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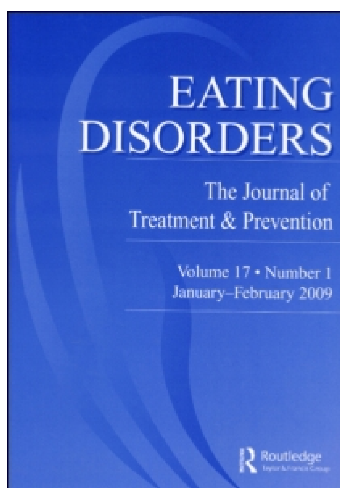

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First Aid for Eating Disorders

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First Aid for Eating Disorders

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The objective of this study was to develop first aid guidelines, based on expert consensus, that provide members of the community with information on how to assist someone who is thought to be developing or experiencing an eating disorder. An online Delphi study was carried out with expert panels consisting of 36 clinicians, 27 care-givers and 22 consumers. The panel members rated statements that described potential first aid actions. If between 80 and 100 percent of all three panels rated a statement as either Essential or Important, the statement was endorsed as a guideline. Three rounds were conducted before consensus was reached. From a total of 456 statements, 200 were endorsed as guidelines. A cohesive guideline document was developed by writing the endorsed statements into sections of prose based on common themes. Clinicians, care-givers and consumers were able to reach consensus about guidelines for eating disorder first aid. Further research is needed to evaluate their efficacy.

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In the last decade four national mental health surveys (conducted in the Netherlands, Germany, the United States and New Zealand), have reported on the prevalence, disability and mental health service utilization associated with eating disorders, by completing the Composite International Diagnostic Interview (CIDI) with thousands of adults (ages 16–75; Bijl, Ravelli, & van Zessen, 1998; Hudson, Hiripi, Pope, & Kessler, 2007; Jacobi et al., 2004; Wells et al., 2006). While there is vigorous debate about the validity of estimates produced by the national surveys (Jorm, 2006), some important themes in the eating disorders have emerged. First, the median age of onset is early (around 18 years; Hudson et al., 2007; Oakley Browne, Wells, Scott, & McGee, 2006). Second, despite the majority of those who meet criteria for an eating disorder experiencing symptoms that are classified as severe and disruptive to normal life functioning, less than half (around 47%) seek help from any form of health care provider and only a quarter (around 28%) seek help from any mental health care specialist, in the 12 months before the time of survey (Hudson et al., 2007; Oakley Browne, Wells, & McGee, 2006). Perhaps the most outstanding of these findings is that the median duration of treatment delay is extraordinarily long (10 years for those meeting criteria for bulimia and 15 years for those meeting criteria for anorexia) (Oakley Browne, Wells, & McGee, 2006). If symptom severity, associated disability and economic burden are to be reduced, the very poor health service utilization of those experiencing eating disorder behaviours must be addressed.

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Research investigating barriers to help seeking has illuminated some important internal and external factors that may prevent individuals with eating disorder behaviors from seeking treatment. Hepworth and Paxton (Hepworth & Paxton, 2007), for instance, report that an individual's ability to recognise their behavior as a problem is an important factor in the initiation of health care. Using a concept mapping approach they found that, although symptom severity was most strongly associated with participants' ability to recognize their behaviors as a problem, an individual's own experience was not always sufficient to bring about such recognition. Rather, comments from friends about changes in an individual's behavior, weight and appearance also reinforced awareness of problem behavior. In addition, the authors reported that once individuals had recognised their behaviour as a problem, 61.5% first consulted a lay person with their concerns. The authors concluded that extensive community education is required to improve the ability of individuals with eating disorder behaviors, and their significant others, to identify symptoms accurately and early, and to encourage help seeking, before symptom severity has the opportunity to create disability.

