SCHEDULE 14: DISORDERED EATING EARLY IDENTIFICATION & PREVENTION

DOCUMENT CONTROL

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Applicable setting:	All HP training and clinical environments

RELATED DOCUMENTS & LINKS

Document Name	Location
The AIS-NEDC Position Statement on Disordered Eating in High Performance Sport	*https://www.ausport.gov.au/ais/disorderedeating*
AC Body Composition Governance Framework	*Schedule 12 – Body Composition Governance*
AC Mental Health Case Management Guidelines	*ZenDesk*
AC Policy for Safeguarding Children and Young People	*AC Policy for Safeguarding Children and Young People*
AC Processes for Management and Return to Play of Players with Disordered Eating	*Processes for Management and Return to Play of Players with Disordered Eating*
Athletic Disordered Eating Scale	*Athletic Disordered Eating Scale*

AIS Female Performance & Health Initiative - Understanding Your Menstrual Cycle: What's Normal, What's Not?	*AIS Female Performance & Health Initiative- Understanding Your Menstrual Cycle: What's Normal, What's Not*
REDs Return to Play Clinical Assessment Tool 2	*ZenDesk*

1. PURPOSE

1.1 Disordered eating (**DE**) and eating disorders (**ED**) are serious and complicated issues that can affect the health and performance of ALL players, from pathway to senior elite levels (see *Appendix 1* for definitions).

1.2 These guidelines aim to support the development of a healthy cricket environment by promoting the prevention, early identification, and effective management of disordered eating (DE) and eating disorders (ED) across Australian Cricket (**AC**). Specifically, the guidelines seek to:

a) Prevent the development of disordered eating and eating disorders among players and staff.

b) Facilitate the early identification of individuals at risk of, or experiencing, disordered eating or eating disorders.

c) Promote a coordinated, multidisciplinary approach to assessment, management, treatment, and recovery.

d) Reduce anxiety related to body composition, weight, and appearance, and foster a positive body image culture.

e) Enhance the knowledge and capability of players, coaches, support staff, and high-performance personnel through education on disordered eating, eating disorders, and positive body image.

f) Support the creation and maintenance of a healthy sport system that prioritises both physical and mental wellbeing.

1.3 Australian Cricket (**AC**) endorses the Australian Institute of Sport (**AIS**) and the National Eating Disorders Collaboration (**NEDC**) *Position Statement on Disordered Eating in High Performance (HP) Sport*. This guideline is to be read in conjunction with the AIS-NEDC Position Statement.

2. SCOPE

2.1 These Guidelines apply to all national and State/Territory programs,

2.2 pathway environments,

2.3 contracted and externally engaged practitioners,

2.4 all performance team personnel (including coaches, performance services staff, player development managers, team management, security, and media staff)

3. THE DISORDERED EATING CORE MULTIDISCIPLINARY TEAM

AC recognises that the role of the organisations DE Core Multidisciplinary Team (**CMT)** provides a vital function in the early identification, assessment, diagnosis, treatment (where appropriate) and referral (as required) of DE and ED.

3.1 AC (State, Territory and National) programs should establish a DE CMT when a player is identified as showing signs of DE or an ED, using the process outlined in the *AC Mental Health Case Management Guidelines*.

3.2 An AC Case Manager (refer to *MH Case Management Guidelines*) must be appointed for the CMT.

3.3 The Case Manager for DE /ED must be an AHPRA registered Psychologist, Medical Officer, or Dietitians Australia registered Dietitian, unless approved by the CA CMO (men's or women's program) or the CA Senior Manager – Mental Health.

3.4 The CMT will be appointed by the Case Manager with the approval of the player.

3.5 The CMT must include:

a) a medical practitioner (treating doctor, team doctor, State Medical Officer etc..), sports dietitian and psychologist. The CMT can include any other appropriate health professionals.

b) these providers can include AC staff and from external to AC, based on the preference of the player and the expertise available to manage DE / ED within the AC program.

