eating Disorders: The Way Forward – An Australian National Framework* (The Butterfly Foundation, Sydney, 2010) at 36.

43 P Knightsmith, J Treasure and U Schmidt "Spotting and supporting eating disorders in school: recommendations from school staff" (2013) 28 Health Educ Res 1004 at 1005.

44 At 1004.

A The effects of the pandemic

In New Zealand, eating disorder prevalence has reached crisis levels. Following the first COVID-19 lockdown in March 2020, eating disorder specialists were widely reported in the media as being at a breaking point. Clinical Psychologist Dr Marion Roberts reported that families were being told that help in the public sector was a four-to-six month waitlist away—losing vital time for intervention to prevent the entrenchment of disordered habits.[45] A New Zealand study considered pandemic-associated stress and anxiety arising from social restrictions and altered routines as potential drivers for disordered eating behaviours, as well as increased exposure to social messaging around exercise and weight gain.[46]

These observations from healthcare professionals and studies suggest that COVID-19 had a significant effect on the eating habits of those with and without eating disorder diagnoses prior to pandemic restrictions. However, while COVID-19 restrictions have largely been lifted, there is no quick fix for eating disorders which, as previously mentioned, benefit immeasurably from early intervention.

B The government's response

This section considers the New Zealand government's response to the eating disorder crisis, both prior to and following the pandemic. The following analysis benefits from information provided through a request under the Official Information Act 1982 for any documentation and information relating to eating disorder prevention policy and initiatives, as the government has not yet created a formal public strategy to address eating disorder treatment or prevention.

In 2018, the government initiated the Government Inquiry into Mental Health and Addiction.[47] The Eating Disorder Association of New Zealand (EDANZ), a not-for-profit organisation which supports those caring for individuals with eating disorders,[48] submitted recommendations to increase funding for diagnosis training, evidence-based treatment and specialist capacity.[49] However, the Government Inquiry's recommendations made no

45 Strongman, above n 41.

46 Sara J Hansen, Alice Stephan and David B Menkes "The impact of COVID-19 on eating disorder referrals and admissions in Waikato, New Zealand" (2021) 9 J Eat Disord 1 at 7.

47 Strongman, above n 41.

48 Eating Disorder Association New Zealand "About Us" <www.ed.org.nz>.

49 Eating Disorder Association New Zealand "Submission to the New Zealand Government Mental Health Inquiry" at 22.

mention of eating disorders. The Hon Andrew Little MP, the Minister of Health at the time, acknowledged the increase in those seeking eating disorder treatment since COVID-19 and pointed to the government's increased funding to treat mental health and addiction issues.[50] However, Nicki Wilson of EDANZ was quoted as saying that the increase was making no difference to people with eating disorders—for example, EDANZ continued to hear that general practitioners were under resourced and required better knowledge and support regarding eating disorders.[51]

As a result of increased media attention to New Zealand's eating disorder crisis following pandemic restrictions, the Ministry of Health confirmed in July 2021 that it would be speaking with stakeholders in the eating disorder community to "inform policy around future support and treatment".[52] Advocates criticised the Ministry's lack of comment on a funding timeline, stating it was urgent that a strategy be finalised and funded, or else people would die waiting for treatment.[53]

Ministry of Health briefings reveal that eating disorder prevention initiatives were on the government's radar.[54] In August 2021, Philip Grady, then-Acting Deputy Director-General for Mental Health and Addiction, responded to a petition by Rebecca Tom which asked the government to review current eating disorder treatment and develop an action plan to provide treatment resources such as training and funding for health care professionals and funding for a national organisation to provide support services.[55] The Deputy Director-General highlighted the government's "Access and Choice" programme which is "based on a brief intervention model of support",[56] commenting that this programme's early-intervention strategy would prevent eating disorders from escalating to the

50 Strongman, above n 41.

51 Strongman, above n 41.

52 Anna Leask "Eating disorder breakthrough: Govt starts 'work' on desperately needed treatment, service plan" *The New Zealand Herald* (online ed, Auckland, 28 July 2021).

53 Leask, above n 52.

54 Letter from Philip Grady (Acting Deputy Director-General, Mental Health and Addiction, Ministry of Health) to Britney Clasper regarding request for documentation relating to government policy concerning the prevention of eating disorders (14 February 2022) at 3 (Obtained under Official Information Act 1982 Request to the Ministry of Health) [document held by author, available upon request].

55 Philip Grady "Response to Select Committee Submission 2020/83: Rebecca Toms" Health Report: 20211827 at 2 (Obtained under Official Information Act 1982 Request to the Ministry of Health, Document 3) [document held by author, available upon request].

56 Robyn Shearer "Eating disorders health promotion and prevention initiatives" (3 September 2021) Briefing HR20211781 at 4 (Obtained under Official Information Act 1982 Request to the Ministry of Health, Document 4) [document held by author, available upon request].

point of requiring specialist services. As of June 2021, the new programme had delivered over 170,000 sessions. However, the Deputy Director-General did not provide information as to what proportion of patients were seeking help for disordered eating. Additionally, the government intends to roll out increased mental health supports in primary and intermediate schools, including adding eating disorder information on the "Stronger Schools" platform.[57] These measures read well on paper, but the author has been unable to find evidence of their implementation at the time of writing this article. Consequently, while the government is aware of the current eating disorder crisis, it has neglected to create a targeted response.

The government's "prevention initiatives" focus too much on symptom identification and diagnosis, aligning with an early-intervention strategy, as opposed to preventing the emergence of disordered eating behaviours in the first place. A report to the Associate Minister of Health, the Hon Dr Ayesha Verrall MP, indicates that the government is aware of the value in taking a prevention approach. The report states:[58]

> There is a developing evidence base for the effectiveness of health promotion and prevention initiatives for eating disorders which aim to address knowledge, attitudes, behaviours and risk factors associated with eating disorders. Evidence is mainly international, but the evidence from Australia offers insights that could be applied to health promotion and prevention initiatives in a New Zealand context.

Despite the report's ostensible enthusiasm for prevention, such initiatives have been neglected due to the government's focus on early intervention. Consequently, community groups have spearheaded the prevention approach in New Zealand. For example, the Regional Eating Disorders Services, in conjunction with the University of Canterbury and several Nelson intermediate schools, is trialling two versions (one online version for 16–25 year olds and one being delivered through school lessons to Year 8 students) of *Media Smart*, an Australian-developed eight-lesson media literacy programme.[59] The Ministry has no connection to the programme's delivery, which is seeking philanthropic funding to make the programme available to all Year 8 students in Canterbury and Nelson. Interestingly, ministerial briefings state a desire to establish an eating disorder advisory group to collaborate on health promotion and prevention,

57 Shearer, above n 56, at [12]–[13].

58 At [15].

59 At [23]–[25].

education and early intervention.[60] The briefing elaborates that over the longer-term and with more resources, the Ministry could work with sector leaders such as EDANZ in the area of health promotion and prevention initiatives.[61]

The Deputy Director-General cited the "still developing" evidence concerning the efficacy of prevention initiatives as the reason for their apprehension to funding prevention measures.[62] Unfortunately, the same approach is observed internationally. In Australia, for every autistic person, around AUD 32 is spent on research on autism, while just over AUD 1 is spent on eating disorder research per person with an eating disorder, even though autism and eating disorders have similar prevalence.[63] The most recent data from the United States reported comparable figures for research funding, at USD 58.65 for an individual with autism, compared to USD 0.73 per individual with an eating disorder.[64] This lack of research on eating disorders is paradoxical: a lack of research has led to a general dearth of empirical data on the risk factors and efficacy of eating disorder treatments, preventative or otherwise, leading to little scientific evidence for policymakers to rely on.

C A treatment response

The government's low view of the value of a preventative strategy to eating disorders means it is unlikely the government will depart from a treatment-focused approach. The current approach is like an "ambulance at the bottom of the cliff", providing hospital beds to the most malnourished and using the Mental Health (Compulsory Assessment and Treatment) Act 1992 to involuntarily hospitalise and treat patients. This regime reflects the treatment focus of the government's regulatory response to New Zealand's eating disorder crisis. The next part of this article considers the feasibility of a shift from a policy focusing

60 Ministry of Health "Background and talking points regarding Rebecca Tom's petition and oral hearing at Health Committee 8/12/21" at 3 (Obtained under Official Information Act 1982 Request to the Ministry of Health, Document 6) [document held by author, available upon request].