Research investigating mental health literacy also indicates a need for a greater level of community education about the importance of early intervention in developing mental illness (Kelly, Jorm, & Wright, 2007). Mental health literacy is defined as the "knowledge and beliefs about mental disorders

which aid their recognition, management or prevention" (Jorm et al., 1997). Investigations of eating disorders literacy suggest that there is a strong dissonance between the public's understanding of risk-factors, severity and effective treatments, and the beliefs of mental health professionals (Hay, Darby, & Mond, 2007; Hay, De Angelis, Millar, & Mond, 2005; Hay & Mond, 2008; Mond, Hay, Rodgers, & Owen, 2006; Mond, Hay, Rodgers, & Owen, 2008; Mond & Marks, 2007). In a study that examined community perceptions of bulimia nervosa, for example, a sample of 207 women was found to be sceptical of the value of mental health specialists in the treatment of bulimia nervosa, but sympathetic to the use of primary care providers and self-help interventions (Mond et al., 2004). This public perception of bulimia nervosa occurs despite the scientific literature suggesting that the most effective forms of treatment are a combination of psychological treatments (especially cognitive behavioral therapy, which is generally provided by psychologists or psychiatrists) and antidepressants (Bacaltchuk & Hay, 2003; Hay, Bacaltchuk, & Stefano, 2004). In addition, the literature provides only limited evidence for self-help interventions, which are at best considered a preliminary step to occur either before, or in conjunction with, other conventional methods of psychological treatment (Perkins, Murphy, Schmidt, & Williams, 2006).

One program aimed at improving mental health literacy is Mental Health First Aid (MHFA; Kitchener & Jorm, 2002). This training program was started in 2002 to teach members of the public how to provide first aid to someone who is developing a mental disorder or experiencing a mental health crisis, until appropriate professional treatment is received, or the crisis resolves (Kitchener & Jorm, 2008). Since its inception, the program has been subject to three evaluations and been shown to be effective in increasing mental health literacy, changing beliefs about treatment to be more like those of health professionals, decreasing social distance from people with mental disorders, increasing confidence in providing help to someone with a mental disorder, increasing the amount of help provided to others, and improved mental health of participants (Kitchener & Jorm, 2006). In order to improve the quality of the mental health first aid techniques being taught to the public, research has been carried out to develop guidelines on what constitutes best practice first aid, using expert consensus (Kelly, Jorm, Kitchener, & Langlands, 2008a; Langlands, Jorm, Kelly, & Kitchener, 2008a, 2008b). Use of expert consensus is a practical alternative to randomised controlled trials, which are not feasible or ethical for evaluating specific first aid strategies. While the studies developing mental health first aid guidelines have been successful in reaching consensus on best practice techniques, there has not yet been an investigation of how one might provide first aid to someone developing, or experiencing, an eating disorder.

The aim of the current study was to develop consensus-based guidelines for eating disorder first aid. This involved the Delphi consensus method, a mixed qualitative and quantitative research framework for gathering expert

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opinion. Clinicians involved in eating disorder treatment or research were approached to be involved as experts, as well as care-givers and consumers who were proactive in raising awareness about eating disorders through authoring books, blogs or websites, mentoring, support or advocacy groups, education, training or treatment, research or policy development. The inclusion of care-givers and consumers was seen as particularly important to the acceptability and validity of guidelines for first aid because care-givers are the individuals most likely to provide the first aid and consumers the individuals who will receive it.

METHOD

The Delphi Method

The Delphi method involves a group of experts making private, independent ratings of agreement on a series of statements. Once ratings are received and collated, a summary is fed back to the panel members, who then complete a second round of rating. They can choose whether to change or maintain their original ratings. Several rounds may be required, depending on the desired level of consensus. The output from the process is statements about which there is substantial consensus in ratings. The research process undertaken here involved four steps.

Panel Formation

Experts were recruited via an emailed invitation to participate accompanied by an information sheet about the study. Potential expert clinicians were identified through their association with professional organisations such as the Academy of Eating Disorders or through their authoring of relevant scientific or clinical resources. Only those clinicians who were considered as specialised in the area of eating disorders, or leaders in the field of research or training, were invited to participate. Potential expert consumers and care-givers were identified through an established public profile. Public participation in awareness-raising was an inclusion criterion that was designed to ensure that participants could respond as experts, with exposure to a range of experiences within the eating disorders realm, rather than responding based solely on their own individual experience, which may vary significantly from individual to individual. It also ensured that participants were comfortable reflecting on their experiences, which was particularly important for those who participated on the consumer panel; consumers were required to consider themselves as recovered and not currently seeking treatment.

Panel members were recruited from Australia, Canada, Ireland, New Zealand, the United Kingdom and the United States. A total of 85 participants

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responded to the first round. Informed consent was implied by responding to the online questionnaire. This research was granted human research ethics committee approval by the University of Melbourne.