3.6 The Case Manager is responsible for coordinating the communication channels within the CMT and from the CMT to the broader support team, including PDMs and external treatment providers. Any communication outside the CMT must be kept to relevant information that is useful to be shared and conducted only with the documented informed consent of the player.

4. PRIMARY PREVENTION OF DISORDERED EATING

Primary Prevention is defined as actions taken to reduce the risk of developing a condition and also aims to specifically remove causal factors for the development of the condition.

4.1 Education

a) AC supports the tiered education of our coaches, SSSM staff, players, and player support system to assist in early identification and prevention of DE.

b) Education sessions should occur with the following frequency (at a minimum):

(I) AC Dietitian and/or AC Medical Officer and Psychologist to provide an annual education session for players; and

(II) Incorporation into the Annual Integrity Education program for all HP staff

4.2 Optimised Nutrition

a) AC recognises that players should be able to access nutrition support that meets the criteria for optimised nutrition; a harmony between health and performance underpinned by concepts that are safe, supported, purposeful and individualised.

b) An appropriately qualified and experienced AC Sports Dietitian should provide the nutritional education to players as outlined in the *AIS-NEDC DE Position Statement*.

4.3 Role of Body Composition

a) Body composition plays a role in sports performance, that should be understood and integrated into an appropriate personalised plan for each player. AC recognises that the assessment of body composition can be a justified part of player monitoring but needs to be appropriately implemented to safeguard the player's health and well-being.

b) AC Sports Dietitians are responsible for player body composition assessment and management. No other SSSM staff member can instigate a body composition assessment or recommend a management plan. Body composition assessments can only be conducted by other SSSM staff under the instruction and supervision of the AC Sports Dietitian.

c) Appropriate implementation of body composition assessment includes a range of considerations. These considerations should be followed whenever body composition assessment techniques are utilised, (See *AC Body Composition Governance Framework*).

d) When DE or ED is suspected or established with a particular player, or for players who have had a history of DE or ED, the AC Sports Dietitian must consult both the player's treating doctor and treating psychologist to determine how to best manage body composition assessments or management for that player. Importantly, if a player shows signs of developing DE / ED then the DE CMT is activated.

4.4 Body Image

a) AC recognises that a positive body image is one of the protective factors that enable a player to be more resilient to developing DE or an ED. Appropriate support should be provided to players to encourage a positive body image, using activities targeted at groups and individuals. Positive body image is promoted through education and support for all High Performance staff at AC, not just in our players.

b) When body image concerns are evident or emerging with a particular player, early interventions should be actioned and escalated through the AC Medical Officer, Psychologist and / or Sports Dietitian.

4.5 Use of language

a) Respectful language should be used when speaking with and about players and their bodies. Players, coaches and performance support staff should receive education around such language.

b) AC believes all players deserve to be treated with respect, no matter their size, shape, composition, colour or ability.

4.6 Use of images of players

a) AC will focus on using images that encourage positive body image and aim to avoid images that may motivate some people or players at risk to strive to achieve an unrealistic shape, weight, or size.

b) Noting that players across cricket have a wide range of body weights, shapes or body composition, images showing body diversity are encouraged.

c) Priority will be given to images that show a player undertaking sporting activity, rather than images where it can be perceived the focus is on body composition.

4.7 Vulnerable Periods

Based on the *AIS-NEDC DE Position Statement*, AC recognises that there are a number of vulnerable periods in a player's life that may place them at an increased risk of DE including, but not limited to:

a) starting sport specific training at an early age,

b) making a senior (professional) team at a young age,

c) retirement (forced or voluntary),

d) non-selection or de-selection from a team, squad or State, Territory or National contracted list,

e) injury, illness, surgery, time away from playing and training,

f) changes in weight and/or body shape following injury or illness,

g) major life transitions and stressful life events (e.g. moving away from home, moving between schools, moving overseas),

h) preparation for and competing in a significant series (e.g. in the selection process, the period prior to during and after the series),

i) within season where nutritional intake is compromised (due to factors associated with team travel etc.),

j) pre-season where anthropometric targets are a focus,

k) current or previous diagnosis of a mental health condition,

l) during periods of high psychological distress, and

m) adolescence.