61 Shearer, above n 56, at 7.

62 Ministry of Health "Talking points for eating disorders health promotion and prevention initiatives 6/9/2021" (6 September 2021) at 1 (Obtained under Official Information Act 1982 request to the Ministry of Health, Document 5) [document held by author, available upon request].

63 Eating Disorders Genetics Initiative "The great underfunding of eating disorders research" (22 December 2021) <www.edgi.nz>.

64 Stuart B Murray and others "When illness severity and research dollars do not align: are we overlooking eating disorders?" (2017) 16 World Psychiatry 321 at 321.

on treatment to one focusing on prevention, and the legislative response that would have to come with that shift.

VI The Case for a Preventative Approach

The New Zealand government should prioritise a preventative approach to eating disorders. This part discusses the economics of government intervention to justify intervention and uses Smokefree Aotearoa as a case study to demonstrate how government intervention can lead to successful public health outcomes.

Negative externalities are a kind of market failure that occurs when an economic agent's actions impose a cost on another without compensation.[65] Body dissatisfaction and disordered eating are negative externalities whose costs producers are not internalising. In this analysis an economic agent could be an individual or producer. Here, "producer" refers to the fashion and modelling industry, the entertainment industry, the advertising industry, social media conglomerates, and media outlets who contribute towards popularisation of the thin-ideal. Similarly, "consumers" are the general public who are exposed to "thin-ideal" and "muscular-ideal" messaging. Left alone, producers will continue to produce these negative externalities, such as body-dissatisfaction messaging.

The performance of a market is a function of economic agents' decisions, and thus the government can influence the behaviour of producers and consumers to achieve desired outcomes.[66] New Zealand's response to cigarette smoking is a useful example of a government-led intervention to correct a market failure: cigarette use causing lung cancer and cigarette mortality.[67] In 1985, New Zealand introduced a nationwide Tobacco Control Programme (TCP) with the goals of reducing tobacco harm by reducing smoking in general, as well as smoking amongst youth, Māori and lower income groups in particular, reducing exposure to second-hand smoke, and decreasing cigarette mortality.[68] The TCP included the Smokefree Environments and Regulated Products Act 1990, which increased taxes on tobacco, created more legally mandated smokefree environments, introduced health warnings on cigarette packets, banned advertising and sponsorship from tobacco companies, and restricted adolescent access to tobacco products. Over the period from 1981–1996, tobacco product consumption almost

65 Joseph Boniface Ajefu and Faith Barde "Market Efficiency and Government Intervention Revisited: What Do recent Evidence Tell Us?" (2015) 3 Int J Bus Econ 20 at 21.

66 Mrinal Datta-Chaudhuri "Market Failure and Government Failure" (1990) 4 JEP 25 at 25.

67 Murray Laugesen and Boyd Swinburn "New Zealand's tobacco control programme 1985-1998" (2000) 9 Tobacco Control 155 at 156.

68 At 155.

halved in New Zealand.[69] Furthermore, in 2010, the government introduced Smokefree Aotearoa 2025, following a Māori Select Committee inquiry which found that while overall smoking rates continued to decline, they were increasing among Māori and Pacific peoples.[70] By expanding Māori leadership in the Smokefree policy-making space, Māori smoking rates have declined from 40.2 per cent in 2011/2012 to 13.4 per cent in 2019/2020.[71] In this instance, law and policy proved to be a powerful tool for promoting public health and prevention of a negative externality.

The establishment of Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (the Māori Health Authority) reflects the increasing importance placed on both preventative approaches to public health and on improving Māori health outcomes to ensure everyone has the same access to good health outcomes.[72] The foundations of New Zealand's new health system are outlined in the Pae Ora (Healthy Futures) Act 2022, which states that adopting preventative health approaches is a health sector principle.[73] When performing a function or exercising a power or duty under the Act, the Minister of Health is required to consider the health sector principles "as far as reasonably practicable".[74] Many governments around the world rely on interventional public health laws to address health conditions and risk factors, and empower agencies to implement policy action.

However, such policies ought to be grounded in empirical evidence to ensure success in correcting negative externalities. A 2009 study on public health laws analysed 65 reviews on the effectiveness of 52 public health laws.[75] The study found that of these 52 laws, 27 were effective, 23 had insufficient evidence to judge effectiveness, one was harmful to public health and one was ineffective. The study highlights the potential for policy to have an impact in improving public health outcomes, while warning that poorly crafted policy can instead have middling or even harmful effects.

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69 At 156.

70 Māori Affairs Committee *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori* (November 2010) at 12.

71 Ministry of Health "History of Smokefree Aotearoa 2025: Progress to Smokefree 2025" <www.health.govt.nz>.

72 Department of the Prime Minister and Cabinet "Te Aka Whai Ora / Māori Health Authority" Future of Health <www.futureofhealth.govt.nz>.

73 Section 7(1)(e)(i).

74 Section 7(2).

75 Anthony D Moulton and others "The Scientific Basis for Law as a Public Health Tool" (2009) 99 Am J Public Health 17.

VII Policy Responses

This part evaluates various initiatives from around the world that may directly or indirectly reduce eating disorder incidence. The initiatives are categorised under three headings: awareness and education, early intervention, and targeting the causes of body dissatisfaction. After evaluating these policies, this part will go on to propose an eating disorder prevention policy response for New Zealand.

A Awareness and education

The United States has been a frontrunner in proposing legislation to improve eating disorder awareness. For example, the Supporting Eating disorders Recovery through Vital Expansion Act (SERVE Act) would have required military leaders to be trained to recognise the signs of eating disorders in service members.[76] However, the SERVE Act was referred to the Committee on Armed Services in 2019 and there has been no further action since.[77] Another example is House Bill 2158 in Pennsylvania, which seeks to amend the Public School Code of 1948 by providing for parent educational information regarding eating disorders on an annual basis.[78] The Bill has been with the Education Committee since December 2021. The Bill's memorandum mentions the scientifically proven connection between media exposure, body dissatisfaction and eating disorders.

Pennsylvania is following in the footsteps of Virginia, which in 2013 became the first state to enact mandatory eating disorder education into law.[79] House Bill 1406 amended the Code of Virginia to require schools to provide parents educational material on eating disorders to pupils in Grades 5–12.[80] Examples of the kinds of material provided to parents include descriptions of eating disorders and symptoms, and a statement as to the importance of early detection. The impact of the law on administrative costs for the state to conform

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76 Supporting Eating disorders Recovery through Vital Expansion Act 2019, HR 2767, 116th Cong, § 6.

77 "S.2673 - SERVE Act" (23 October 2019) Congress.gov <www.congress.gov>.

78 An Act amending the act of March 10, 1949 (PL30, No 14), known as the Public School of Code of 1949, in school health services, providing for parent educational information regarding eating disorders 2021, HB 2158, RS 2021–2022 (Penn). The Bill was referred to the Education Committee on 13 December 2021.

79 Behavioral Healthcare Executive "Virginia becomes first state to enact eating disorder education law" (29 March 2013) HMP Global Learning Network <www.hmpgloballearningnetwork.com>.

80 An Act to amend the Code of Virginia by adding a section numbered 22.1-273.2, relating to parent educational information; eating disorders, HB 1406, S 2013 (Va), which was enacted as Va Code Ann § 22.1-273.2.

with the legislation was deemed nominal and no budget amendment was necessary.[81]

While no empirical data exists on the efficacy of the Virginia legislation, the policy is likely effective because it equips parents to recognise signs of disordered eating. Parents are in a unique position to notice changes in their child's behaviours, such as if the child begins to talk more about weight or stops eating foods they used to enjoy. The materials parents receive mitigates the stigma around eating disorders by describing them as "serious health problems that … affect both girls and boys".[82] Furthermore, the material itself is practical, providing concise checklists of risk factors and key things to look out for. It also advises parents on how to communicate with their child, and to contact a medical professional if concerned their child has an eating disorder, rather than "waiting it out".