Questionnaire Development

A systematic literature review was conducted of websites, books, care-giver and consumer manuals, and journal articles for statements about how to help someone who was thought to be developing or experiencing an eating disorder. This involved entering key search terms (eating disorders, anorexia, bulimia, helping, help, intervention, self-help, carer) into three search engines (Google.com, Google.co.uk and Google.com.au). The first 50 sites for each set of search terms were examined. Any links appearing on these websites, which the authors thought may contain useful information, were followed. Relevant journal articles were located by searching a number of academic databases (CSA PsycINFO, PubMed and Google Scholar). Key print texts were identified through library searches, recommendations from relevant mental health web sites, and Amazon.com.

Development of the first round questionnaire involved dividing the information gleaned from the systematic literature search into sections based on common themes and then developing statements that described first aid actions.

This process involved consultation with a working group, which had previous experience in Delphi research (Kelly, Jorm, & Kitchener, submitted; Kelly et al., 2008a; Kelly, Jorm, Kitchener, & Langlands, 2008b; Langlands et al., 2008a, 2008b). The working group attempted to remain as faithful as possible to the original wording of the information, but modified the text where necessary to ensure comprehensibility and consistency of format across statements.

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Data Collection and Analysis

The questionnaire was distributed to participants via an electronic link to an online survey software system (surveymonkey.com) sent in an email. Panel members were asked to rate how important each first aid action statement was to the development of a set of guidelines on providing mental health first aid for eating disorders. The questionnaire involved a 5-point scale including the following options: *Essential, Important, Don't Know/Depends, Unimportant, Should not be included.* In Round 1, panel members were also invited to make comments on any ambiguity in the statements presented and to suggest any new ones that had not yet been considered.

Once all participants had logged their answers, statements were placed into one of three categories, following the procedure used in previous studies

(Kelly et al., submitted; Kelly et al., 2008a, 2008b; Langlands et al., 2008a, 2008b):

1. *Endorsed*. If between 80 and 100 percent of all three panels rated a statement as either *Essential* or *Important*, the statement was endorsed as a guideline.
2. *Re-rate*. There were two scenarios that would categorise a statement for re-rating in a second round survey:
   a. If between 70 and 79 percent of two or more panels rated a statement as either *Essential* or *Important;*
   b. If between 80 and 100 percent of any one panel rated a statement as either *Essential* or *Important*;
3. *Rejected*. If none of the above conditions were met.

The protocol of using the *Essential* and *Important* ratings for categorisation was designed to allow selection of only those statements that were clear and universally applicable for inclusion in the guidelines.

Comments that were submitted by panel members were also analysed for any content that had not yet been addressed. To ensure comprehensibility and consistency, any additional ideas gleaned from the comments were written into first aid action statements and presented to the working group. Any statement that was judged by the group to be an original idea was included as a new item in the second round survey questionnaire.

Panel members were sent a report, outlining the results of the survey. The statements to be re-rated were displayed with the group percentages for each possible rating, and also with the panel member's individual rating, so that panel members could compare their response to that of the group. Presentation of the report in this way allowed the panel members to decide whether to maintain or modify their ratings in the next survey round.

The same criteria for endorsing, excluding and re-rating statements were applied to the data collected in Round 2, with one exception. If a statement was re-rated in the second round and again failed to achieve a consensus of between 80 and 100 percent across all three panels, it was then excluded. Only those statements that had been entered as new items in Round 2, and afterward fell into the *Re-rate* category, were entered into a third round survey.

Guideline Development

All endorsed statements were written into a guideline document. This process involved grouping statements based on common themes, then writing sections into prose. Once the guideline document had been drafted (by LMH),

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consultation was again sought from the working group, who endeavoured to retain, as closely as possible, the wording of the original items. A copy of the final draft was sent to each panel member for endorsement. Upon final endorsement by the expert panel, the guideline was made available for free download in PDF format (see the Mental Health First Aid website: www.mhfa.com.au).

RESULTS

From the systematic literature search, 326 statements across 13 categories were presented to the panel members for rating in Round 1. Comments from the panel members contributed to a further 130 statements being included in Round 2. Thirty-six clinicians (29 female, 7 male, range = 25–64 years), 27 care-givers (24 female, 3 male, range = 30–70 years), and 22 consumers (22 female, 0 male, range = 18–70 years) participated in the first round. The retention rate after each round was good (76.74% in Round 2, 75.58% in Round 3), which ensured that the consensus reached in subsequent rounds was not biased by panel attrition (Hasson, Keeney, & McKenna, 2000).