AC HP programs should apply appropriate support around the athlete at these times, with activities involving the coach, support staff and/or the CMT directly.

4.8 Working with minors

a) AC recognises working with minors (under 18 years of age) requires appropriate care and consideration for this population (see *AC Policy for Safeguarding Children and Young People*).

b) Whilst DE/ED can occur at any age, we understand that adolescence is a formative time in the development of a player's body image and eating behaviour. AC players in this age group should be provided with appropriate education and support to assist in the development of optimal body image and eating behaviours.

c) A minor's right to privacy will be respected in accordance with the specific State/ Territory legislation

d) A registered medical professional is responsible for determining if and when an under-age athlete's family will be informed of DE or an ED, subject to applicable privacy laws.

4.9 Players with a Disability

a) AC recognises that players with a disability have unique considerations around body image and eating behaviour. The CMT should work individually with each

player and their coach and performance support staff to ensure that the needs of the player are met.

4.10 Travel

a) AC recognises its role in creating a safe environment during travel, just as it does in the State Cricket Association and National Cricket Centre environments. A player known to have an ED should have an individual support plan developed with the CMT and any relevant external service providers prior to travel.

b) If a player is identified as having a potential ED while travelling, or an escalation / relapse of ED, the treating practitioner (doctor, dietitian, psychologist etc..) must consult with the AC Medical Officer involved in the regular management of the player (whether they are travelling with the team or not) so they are part of the decision making process to withdraw the player from tournament on medical grounds and have them return home if it is in their best interests, physically and/or mentally.

c) Where a player is touring internationally the CMT should ensure due care and appropriate access to the required medical, nutritional and psychological support.

5. DIAGNOSIS AND TREATMENT

The average time to diagnosis in an athlete with an ED is more than nine years. Australian Cricket has taken steps to reduce the time to diagnosis. Strategies should aim to identify players with clinical or subclinical eating disorder at the earliest possible stage, where management is likely to be most effective.

The practical processes for management and return to play of a player are outlined in *AC Processes for Management and Return to Play of Players with Disordered Eating*.

5.1 Early Identification

a) AC recognises that early identification of changes in a player's thoughts around their body image and/or eating behaviours (along the spectrum of eating behaviour) is important in allowing a greater opportunity for reversal and recovery from DE and ED (see *Appendix 1*).

b) Timely identification and intervention is also important to minimise any physical development or performance impact.

c) Player support staff and coaches that identify warning signs/red-flags of DE/ED (listed in Table 4 *of the AIS-NEDC DE Position Statement*) in a player, should report their concerns to either the AC Sports Dietitian, AC Psychologist or AC Medical Officer.

d) Early detection can be achieved through population level screening, self-assessments or through symptom checklists that alert someone to seek help,.5.2 Screening tools

e) Screening tools will be used where appropriate within the AC environment. Where DE or an ED is suspected with an athlete in the care of AC, clinical interviews with the appropriate CMT will be organised. A summary of well-known screening instruments can be found on the *NEDC website*.

5.2 Menstrual function in female athletes

a) AC recognises the importance of menstrual function on health and performance in female players. AC will encourage players, through education programs, to track their menstrual function.

b) In the case where any menstrual irregularity is identified, it is strongly recommended these be investigated with a doctor who has experience working with female athletes within an appropriate timeframe (*see AIS - Understanding Your Menstrual Cycle* for further details).

5.3 Low energy availability and other signs of Relative Energy Deficiency in Sport (RED-S)

a) (a) AC recognises that DE/ED can occur in isolation or in combination with low energy availability (LEA), and their interaction and associated forms of presentation should be properly identified. Players should be assessed for evidence of LEA by an AC Sports Dietitian in the circumstances below:

b) Any player with known or suspected DE/ED,

c) any player who is diagnosed with a bone stress injury and/or identified with menstrual dysfunction, and/or

d) any player with recurrent upper respiratory and/or gastrointestinal illness or any other injury or illness that may be suggestive of LEA.