A limitation of this policy is that education is confined to parents. Ideally, students themselves should also be taught to recognise disordered eating among their peers, as a parent's ability to do so is limited to the home environment. As students age and gain independence, they become more difficult for parents to monitor. Conversely, peers implicitly supervise one another's behaviours during school hours. An individual engaging in disordered eating behaviours may also feel more comfortable with a friend rather than a parent expressing concern towards them, as they may perceive the latter interaction as an intrusion on their independence.

Overall, initiatives targeting raised awareness are valuable. Practically, they equip parents and fellow students—two major stakeholders in an adolescent's life—at nominal cost with the knowledge to identify disordered eating behaviours and to act accordingly. Education must be a primary component of a prevention response in New Zealand; indeed, Part VII of this article argues that eating disorder education should be integrated into the New Zealand health curriculum.

B Early intervention

At the United States federal level, the Eating Disorder Prevention in Schools Act of 2020 was introduced in Congress in May 2020.[83] The Bill sought to amend the

81 Virginia Department of Planning and Budget "2013 Fiscal Impact Statement" (Bill No HB1406, 18 December 2013).

82 Scott County Schools "Eating Disorders: Scott County School Policy" <www.scottschools.com>.

83 Eating Disorder Prevention in Schools Act of 2020, HR 6703, 116th Cong.

Richard B Russell National School Lunch Act by requiring local education agencies that participate in school breakfast or lunch programmes to include goals for reducing disordered eating in children in their local school wellness policies.[84] The Bill also encouraged more frequent screening for eating disorders in schools. Although the Bill was not moved out of committee, as at the time of writing this article Congresswoman Alma Adams intends to introduce it again in the future.[85]

The Bill is aspirational yet lacks specificity. Its goal to reduce disordered eating is commendable, but it does not provide guidance as to what policies schools should introduce to reduce disordered eating beyond merely encouraging screening. The Bill does mandate involving registered dietitians and licensed mental health professionals in developing a response but is silent on how this involvement will be achieved. Furthermore, delegating the creation of prevention policies to professionals who typically focus on diagnosis and treatment, without any resourcing, is unlikely to be successful. Notwithstanding these practical implementation challenges, the screening that the Bill encourages has at least been endorsed as an effective eating disorder tool (further explained below).

Screening is a tool to make individuals aware of the significance of their symptoms and is generally accepted as a crucial first step in intervention. One study in collaboration with the National Eating Disorders Association had over 70,000 respondents complete an online screener over six months, with the majority screening positive for a clinical eating disorder.[86] The National Eating Disorders Screening Program (NEDSEP) in 2000 remains the only national screening programme to have been conducted in the United States.[87] Although the programme was considered successful, Rindahl noted how researchers deemed the EAT-26 screening questionnaire as too lengthy and an administrative burden in a time where the availability of technology in schools was much poorer. A literature review by Rindahl assessed 180 articles on screening for eating disorders amongst adolescents from 1999 to 2015 and found that the SCOFF

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84 Richard B Russell National School Lunch Act 1946 79 Pub L No 396, 60 Stat 230.

85 Email from Richa Patel (Legislative Correspondent for North Carolina Congresswoman Alma Adams) to Britney Clasper regarding the Eating Disorder Prevention in Schools Act of 2020 (28 March 2022) [document held by author, available upon request].

86 Ellen E Fitzsimmons-Craft and others "Results of disseminating an online screen for eating disorders across the U.S.: Reach, respondent characteristics, and unmet treatment need" (2019) 52 Int J Eat Disord 721 at 721.

87 Kathleen Rindahl "A Systematic Review of Literature on School Screening for Eating Disorders" (2017) 5 Int J Health Sci 1 at 2.

questionnaire is the most useful screening tool.[88] The SCOFF questionnaire comprises five yes-or-no questions; two or more affirmative answers indicates eating disorder risk, and its brevity means students can complete it quickly.

The ubiquity of information technology in modern schooling means accessing an online questionnaire is no longer a significant issue. However, nothing prevents a student from lying on a screening to disguise their disordered eating habits. Eating disorder sufferers enjoy the control eating disorders seem to afford them, and a screener could be viewed as a threat to that sense of control. Consequently, the use of screening tools may be more effective as part of a broader education initiative, where students are first taught about the long-term implications of having an eating disorder. Awareness of the social, economic and health consequences of disordered eating may provoke honest answers.

While early intervention through initiatives such as screening are invaluable in stopping disordered eating habits from becoming entrenched, they are not as effective as prevention in the first place. The next section considers preventative policy responses aimed at suppressing variables which contribute to body dissatisfaction—an indisputable risk factor for the development of disordered eating behaviours.

C Targeting the causes of body dissatisfaction

Myriad legislation, regulation and other policies have been implemented or proposed around the world which target the causes of body dissatisfaction. This section evaluates nine such policies: reducing diet pill sales, clothing size availability, limiting advertisements, Body Mass Index (BMI) bans, protective factor programmes, warning labels, taxation, codes of conduct and voluntary certification programmes.

1 Diet pill sales

Diet pills are a major problem in the United States. By 2024, the value of the United States' dietary supplement market is expected to reach USD 56.7 billion, and studies have shown that 11 per cent of adolescents have used weight-loss pills in their lifetime—a figure comparable to adult use.[89] California Assemblywoman Cristina Garcia proposed Assembly Bill 1341 to require a

88 At 3. See also John F Morgan, Fiona Reid and J Hubert Lacey "The SCOFF questionnaire: a new screening tool for eating disorders" (2000) 173 WJM 164 for the article that first proposed the SCOFF questionnaire.

89 Jason Nagata and S Bryn Austin "Diet pills are incredible dangerous for teens. California needs to regulate them like cigarettes" *San Francisco Chronicle* (online ed, San Francisco, 12 January 2022).

prescription for minors to purchase weight-loss or over-the-counter diet pills online or in store.[90] The Bill was supported by Professor S Bryn Austin of Harvard Medical School, whose research found that young women who used diet pills and laxatives for weight control had a higher probability of subsequent eating disorder diagnosis within one to three years than those who did not use such products.[91]

There is a lack of data concerning the prevalence of diet pill use in New Zealand. However, there is less impetus for legislation like Assembly Bill 1341 as diet pills are less accessible: only four are approved for sale, with three being prescription-only and the fourth requiring assessment by a pharmacist.[92] For completeness, the Medicines Act 1981 currently regulates prescription and pharmacist diet pills in New Zealand, but it is set to be replaced by the omnibus Therapeutic Products Act 2023 which will not materially change access to these diet pills.[93] Overall, New Zealanders' limited access to diet pills suggests that diet pill use amongst young people is low.

2 Clothing size availability

Argentina has the second highest rate of eating disorders in the world, with at least 29 per cent of Argentines having an eating disorder.[94] Clothing sizes in retail shops were recognised as a contributor to eating disorder prevalence, as many stores sold clothing that only 30 per cent of women could fit into.[95] As a response, the "Sizes Law" was enacted in December 2005, requiring retailers to

90 An act to add Section 110423.7 to the Health and Safety Code, relating to public health 2021, AB 1341, RS 2021–2022 (Calif). The Bill was passed by the California legislature but vetoed by Governor Gavin Newsom.

91 Nearly six times more likely than peers who did not use these products to be diagnosed with an eating disorder within one to three years of beginning use of these products.

92 Health Navigator "Common questions about weight loss medicines" Healthify <www.healthify.nz>.

93 Therapeutic Products Act 2023, pt 11 sub-pt 4.

94 Vanessa Rivera de la Fuente "Argentine Legislators Consider Law to Regulate Clothing Sizes, Advocates Promote Positive Body Image" (28 November 2012) Global Press Journal <www.globalpressjournal.com>.

95 Marilyn Krawitz "Beauty is only photoshop deep: Legislating models' BMIs and photoshopping images" (2014) 21 J Law Med 859 at 869.

stock a full range of clothing sizes equivalent to United Kingdom sizes 10–20,[96] but Tucker's thesis indicates that the law has had little effect.[97]

Clothing size availability in New Zealand is not an issue to the same extent as in Argentina. Most stores go up to a size 16, which is the average size for women in New Zealand. Additionally, unlike Argentina, the number of brands making clothes larger than size 16 is increasing due to a stronger culture of inclusive fashion. For example, locally owned brand "Ruby" began stocking clothing up to size 24 in 2021.[98] Therefore, the need for a strong policy response targeting clothing size availability is minimal.