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Endorsed Items

From a total of 456 statements, 200 were endorsed. A list of each of the endorsed statements, by category, and their percentage rating from each panel is provided in Tables 1–11.

In Round 1 the category entitled *What is a medical emergency?* was designed to have panel members agree upon the circumstances in which a first aider should seek emergency medical assistance for someone with an eating disorder. Because the statements in this section required some knowledge of emergency medicine, only those panel members who had some form of medical training were requested to rate these statements. Of the 15 panel members who were qualified, there was 1 psychiatrist, 3 physicians, 4 general practitioners/family doctors and 7 nurses. Of 25 possible statements, 16 were endorsed (Table 12).

Rejected Items

Some statements were strongly rejected by the panels, with a high percentage of participants rating a statement as either *Unimportant* or *Should not be included*. Other statements were rejected because there was disagreement across panels. For instance, some statements failed to be endorsed, even though at least one group had a high percentage of members rating it as either *Essential* or *Important,* because at least one other panel, even after a second rating, failed to achieve at least an 80% consensus rating. Because

TABLE 1 Endorsed Statements Concerning "Understanding and Awareness," Showing Percentage of Panel Members Who Endorsed Each Statement as Either "Essential" or "Important"

Endorsed statements	Consumers	Care-givers	Clinicians
1. The first aider should . . .			
. . . be aware that EDs are illnesses in which a person experiences severe disturbances in eating behaviours, thoughts and emotions.	95.5	100.0	97.2
. . . be aware that EDs affect people in all age groups, genders, socio-economic and cultural backgrounds.	95.5	100.0	94.4
. . . consider an ED a serious and potentially life threatening mental illness.	95.5	100.0	91.7
. . . reject the myths that EDs are just about food, weight, vanity or will-power.	95.5	82.1	100.0
. . . be aware that there is no quick and easy solution to overcoming an ED.	86.4	100.0	94.4
. . . be aware that for most people, the earlier help is sought for disordered eating behaviours, the easier it will to overcome the problem.	86.4	100.0	91.7
. . . know the early warning signs of disordered eating.	90.9	96.4	94.4
. . . know that disordered eating occurs when a person's attitude about food, weight, body size or shape leads to marked changes in eating or exercise behaviours that interfere with the person's life.	90.9	82.1	83.3
. . .be aware that a person with an ED may attempt to control their weight by using weight loss strategies such as: dieting, fasting, over-exercising, using slimming pills, diuretics, laxatives, and/or purging.	100.0	100.0	97.2
. . . be aware that if the person is underweight and using extreme weight-loss strategies, they may have anorexia.	81.8	85.7	94.4
. . . be aware that if the person is engaging in binge eating followed by weight-loss strategies, they may have bulimia.	86.4	85.7	86.1
. . . be aware that individuals with bulimia can be slightly underweight, normal weight, or overweight.	100.0	100.0	91.7
. . . be aware that not all people with binge eating disorder are overweight.	95.5	85.7	86.1
. . . be aware that many disordered eating behaviours occur in secret.	100.0	100.0	100.0
. . . be aware that people with anorexia usually deny having a problem.	95.5	100.0	94.4
. . . be aware that the person may use deceit to hide their eating and exercising behaviours.	95.5	100.0	91.7
. . . be aware that a person with an ED may feel shame, guilt and distress about their disorder.	100.0	96.4	100.0
. . . be aware that a person with an ED might find it difficult to ask for help from family and friends.	100.0	100.0	94.4
. . . be aware that a person with an ED may be at risk of becoming suicidal.	90.9	96.4	86.1

(*Continued*)

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TABLE 1 (*Continued*)