5.4 Diagnosis

a) AC recognises that the most useful tool in assessing the presence of DE or an ED in an individual player is a clinical interview by an appropriately qualified professional and include medical and psychological oversight.

5.5 Treatment

a) Treatment of an athlete with a diagnosed ED may most appropriately be through an ED specialist service (for example an ED clinic, or ED treatment team/unit), independent of AC and the HP sporting environment. There are times however, where it may be appropriate for one or more members of the AC DE CMT to be involved in an athlete's ED treatment. AC should support and enable our DE CMT to undertake this role as required.

6. OTHER CONSIDERATIONS

6.1 Co-occurrence with mental health conditions

a) Eating disorders often co-occur with other mental health concerns, for example, depression, anxiety, stress and trauma. Therefore, it is important to promote overall mental health and wellbeing of the player and to have mental health support available for a range of presentations.

b) On diagnosis, the AC MO may refer the player to a Psychiatrist for a diagnostic psychiatric interview, to ascertain any co-occurrence of mental health conditions for inclusion in the management plan.

6.2 Return to training and play

a) *Processes for Management and Return to Play of Players with ED* should be used as a guide with players.

b) The DE CMT should work together, and with any external ED treatment team, to ensure the return to play of a player is appropriate for their individual case. A player identified with DE/ED may need training modifications or exclusions to minimise the risk of potential injury and/or illness.

c) AC DE CMT should work together with coaches and other performance team members to ensure an individual approach is taken to the player's training regime. If a player is deemed unfit to play by AC medical staff they will be unavailable for selection and this will be reflected in the AMS.

d) The ultimate decision to allow a player diagnosed with DE or ED to return to play sits with the AC Medical Officer (SMO / CMO) after consultation with the Case Manager and the CMT. The *RED-S Clinical Assessment Tool 2 (CAT2)* is an example of an exclusion and return to play guideline.

6.3 Prevention of recurrence, relapses and regression of symptoms

a) Players diagnosed and receiving treatment for an ED should undergo management plans for their career. Management does not cease when active treatment does. This should be communicated to the player and appropriate self-management tools provided by the CMT at the clinically appropriate time.

6.4 Retirement

a) In some, but not all cases, retirement from high performance sport may occur due to the mental health impact of DE/ED or the ongoing medical concerns related to DE/ED. While all care will be provided to the player to minimise the risk of this occurring, the outcome may still present.

b) If retirement due to DE/ED is in the players best interests, then AC will provide resources to assist the player in this transition via available support networks and programs.

6.5 Prevention of subsequent health problems

a) While a player is under management by the CMT, there is an opportunity to provide prevention plans to reduce risk of serious consequences of the DE/ED. A deficit in energy balance, related to the DE/ED may present as may injury or illness.

b) Best practice management should include strategies to manage and where possible mitigate the risk of adverse health outcomes cause by the primary condition of DE/ED.

7. CONSENT & CONFIDENTIALITY

7.1 All clinicians involved in the care of players with DE/ED should abide by consent principles and confidentiality standards as outlined in the relevant Professional Codes of Conduct (e.g. SDA, AMA/ACSEP, ASP, relevant AHPRA Boards).

7.2 All information relating to DE/ED identification, assessment and management, including data, discussions, and management plans, must be treated as confidential medical information (sensitive health information). Information must be collected, stored, used, shared and managed accordingly (see *Schedule 2: HP Data Governance*).

7.3 Access is restricted to the CMT directly involved in the player's care, unless otherwise consented to by the player. A player's informed consent must be obtained to release/share information with those outside of the CMT (see *Appendix 2* for an example template).

7.4 Players have the right to access their data at any time.

8. CONFIDENTIAL PROCESS TO DISCUSS CONCERNS

8.1 Players and staff must have access to a confidential process to raise concerns regarding their own or a team member's health as it relates to DE/ED.

8.2 Concerns may be raised with the Sports Dietitian, Psychologist, Medical Officer, Player Development Manager, or another trusted staff member.