3 Limiting the advertisement of certain products

In 2010, the Spanish government identified advertising as a force pushing the public into eating disorders.[99] The General Audiovisual Communication Law (Audiovisual Law) was enacted, prohibiting the advertisement of products promoting the "cult-of-the-body" and "rejection of self-image" during minor protection hours (before 10 pm).[100] The Audiovisual Law was amended to remove the "minor protection hours" limitation in July 2022, such that the ban applies absolutely. The absolute prohibition in Article 124 states that:[101]

> 1. Audiovisual commercial communications must not cause physical, mental or moral harm to minors or incur in the following conduct:
>
> […]
>
> (g) promote body worship and the rejection of self-image through audiovisual commercial communications of slimming products, surgical interventions or aesthetic treatments, which appeal to social rejection due to physical condition, or success due to weight aesthetic factors.

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96 This law, which covers the Buenos Aires province, was followed in 2019 by a state-level law along the same lines in 2019: see Sistema Único Normalizado de Identificación de Talles de Indumentaria (Single Standardized Clothing Size Identification System) Law No 27,521, 20 December 2019.

97 Ann Robin Tucker "Body Modification and Body Image Among Argentines: The Prevalence of Plastic Surgery and Eating Disorders in Buenos Aires" (BA Thesis, University of Mississippi, 2010) at 45.

98 Kirsty Lawrence "Ruby releases clothing line with larger size range, and zero waste" (30 September 2021) Stuff <www.stuff.co.nz>.

99 Giles Tremlett "Spain curbs 'body image' ads on television" *The Guardian* (online ed, London, 18 January 2010).

100 "Legislación Consolidada: General de la Comunicación Audiovisual (Consolidated Legislation: General Law of Audiovisual Communication)" (1 April 2010) *Boletín Oficial Del Estado* BOE-A-2010-5292.

101 Article 124(1)(g).

The burden of compliance is placed upon audiovisual communication service providers, defined as services with editorial responsibility through electronic communication networks and programs with the aim of informing, entertaining or educating the public, as well as broadcasting audiovisual commercial communications.[102] The prohibition is limited to services which are established in Spain, which covers entities whose headquarters are in Spain.[103]

Although "body worship" is only a small aspect of the Audiovisual Law, one can infer the law was passed as an attempt to improve Spanish citizens' body image. The law is a unique intervention by the government, but the efficacy of the law is limited in that it only applies to audiovisual communications by Spanish-based services, whereas the Internet and globalisation allows Spaniards to access content from almost any country. Globalisation allows people to access almost any jurisdiction's channels from almost anywhere. Nonetheless, there are yet to be any proceedings brought for breach of Article 124, which suggests the services are complying with the law. The Ministry of Economic Affairs and Digital Transformation is tasked with bringing proceedings and the National Commission of Markets and Competition with supervising compliance.[104] A failure to comply with Article 124 is deemed a serious offence under Article 158. Article 160 stipulates fines which depend on the service provider's income, ranging from up to €30,000 for services which earn less than €2,000,000 and up to 1.5 per cent of income (with a maximum of €750,000) accrued in the year prior to the breach where income is greater than €50,000,000.

In New Zealand, it is uncommon to see advertisements of slimming products or aesthetic treatments on television. Further, the Advertising Standards Authority's "Therapeutic and Health Advertising Code" sets out stringent content guidelines which, amongst other things, prohibit dietary supplements advertisements from making weight loss claims.[105] Although compliance with Authority's advertisement decisions is voluntary, the ASA has a high compliance rate as decisions are released to the media and "negative publicity is a driver for compliance".[106] Consequently, a New Zealand law analogous to Spain's Audiovisual Law is unlikely to have a tangible impact on eating disorder prevalence. A policy response ought instead to focus on targeting more

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102 Article 2.

103 Article 3.

104 Article 155.

105 Advertising Standards Authority "Therapeutic and Health Advertising Code" <www.asa.co.nz>.

106 Advertising Standards Authority "What happens if an advertisement is found to be in breach of a Code?" <www.asa.co.nz>.

significant causes of body dissatisfaction, such as the use of unrealistic bodies in advertisements.

4 Bans on the body mass index

Minimum BMI thresholds are a policy response aimed at targeting the portrayal of unattainable bodies in the media. Spanish fashion administrators were the first to introduce bans on models with BMIs under 18.5 at Madrid Fashion Week in 2006.[107] Italian fashion administrators followed suit, requiring models to have a BMI of at least 18 to participate in fashion shows. However, anecdotal reports concluded officials did not enforce the obligations. Furthermore, BMI is criticised as a siloed approach to measuring one's health, with a 2012 study finding that it incorrectly identified 30 per cent of those measured as obese.[108] The medical community has also criticised BMI due to its inability to consider cartilage, water, muscle, race, age or gender.[109] New Zealand policymakers should not endeavour to define "health" as a single metric in a policy response that targets causes of body dissatisfaction.

5 Protective factor programmes

Given the correlation between media use and body dissatisfaction, media education is a plausible means to prevent eating disorders. Media literacy is a "protective factor" which can disrupt risk factors (such as social media exposure) by teaching social media users to be more critical about what they are viewing.[110]

A literature review of 42 articles describing 39 studies examined the success of various eating disorder programmes and lifestyle interventions.[111] The review was prompted by studies which showed that girls and boys were significantly invested in thin and muscular ideals by 5–9 years old.[112] These studies reiterate that preadolescence is an important age for prevention initiatives before weight-loss behaviours and cognitions become entrenched. Across the reviewed studies, the implementation of protective factor education showed a

107 Krawitz, above n 95, at 869.

108 Nirav R Shah and Eric R Braverman "Measuring Adiposity in Patients: The Utility of Body Mass Index (BMI), Percent Body Fat, and Leptin" (2012) 7 PLoS ONE 1 at 1.

109 Marilyn Bromberg and Cindy Halliwell "'All About That Bass' and Photoshopping a Model's Waist: Introducing Body Image Law" (2016) 18 UNDALR 1 at 12.

110 Jake Linardon "Positive body image, intuitive eating, and self-compassion protect against the onset of the core symptoms of eating disorders: A prospective study" (2021) 54 Int J Eat Disord 1967 at 1968.

111 Kirrilly M Pursey and others "Disordered eating, body image concerns, and weight control behaviours in primary school aged children: A systematic review and meta-analysis of universal-selective prevention interventions" (2021) 54 Int J Eat Disord 1730 at 1730.

112 At 1732.

trend towards a reduction in risk factors and an increase in positive body image.[113] The programmes themselves were variable, with the most promising being the interactive learning opportunities (such as guided group discussions and role-play) and gender-specific initiatives (such as sessions focussed on masculine and thin stereotypes for boys and girls, respectively). While the New Zealand government has acknowledged the potential of literacy initiatives, such as *Media Smart*, in their internal policy documents, the need for clarity regarding what constitutes an effective programme has also been highlighted.[114]

The World Health Organisation has called for more research on what differentiates successful and unsuccessful protective factor programmes.[115] While studies have shown empirical support for decreasing the internalisation of idealised body types, they have not found direct evidence for reduced eating disorder onset following the workshops. Furthermore, it is problematic that companies can continue their advertising practices of presenting unattainable and unrealistic body imagery, while the onus of reducing eating disorders is placed on children to understand that they are being manipulated and on the government to resource workshops. A stronger intervention into company advertising practices is warranted to address body dissatisfaction.

6 Warning labels

The most eminent example of a legislative attempt to address body dissatisfaction is Israel's The Law Restricting Weight in the Modelling Industry 2012, commonly known as the "Photoshop Law".[116] The Act took effect in January 2013 and was "designed to minimize the negative impact of exposure to advertisements depicting models as extremely thin on positive body image and self esteem and on the development of eating disorders in Israel".[117] The Act requires models to obtain certification that they have a minimum 18.5 BMI three months prior to a shoot or filming.[118] The Act also requires that if a model is photoshopped to make them appear thinner, a clearly visible statement, at least seven per cent of the image size, must be inserted as a disclaimer the image has

113 At 1762.

114 Shearer, above n 56, at 6.

115 World Health Organisation *Prevention of Mental Disorders: Effective Interventions and Policy Options* (Summary Report, 2004).