Endorsed statements	Consumers	Care-givers	Clinicians
. . . be aware that it is common for a person with an ED to also experience another mental illness, such as depression.	86.4	96.4	80.6
. . . be aware that a person who is malnourished due to severe anorexia, may appear to have psychotic symptoms such as disordered thinking, delusions or hallucinations.	95.5	100.0	83.3
. . . be aware that rapid weight loss or being very underweight can bring about a range of serious physical and psychological problems.	100.0	100.0	94.4
. . . be aware that a person with an ED can experience a wide range of physical health complications including serious heart conditions and kidney failure which may lead to death.	100.0	100.0	94.4
. . . be aware that people do not need to be underweight to suffer from the serious health consequences associated with Eds, including severe malnutrition, brain dysfunction, and heart or kidney failure.	100.0	92.9	94.4
. . . be aware that effective treatment is available for EDs.	100.0	92.9	94.4
. . . be aware that effective treatment involves a multidisciplinary approach.	81.8	85.7	86.1
. . . be aware that a person with an ED will benefit from professional help.	81.8	85.7	94.4
. . . be aware that a person does not have to be underweight to have an ED.	92.9	100.0	100.0
. . . be aware that individuals with an ED can be slightly underweight, normal weight, or overweight.	92.9	95.8	100.0
. . . be aware that people with an ED usually deny having a problem.	92.9	91.7	89.3
. . . be aware that it is possible that a person may lose consciousness as a result of an ED. (Re-rated in Round 2)	100.0	100.0	82.1
. . . be aware that while death occurs less often among people with bulimia than people with anorexia, there have been cases of heart failure in both groups. (Re-rated in Round 2)	85.7	95.8	82.1
2. Social and behavioural warning signs			
Dieting behaviours (e.g., fasting, counting calories, avoidance of food groups or types).	85.7	95.8	100.0
Evidence of binge eating (e.g., disappearance or hoarding of food).	100.0	100.0	96.4
Evidence of vomiting or laxative use (e.g., taking trips to the bathroom during or immediately after meals).	100.0	100.0	100.0
Excessive, obsessive or ritualistic exercise patterns (e.g., exercising when injured or in bad weather, feeling compelled to perform a certain number of repetitions of exercises or experiencing distress if unable to exercise).	100.0	100.0	96.4

(*Continued*)

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TABLE 1 (*Continued*)

Endorsed statements	Consumers	Care-givers	Clinicians
Changes in food preferences (e.g., refusing to eat certain "fatty" or "bad" foods, or cutting out whole food groups such as meat or dairy, claiming to dislike foods previously enjoyed, a sudden concern with "healthy eating," or replacing meals with fluids).	92.9	95.8	92.9
Development of rigid patterns around food selection, preparation and eating (e.g., cutting food into small pieces, eating very slowly).	100.0	100.0	92.9
Avoidance of eating meals, especially when in a social setting (e.g., skipping meals by claiming they have already eaten or have an intolerance/allergy to particular foods).	100.0	100.0	96.4
Lying about amount or type of food consumed or evading questions about eating and weight.	100.0	95.8	89.3
Pre-occupation with food (e.g., planning, buying, preparing and cooking meals for others but not consuming meals themselves, interest in cookbooks, recipes and nutrition).	100.0	95.8	92.9
Pre-occupation with body shape and weight (e.g., interest in weight-loss websites, books and magazines, or images of thin people).	92.9	91.7	85.7
Development of repetitive or obsessive behaviours relating to body shape and weight (e.g., body-checking such as pinching waist or wrists, repeated weighing of self, excessive time spent looking in mirrors).	85.7	95.8	92.9
Social withdrawal or avoidance of previously enjoyed activities.	100.0	95.8	92.9
3. Physical warning signs			
Weight loss or weight fluctuations.	100.0	91.7	96.4
Changes in or loss of menstrual patterns.	100.0	95.8	92.9
Swelling around the cheeks or jaw, calluses on knuckles, or dental discolouration from vomiting.	85.7	87.5	92.9
Sensitivity to the cold or feeling cold most of the time, even in warm temperatures. (Re-rated in Round 3)	95.8	88.9	85.7
Extreme body dissatisfaction.	92.9	95.8	96.4
Distorted body image (e.g., complaining of being/feeling/looking fat when a healthy weight or underweight).	100.0	95.8	89.3
4. Cognitive and emotional warning signs			
Sensitivity to comments or criticism about exercise, food, body shape or weight.	92.9	95.8	82.1
Heightened anxiety around meal times.	100.0	91.7	96.4
Depression, anxiety or irritability	92.9	100.0	89.3
Low self-esteem (e.g., negative opinions of self, feelings of shame, guilt or self-loathing).	100.0	91.7	89.3
Rigid 'black and white' thinking (e.g., labelling of food as either "good" or "bad").	92.9	91.7	89.3

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TABLE 2 Endorsed Statements Concerning "What Do You Do If You Suspect an ED?" Showing Percentage of Panel Members Who Endorsed Each Statement as Either "Essential" or "Important"