116 The Law Restricting Weight in the Modelling Industry, 5772–2023, SH 2347 229 (Israel).

117 Krawitz, above n 95, at 867.

118 The Law Restricting Weight in the Modelling Industry, s 1.

been modified.[119] A breach of the Photoshop Law incurs civil liability.[120] In addition to the civil claim, Israel's Ministerial Committee for Legislation recently approved an amended version of the Photoshop Law to fine publications which fail to attach clear warnings to altered photos.[121]

Multiple issues with the Act exist, even beyond the use of BMI as a health measure. First, parents likely prefer to devote resources to helping their child recover from an eating disorder, rather than suing the entities which caused the eating disorder. Secondly, it is difficult to prove that a particular advertisement partially or wholly contributed to an eating disorder. Thirdly, models can simply slim down in the three-month period between the certification and relevant shoot or film or move to another country. Finally, the law has been criticised as being unfair to naturally thin models who may lose their jobs if they choose to stay in Israel. These issues likely explain why there is no evidence of a lawsuit being brought under the Photoshop Law.

Warnings are not the right way to target body dissatisfaction, as they do not prohibit the continued use of a preferred body type or the alteration of a model's body. This conclusion is reinforced by five studies yielding little support for the use of media warning labels.[122] Only one study concluded that warning labels prevented an increase in body dissatisfaction.[123] Most studies found that the warnings had either no effect on body dissatisfaction or led to greater body

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119 Section 3.

120 Krawitz, above n 95, at 868.

121 Eran Swissa "Israel's Ministerial Committee for Legislation approves upgraded 'Photoshop Law'" *Jewish News Syndicate* (online ed, Tel Aviv, 7 February 2022).

122 Mun Yee Kwan and others "Warning labels on fashion images: Short- and longer-term effects on body dissatisfaction, eating disorder symptoms, and eating behaviour" (2018) 51 Int J Eat Disord 1153 at 1154. The five studies which concluded there was little support for the use of media warning labels were Rheanna N Ata, J Kevin Thomspon and Brent J Small "Effects of exposure to thin-ideal media images on body dissatisfaction: Testing the inclusion of a disclaimer versus warning label" (2013) 10 Body Image 472; Belinda Bury, Marika Tiggemann and Amy Slater "Disclaimer labels on fashion magazine advertisements: Impact on visual attention and relationship with body dissatisfaction" (2016) 16 Body Image 1; Belinda Bury, Marika Tiggemann and Amy Slater "The effect of digital alteration disclaimer labels on social comparison and body image: Instructions and individual differences" (2016) 17 Body Image 136; David A Frederick and others "Reducing the negative effects of media exposure on body image: Testing the effectiveness of subvertising and disclaimer labels" (2016) 17 Body Image 171; and Marika Tiggemann and others "Disclaimer labels on fashion magazine advertisement: Effects on social comparison and body dissatisfaction" (2013) 10 Body Image 45.

123 Kwan and others, above n 122, at 1154. For the study that concluded that warning labels prevented an increase in body dissatisfaction, see Amy Slater and others "Reality Check: An Experimental Investigation of the Addition of Warning Labels to Fashion Magazine Images on Women's Mood and Body Dissatisfaction" (2012) 31 J Soc Clin Psychol 105.

dissatisfaction than images without labels.[124] Researchers have attempted to explain this backfire effect; it is generally thought the inclusion of warning labels directly increases attention to idealised images whereby even the models are not 'ideal' enough. Overall, it is arguable that warning labels do not actually promote change in beauty standards, but simply draw more attention to them.[125] Furthermore, like media literacy, warning labels focus on the *audiences* of publications. Their dubious efficacy adds weight to the argument that the *sources* of the publications ought to be the target of a policy response instead.

7 *Taxation*

Policymakers have suggested that taxes on sources of body dissatisfaction could correct the negative externalities they cause.[126] For example, a direct sales tax on advertisements using digitally altered images would theoretically incentivise advertisers to use unedited images to reduce their costs. However, consumers would likely be unable to tell which publications were subject to the tax, meaning the images would still cause harmful body idealisation.

While a direct sales tax is a "stick" approach in that it penalises those purchasing publications with digitally altered images, a tax credit is a "carrot" approach in that it rewards companies for renouncing the use of digitally altered images. In 2019, Representative Kay Khan proposed a Bill in the Massachusetts Legislature to offer a tax credit of up to USD 10,000 for cosmetic, personal care, and apparel companies who refrain from using digitally altered advertisements.[127] Progress on the Bill has stalled since it was accompanied with a study order in February 2020.[128] In principle, incentivising companies not to digitally alter images is useful. However, for many companies, a tax credit is unlikely to be worth overhauling their marketing strategy.

A third kind of tax was proposed by the Royal College of Psychiatrists in the United Kingdom: a "turnover tax" on social media companies to fund

124 Kwan and others, above n 122, at 1154.

125 Caitlin McBride, Nancy Costello and Suman Ambwani "Digital Manipulation of Models' Appearance in Advertising: Strategies for Action Through Law and Corporate Social Responsibility Incentives to Protect Public Health" (2019) 45 Am J Law Med 7 at 12.

126 At 20.

127 An Act relative to mental health promotion through realistic advertising images 2020, H 3892, S 191 (Mass) § 1; and see Tessa Yannone "This New Bill Incentivizes Companies to Use Unedited Images of Models" *Boston Magazine* (online ed, Boston, 31 May 2019).

128 See the Bill's progress on the Massachusetts legislature website: "Bill H.3892" Commonwealth of Massachusetts <malegislature.gov/191/H3892>.

research into the impact of harmful internet content on users.[129] The Royal College of Psychiatrists has also called for the compulsory sharing of data from social media companies with universities to supplement this research. Taxation of the "digital economy" is a difficult issue which requires international cooperation.[130] Nonetheless, France demonstrated the concept was possible when it imposed a three per cent levy on digital service companies earning over €25 million in France and €750 million worldwide.[131] However, the tax was met with retaliatory threats by the United States, where most social media companies are based, to impose a 100 per cent tariff on champagne and French luxury goods.[132] Consequently, taxing social media companies to fund eating disorder research is likely unsuitable due to New Zealand's relatively small economy and political power on the international stage. The challenges of using taxation to change the behaviour of sources of eating disorders who use altered images render this government intervention an unattractive avenue to target body dissatisfaction.

8 Industry codes of conduct

Industry self-regulators across jurisdictions have increasingly focused their efforts on controlling digitally altered images. In many countries, such as the United Kingdom, Australia, Ireland and New Zealand, Advertising Standards Authorities (ASAs) are used to independently regulate advertising across all media channels.[133] ASAs create voluntary conduct codes prescribing approved practices and investigate consumer complaints regarding harmful, offensive or misleading advertisements. ASAs do not typically levy fines but rely on negative publicity to incentivise compliance with publicly released decisions.[134] The Commerce Commission in New Zealand can prosecute advertisers for misleading and deceptive conduct. Compliance with the codes is generally seen as a means for businesses to insulate advertisers from claims brought by

129 Bernadka Dubicka and Louise Theodosiou *Technology use and the mental health of children and young people* (Royal College of Psychiatrists, College Report CR225, January 2020) at 6.

130 Josh Kallmer "Digital Tax: The Critical Importance of a Multilateral Approach" (14 December 2017) German Marshall Fund of the United States <www.gmfus.org>.

131 Leigh Thomas "France orders tech giants to pay digital tax" (26 November 2020) Reuters <www.reuters.com>.

132 Pinsent Masons "France to resume collection of digital tax" (4 December 2020) <www.pinsentmasons.com>.

133 McBride, Costello and Ambwani, above n 125, at 13.

134 See for example Advertising Standards Authority "About Complaints: Why are there no fines to make advertisers take down the advertisement if the complaint is upheld?" <www.asa.co.nz>.

government agencies.[135] The United Kingdom ASA took action in 2011 to investigate and discipline doctored images.[136] Two celebrity advertisements were investigated for being misleading: Lancôme's "Teint Miracle" and Maybelline's "The Eraser". The ASA concluded the advertisement did not accurately illustrate the effect that could be achieved by the product.[137]

While the ASA's intervention was seen as a sea change for digitally altered images, "misleading" has since proven a high threshold to meet, as advertisers can mitigate their liability by using "actual product results may vary" disclaimers. Furthermore, ASA action for "misleading" advertisements is confined to industries where a product is presented as having a certain effect, such as cosmetics. Thus, the possibility of being subject to ASA intervention for "misleading" advertising does not necessarily stop companies from using unrealistic bodies.

It is misguided to believe the industry alone can successfully achieve reform of advertising ethics. Yet there is a powerful counterexample: Australia's ASA equivalent—The Australian Association of National Advertisers (AANA)—upheld its first complaint relating to unrealistic body ideals in early 2019.[138] Rule 2.6 of the AANA's Code of Ethics states: "Advertising shall not depict material contrary to Prevailing Community Standards on health and safety."[139] The AANA's Code of Ethics Practice Note, a guide to interpretation of the Code of Ethics, states that r 2.6 should be interpreted to include the following prohibition: "Advertising must not portray an unrealistic ideal body image by portraying body shapes or features that are unrealistic or unattainable through healthy practices."[140] The Community Panel, tasked with reviewing complaints from the community about advertisements, stated that while it could not judge whether the female model in a Calvin Klein underwear advertisement was healthy or not, it was deemed irresponsible due to the model's significant thigh gap, visibility of her ribs and collarbones, and the thinness of her upper arms and wrists. Calvin Klein responded by changing the image, evidencing that

135 McBride, Costello and Ambwani, above n 125, at 17.

136 Krawitz, above n 95, at 869.

137 Mark Sweney "L'Oréal's Julia Roberts and Christy Turlington ad campaigns banned" *The Guardian* (online ed, London, 27 July 2011).

138 Australian Association of National Advertisers "AANA's Body Image Rules in action" (17 September 2020) <www.aana.com.au>.

139 Australian Association of National Advertisers *Code of Ethics* (February 2021) at 3.

140 Australian Association of National Advertisers *Code of Ethics - Practice Note* (February 2021) at 12.

it is not impossible to formulate policies that target advertisements which contribute to the "thin-ideal" for women or the "muscular-ideal" for men.

AANA's Code of Ethics has been more successful in regulating the advertising industry than the Australian government-led Voluntary Industry Code of Conduct on Body Image, introduced in 2009.[141] Guidelines include the hiring of models in the fashion industry who are "clearly of a healthy weight" and over 16 years old. The Code also states images should not be digitally altered to the point that bodies look "unrealistic or unattainable through healthy practices". The Code has been criticised as there is no entity empowered to encourage or enforce compliance.[142] A one-off study found that only one of seven Australian magazines complied with the Code fully.[143] Baffsky has suggested a mandatory code ought to be adopted which also prohibits journalists from using derogatory language when reporting on eating disorders.[144]

Critics argue self-regulation is a slow-moving, unreliable option as there are no specific sanctions or enforcement means.[145] While the 2019 Calvin Klein AANA decision is an example of a business responding to an adverse finding, businesses can choose not to comply. Unfortunately, without the publicity of an investigation and determination, businesses will continue using unrealistic body imagery as the perceived economic benefit of potentially harmful business practices currently outweighs the public health costs.[146] This is supported by a 2021 study that found that switching to more authentic and realistic advertisements is not necessary for a brand's success.[147] Brands are unlikely to change the use of harmful body imagery of their own accord and self-regulation has had very limited success.

9 Voluntary certification

Several authors have proposed a voluntary certification scheme to recognise businesses that comply with practices to reduce body dissatisfaction, such as not

141 Australian Government *Voluntary Industry Code of Conduct on Body Image* (A10-0361, 2016).

142 Bromberg and Halliwell, above n 109, at 9.

143 Elizabeth Reid Boyd and Jessica Moncrieff-Boyd "Swimsuit issues: promoting positive body image in young women's magazines" (2011) 22 Health Promot J Aust 102 at 102.

144 Baffsky, above n 9, at 2.

145 Ian Ayres and John Braithwaite *Responsive Regulation: Transcending the Deregulation Debate* (Oxford University Press, New York, 1992) at 44.

146 McBride, Costello and Ambwani, above n 125, at 18.

147 Allyssa Compton "Does Body Positivity Yield Positive Attitudes? The Effects of Female Empowerment in Advertisements on Consumer Perceptions" (Senior Honors Project, University of Lynchburg, 2021).

using digitally manipulated images and using a realistic and diverse range of models in advertising.[148]

B Corp is a notable example of a voluntary certification scheme. To receive B Corp Certification, a business has to meet high standards of social and environmental performance, exhibit transparency about their performance and legally commit to a corporate governance structure that requires accountability to both shareholders and stakeholders.[149] The certification has grown in popularity since its 2007 launch—for example, Sir Richard Branson launched the "B Team" in 2013 to shift his corporation's focus away from short-term profit.[150] A study found there were two key reasons for seeking B Corp status: proving a business is a genuine advocate for stakeholder benefits within the "greenwash revolution", and the fact that "the major crises of our time are a result of the way we conduct business".[151] While B Corp status is not contingent on an entity avoiding use of altered images or idealised body types, the concept illustrates how voluntary certification schemes can influence businesses to adopt more socially conscious practices.

The launch of a new "badge" to certify that a brand takes measures in its advertising to prevent body dissatisfaction would take time to gain traction. B Corp was launched in 2006 and took over a decade to gain increased recognition.[152] New Zealand's eating disorder crisis necessitates consideration of swifter alternatives to producing a novel "badge". For example, policymakers could work with B Corp to amend their standards to require brands to refrain from digitally altering images which contribute to unrealistic body ideals. In a survey on social responsibility, 81 per cent of respondents stated it is important for them to purchase from brands that align with their social values.[153] The invisibility of eating disorders has hindered the inclusion of image altering in the context of corporate social responsibility. Including this in a B Corp certification will influence broader social values and raise awareness of the harms caused by advertisements that contribute to body dissatisfaction.

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148 McBride, Costello and Ambwani, above n 125, at 22.

149 B Corporation "About B Corp Certification: Measuring a company's entire social and environmental impact" <www.bcorporation.net>.

150 Suntae Kim and others "Why Companies are Becoming B Corporations" (17 June 2016) Harvard Business Review <www.hbr.org>.

151 Kim and others, above n 150.

152 B Corporation "How did the B Corp movement start?" <www.bcorporation.net>.

153 Shelley E Kohan "Customers Seek Purpose Driven Companies Creating A Rise in B Corps" *Forbes* (online ed, Jersey City, 28 March 2021).

10 Summary on approaches to targeting the causes of body dissatisfaction

In summary, regulation of diet pills and clothing size availability are not useful approaches to targeting the causes of body dissatisfaction in the New Zealand context, due to sufficient extant regulation and a more inclusive sizing culture. A ban on advertising slimming products or aesthetics treatments is also unnecessary given the ASA already enforces its stringent guidelines, with high compliance across the advertising industry. Adopting a minimum BMI for models has been criticised due to contention that BMI is a poor measure of health. Taxation of social media outlets faces a myriad of issues, most notably the global nature of social media which complicates enforcement. Further, voluntary industry codes will not have a significant impact as there is no economic incentive for brands to change their approach to advertising. Notwithstanding this, voluntary certification may prove particularly effective to influence broader social values and give socially conscious consumers a way to support brands which do not alter images. Further, warning labels and media literacy can be criticised for shifting the onus onto the audience to understand they are being manipulated. However, there is a case for more overt action to be taken as effective prevention measures, such as banning manipulated images and educating young New Zealanders on eating disorder symptoms.

VIII Conceptualising a New Zealand Approach

The final part of this article draws from the discussion in Part VI to devise an approach to eating disorder prevention policies tailored to the New Zealand context. While a critical first step is to fund research to remedy the lack of data on the efficacy of different policies, this part discusses various other initiatives which should be implemented.

A National strategy and funding

First and foremost, the New Zealand government must clarify how it will tackle eating disorders. In 2018, Rodgers and Sonneville pointed out the lack of substantial research aimed at informing strategies for regulating risks associated with eating disorders, as well as research into the influence of legislative efforts on eating disorder cognitions and behaviours.[154] Scientific research informs policymaking too infrequently. This is likely due to researchers not being trained with the goal of influencing policy and engagement with policymakers not being

154 Rachel F Rodgers and Kendrin Sonneville "Research for leveraging food policy in universal eating disorder prevention" (2018) 51 Int J Eat Disord 503 at 503.

encouraged or rewarded in academic settings.[155] Furthermore, researchers do not always receive input from change agents, such as politicians, to shape their research focus. Consequently, a substantial proportion of the laws and regulations targeting social eating disorders lack evidential foundation. As discussed in Part V.B, research funding in Australia per person with autism is around AUD 32 and for eating disorders it is just over AUD 1, despite eating disorders having a much higher social cost.[156] The 2012 Butterfly Report estimated the annual socioeconomic cost of eating disorders to the Australian economy at AUD 69.7 billion.[157] A 2011 report estimated the annual socioeconomic cost of autism between AUD 8.1 billion to 11.2 billion.[158] Although the reports are 10 and 15 years old, respectively, the disparity is eye-opening.

However, eating disorder funding should not be increased merely for the sake of achieving parity with autism funding—it must serve a purpose. Specifically, funding needs to support research to provide an evidence base to inform policy. Australia is an example of a country that has implemented such an approach in its *Australian Eating Disorders Research & Translation Strategy 2021–2031*. Released in September 2021, the strategy has been cited as a "significant turning point" in the country's policy approach to eating disorders.[159] The transdisciplinary strategy was co-designed with eating disorder researchers, clinicians and people with lived experiences with eating disorders—drawing on the expertise and experience of over 480 individuals. With the Australian government's support, the University of Sydney's InsideOut Institute led the strategy's development. Ten priority areas for research were identified: stigma, health promotion, risk and protective factors, prevention, early identification, equity of access, early intervention, support families, individual's medicine, and treatment outcomes. By recognising eating disorders as a nationwide crisis, Australia has become a world leader in the area. The Australian government has committed AUD 268 million to eating disorder initiatives since 2012,[160] and announced an additional AUD 24.3 million in funding in March 2022.[161]

155 Christina A Roberto and Kelly D Brownell "Strategic science for eating disorders research & policy impact" (2017) 50 Int J Eat Disord 312 at 312.

156 Eating Disorder Genetics Initiative, above n 63.

157 The Butterfly Foundation, above n 8, at 9.

158 Synergies Economic Consulting "Economic Costs of Autism Spectrum Disorder in Australia" (April 2011) <www.synergies.com.au> at 11.

159 University of Sydney "Australia's first national strategy for eating disorders released" (21 September 2021) <www.sydney.edu.au>.

160 Australian Department of Health and Aged Care "More support for Australians with eating disorders" (media release, 31 March 2022).

161 Australian Department of Health and Aged Care, above n 160.

Furthermore, AUD 13 million was granted to the University of Sydney to establish the Australian Eating Disorders Research and Translation Centre.[162] Concurrent to the Centre's establishment, a rapid literature review was undertaken to categorise existing research into each of the ten priority areas to identify deficits.[163] Interestingly, research on risk factors constituted the highest proportion of extant literature at 20 per cent, whilst prevention and early intervention were the fourth lowest at nine per cent each.[164] The need for a national "Research & Translation Strategy" is credited to the vital role that research can play in preventing illness.[165] The strategy acknowledges that eating disorder research has been hampered by insufficient resourcing and a lack of coherent vision, resulting in "intermittent discoveries and limited uptake of the evidence".[166]

The development of a New Zealand national strategy need not be in isolation. The close relationship with Australia presents an opportunity to leverage learnings and exchange knowledge between the two countries. Further, the mere act of implementing a strategy is a significant first step to show New Zealanders that the prevalence of eating disorders is a serious issue whose stigma has exacerbated the harms it has caused to individuals and communities. New Zealand ought to follow Australia's lead with respect to co-designing a strategy with relevant stakeholders such as researchers, healthcare providers and the affected population. The Māori Health Authority is an obvious stakeholder for engagement to ensure alignment with the Pae Ora (Healthy Futures) Act which places importance on improving Māori health outcomes to ensure everyone has the same access to adequate health outcomes.[167]

Co-design of an eating disorder prevention policy and strategy with indigenous peoples is of the utmost importance. This imperative has been recognised in Australia, with the new Centre currently developing an "Aboriginal and Torres Strait Islanders Eating Disorders Research Strategy" to ensure the experience of First Nations peoples with eating disorders is better understood

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162 InsideOut Institute "Australian Eating Disorders Research and Translation Centre webinar: four-year plan" (18 March 2022) <www.insideoutinstitute.org.au>.

163 Philip Aouad and others "Informing the development of Australia's National Eating Disorders Research and Translation Strategy: a rapid review methodology" (2022) 10(31) J Eat Disord 1 at 1.

164 At 9.

165 InsideOut Institute "Australian Eating Disorders Research & Translation Strategy 2021-2031" (23 March 2023) <www.insideoutinstitute.org.au>.

166 InsideOut Institute, above n 165.

167 Department of the Prime Minister and Cabinet, above n 72.

through research.[168] Determination of the scope and direction of the strategy is an ongoing collaborative effort between consultancy firm First Nations Co and the Centre. In the New Zealand context, partnership with Māori is fundamental given that Māori are disproportionately affected by eating disorders. The University of Otago exercised partnership with Māori by working with its own Māori Indigenous Health Institute in a study that affirmed rates of eating disorders are higher in Māori communities.[169] In addition to the University of Otago, the University of Auckland has Tōmaiora—the Māori Health Research Group—which endeavours to find solutions through quality evidence-based Māori health research.[170] Genuine consideration of Māori interests and perspectives is essential to ensure the processes to formulate the strategy are transparent to the Māori community.

Australia's eating disorder strategy co-development with Aboriginal and Torres Strait Islanders is a model that New Zealand must follow. Authentic engagement and cultural oversight will increase the likelihood that Māori will be positively impacted by the strategy as well as subsequent research outcomes.

Overall, the New Zealand government's first step in a preventative approach to eating disorders should be to establish a national strategy. Much can be learned from the Australian approach, which has provided sufficient funding, established a targeted research centre, and co-designed strategic goals with indigenous peoples. Furthermore, New Zealand should collaborate with the Australian Centre to share learnings to contribute to a more informed preventative policy approach.

B Appropriate initiatives for implementation

While research is necessary to support a comprehensive eating disorder prevention policy response in the long-term, the New Zealand government should introduce two valuable initiatives in the meantime: restrictions on the distortion of bodies in advertising and targeted eating disorder education for primary school children. As an alternative to advertising restrictions, this section also considers third party certification for companies which practice the portrayal of realistic body image and inclusive representation in advertising.

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168 InsideOut Institute "The Australian Eating Disorders Research & Translation Centre: building a national effort" (10 August 2022) <www.insideoutinstitute.org.au>.

169 Māori Indigenous Health Institute and University of Otago Christchurch "Tangata Kōmuramura: Māori Experiences of Eating Disorders?" <www.otago.ac.nz>.

170 Tōmaiora – Māori Health Research Group "Home" <www.tomaiora-research-group.blogs.auckland.ac.nz>.

1 Restrictions on the distortion of bodies in advertising

The first proposed prevention initiative is a ban on the distortion of bodies in advertising, as less restrictive initiatives have failed in other jurisdictions. As discussed in Part VII, "warning labels" on photoshopped images produce a "backfire" effect, as they simply highlight the idea that even the models' bodies are not "ideal" enough for the purposes of the company's advertisement. Furthermore, media literacy to build resilience to image distortion places the burden on those receiving the education to be aware of companies' advertising practices in the hopes of minimising body dissatisfaction.

Given that the use of "idealised" models is a key driver of sales, companies are unlikely to voluntarily shift away from their current practices. Therefore, a more robust intervention, such as enforcing a prohibition on digitally altered and distorted bodies in advertising visuals, is imperative. Such a prohibition has precedent. In 2017, Getty Images banned images from its libraries that were photoshopped to make female models look thinner and male models more muscular.[171] In 2016, the Mayor of London, Sadiq Khan, banned advertisements that pressure people to conform to "unrealistic body images" on London's tube and bus network, collaborating with the network to implement a steering group to monitor advertisements.[172] In 2018, CVS Pharmacy announced it would no longer feature images where a person's shape, size, proportion, wrinkle or skin colour had been altered, and urged brands to do the same.[173] If the world's largest stock image library, the largest city in the United Kingdom and the largest pharmacy chain in the United States can prohibit body distortion, why not the New Zealand government?

One approach to implementing such a prohibition would be to amend s 9 of the Fair Trading Act 1986. Section 9 states that "no person shall, in trade, engage in conduct that is misleading or deceptive or is likely to mislead or deceive". The Fair Trading Act defines "advertisement" as:[174]

> … any form of communication made to the public or a section of the public for the purpose of promoting the supply of goods or services or the sale or granting of an interest in land

171 Steve Dent "Getty bans images photoshopped to make models look thinner" (27 September 2017) Engadget <www.engadget.com>.

172 Robert Cookson "Sadiq Khan bans body-shaming ads on London transport" *Financial Times* (online ed, London, 14 June 2016).

173 Danielle Selby "CVS is Banning Photoshopped Photos for Product Promotion" (19 January 2018) Global Citizen <www.globalcitizen.org>.

174 Section 2 definition of "advertisement".

Thus, an advertisement constitutes conduct "in trade". As discussed in the context of the United Kingdom ASA's finding that several cosmetic advertisements were "misleading", the ability to make a "misleading" finding has so far been confined to promoting specific product outcomes, which has since been mitigated through actual product result disclaimers. However, the definition of "misleading or deceptive" should be broadened beyond the product to focus on the models used in an image to sell and promote the product. Currently, the Commerce Commission is responsible for upholding fair trading standards. A potential enhancement could involve empowering a dedicated committee within the Commission to enforce a prohibition on distorted bodies with investigatory and declaratory powers.

Opponents may challenge a prohibition on body distortion in advertising as an infringement on freedom of expression. However, while Parliament may enact contrary to the New Zealand Bill of Rights Act 1990, there is nevertheless a strong argument that such a prohibition on distorted images would be a justifiable limitation of freedom of expression, given the impetus for prevention policy action to address New Zealand's eating disorder crisis. A prohibition on photoshopping also avoids complex questions like what is "health" and discrimination arguments which could arise if a prevention policy's focus was on ensuring the use of a diverse range of healthy models in advertising.

2 Targeted education

The second proposal is an eating disorder education initiative targeting primary school students. As mentioned in the "Protective factor programmes" section above, studies have shown that five to nine year old girls and boys were already significantly invested in thin and muscular ideals.[175] These studies reiterate that preadolescence is an important age for prevention initiatives, before weight-loss behaviours and cognitions become entrenched. While media literacy and body image workshops are useful to build resilience when it comes to consuming content, it is a roundabout way to prevent eating disorders. The stigma of eating disorders has been highlighted as an immense barrier to accessing aid, as well as a lack of symptom awareness in the general population—education could curtail this stigma.

Health education in New Zealand has expanded beyond physical to now include mental health and could be easily expanded to cover eating disorders. However, until 2018, guidelines only recommended mental health education for students in Year 7 and above, neglecting the reality that poor mental health does

175 See Part VII.C.5; and Pursey and others, above n 111.

not have a starting age.[176] Positively, an updated mental health education guide was issued in 2022, which is applicable to Years 1–13.[177] However, the guidelines state: "Eating disorders should not be a focus of learning programmes. Rather, learning experiences should focus on thinking critically about societal pressures, taking action, and promoting self-acceptance."[178] Unfortunately, this sentiment only exacerbates the stigma that surrounds eating disorders and contributes to poor early intervention outcomes.

To the extent that measures are recommended to school staff to address body image issues, these also avoid acknowledgement of eating disorders. For example, the guidelines state that schools should review their uniform design, focus on the benefits of physical activity, use diverse body sizes in school publications, and that staff should not discuss weight.[179] Advising against direct discussion about eating disorders is a regressive step. This advice is in stark contrast with the guidelines' approach to alcohol and drug education, which advise teachers to explain the effects of consumption, the effect of media representations, and ways of seeking help personally and amongst peers.[180] Overall, the New Zealand health curriculum has made commendable progress by integrating mental health education from Year 1. Yet, it is essential that curriculum guidelines avoid perpetuating the taboo nature of eating disorders. Addressing these issues openly can empower adolescents to seek help and recognise symptoms amongst their friends. The causes and consequences of eating disorders should be discussed in New Zealand classrooms.

3 Good behaviour certification

The third initiative is endorsement of third-party certification which presents a less interventionist approach to prohibiting body alterations in advertising. A New Zealand government agency could be tasked with certifying companies which market their products in a manner that prevents the promotion of idealised body types. The agency could certify companies that exercise practices consistent with the prevention of eating disorders, such as including diverse body sizes, body types and ethnicities in their advertising.

176 New Zealand Council for Educational Research "Mental health education and hauora: Teaching interpersonal skills, resilience, and wellbeing" (2016) <www.nzcer.org.nz>.

177 Ministry of Education *Mental Health Education Years 1–13: A Guide for Teachers, Leaders, and School Boards* (28 September 2022).

178 At 55.

179 At 44.

180 At 64.

Nonetheless, the efficacy of a government-led certification may be less effective than other well-recognised certifications such as the aforementioned B Corp which certifies that a business has met high standards of corporate social responsibility. With this in mind, a more compelling approach for the New Zealand government could be to engage with B Corp to expand its criteria to include companies that practice eating disorder prevention in their marketing and advertising. B Corp entities are subject to "Impact Assessments" where brands must certify that they are, for example, creating inclusive workplaces.[181] An "inclusive" workplace is not a well-defined inquiry, as is the case for other standards that must be met to achieve certification. Consequently, criteria relating to eating disorder prevention practices would conform with the discretionary nature of B Corp certification, which states lofty expectations and requires companies to provide documentary proof that they meet those expectations. New criteria could mirror the Australian government's Voluntary Industry Code of Conduct, developed by the National Advisory Group on Body Image.[182] For example, the following criterion, reflecting clause one of the Code, could be added: "Use positive content and messaging to support the development of a positive body image and realistic and healthy physical goals and aspirations among consumers." Prospective B Corps could submit their advertising campaigns to prove that they do not solely portray idealised bodies, but also promote healthy body image. This approach is preferable to a government-led certification as B Corp took over a decade to gain increased recognition and New Zealand's eating disorder crisis necessitates consideration of a swifter alternative.

IX Conclusion

Evidence-based policymaking is a formidable tool to address both health and social issues. Nonetheless, the chronic underfunding of eating disorder treatment, prevention, early intervention initiatives and research has resulted in a lack of evidence necessary for a nuanced understanding of these issues for policymakers. Nonetheless, this article has proposed a trio of actions for prevention that the literature supports. Firstly, a prohibition on altering bodies in advertising to reduce the negative impact of body dissatisfaction, which emerges due to discrepancies between what society portrays as an ideal body and a person's real body. Secondly, improved education on eating disorders to reduce the stigma

181 B Corporation "B Impact Assessment" <www.bcorporation.net>.

182 Australian Government, above n 141.

around eating disorders, with such stigma preventing New Zealanders from seeking help before disordered eating behaviours are entrenched. Excluding eating disorders from mental health education prevents young New Zealanders from being aware of the signs and effects of eating disorders. Education can empower adolescents to seek help and support their peers. Thirdly and finally, third-party certification for entities whose advertising practices do not contribute to unrealistic body image idealisation. Such a certification would make it clear to consumers which companies are and are not cognisant of, or responding, to the New Zealand eating disorder crisis, and, ideally, incentivise companies to factor eating disorder prevention into their strategic decisions.

These measures can be monitored by a new or existing government body, such as Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (the Māori Health Authority), established pursuant to a national eating disorder prevention policy and strategy and subject to future studies to examine their efficacy. To facilitate this research, funding should come from a national strategy for eating disorders and New Zealand should follow in Australia's wake to establish a comprehensive strategy to combat eating disorders. A formal strategy would recognise eating disorders as the serious issue it is, which demands a deliberate and categorical preventative response. In conjunction with formulating such a strategy to allocate funding for policy efficacy research, the three initiatives proposed provide a strong foundation for the proactive management of eating disorders in New Zealand.