Endorsed statements	Consumers	Care-givers	Clinicians
The first aider should know that a delay in seeking treatment for an ED can lead to serious long term consequences to physical and mental health for the person.	90.9	96.4	91.7
Even if the first aider thinks the person's problem is not serious, they should not delay talking with the person or seeking professional help.	81.8	96.4	83.3
Before doing anything else, the first aider should . . . Learn as much as they can about EDs by reading books, articles and brochures, or gathering information from a reliable source, such as an ED support organisation or a health professional experienced in treating EDs.	95.5	82.1	83.3
If the first aider suspects that a CHILD is developing or experiencing an ED . . .			
. . . the first aider should approach a family member or loved one of the person, before approaching the person about their eating.	92.9	100.0	85.7
. . . the first aider should approach the person's parents before approaching the person about their eating.	92.9	95.8	85.7

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disagreements across the different panels provide an opportunity to assess some of the priorities different groups give to different statements, those with substantial disagreement were analysed for thematic content. Panels were considered to have substantial disagreement (large effect size) if the difference in endorsement between the panels was ≥30% (Table 13; Rosenthal, 1996).

DISCUSSION

The current study used the Delphi method to develop guidelines for eating disorder first aid. The systematic literature search revealed that there were numerous relevant publications, such as fact sheets and booklets, on how to assist a loved one with an eating disorder. The major sources of first aid advice were publications by eating disorder organisations (such as *Anorexia Nervosa and Related Disorders Inc*. ANRED - USA, *b_eat* - UK, *Eating Disorders Foundation of Victoria* - Aus, *Eating Disorders Association Queensland* - Aus, and *National Eating Disorder Association* NEDA - USA). The majority of these publications however, did not cite the source of the information presented and were most likely constructed using personal opinion. The publications

TABLE 3 Endorsed Statements Concerning "Approaching the Person" Showing Percentage of Panel Members Who Endorsed Each Statement as Either "Essential" or "Important"

Endorsed statements	Consumers	Care-givers	Clinicians
The first aider should . . .			
. . . make a plan before approaching the person.	86.4	92.9	88.9
. . . be aware that having the whole family, or a number of people, confront the person at the same time could be overwhelming for the person.	90.9	85.7	91.7
. . . have an aim to provide support for the person so that they feel safe and secure enough to seek treatment.	86.4	92.9	94.4
. . . be aware that they are unlikely to resolve the problem in the first conversation.	100.0	100.0	100.0
. . . be aware that it is common to feel nervous when approaching the person about their disordered eating.	95.5	92.9	100.0
. . . not fear talking to the person because they think it might make the person angry or upset, or might make their problem worse.	90.9	100.0	97.2
. . . be aware that the person might feel relief at having someone acknowledge their problems.	90.9	96.4	97.2
. . . be aware that the person may find it helpful to know that someone cares about them and has noticed that they are not coping.	90.9	100.0	97.2
. . . pick a place that is private, quiet and comfortable.	95.5	85.7	97.2
. . . try not to approach the person when they or the first aider are drinking, tired, having a meal, or in a place surrounded by food, as this may lead the person to become sensitive or defensive.	86.4	82.1	88.9
. . . avoid approaching the person when they or the first aider are feeling angry, emotional or frustrated.	86.4	82.1	91.7
. . . remember that a person with an ED may respond negatively no matter how sensitively they are approached.	100.0	95.8	100.0
. . . be aware that the sooner they discuss their concerns with the person the better. (Re-rated in Round 2)	85.7	91.7	82.1

that did acknowledge references appeared to be based on a mixture of opinion and literature reviews, which often included outdated clinical sources. In addition to the fact-sheets, books written by clinical experts for care-givers of loved-ones with eating disorders were also a valuable source of information (Costin, 1999; Heaton, Heaton, & Strauss, 2005; Kolodny, 2004; Siegel, Brisman, & Weinshel, 1997). These, however, also presented information based on a mix of opinion and literature; the majority quoted

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TABLE 4 Endorsed Statements Concerning "How to Communicate Your Concerns to the Person" Showing Percentage of Panel Members Who Endorsed Each Statement as Either "Essential" or "Important"

Endorsed statements	Consumers	Care-givers	Clinicians
1. The first aider should . . .			
. . . be non-judgemental and respectful when talking with the person.	100.0	96.4	100.0
. . . stay calm.	100.0	100.0	97.2
. . . be kind to the person.	95.5	89.3	88.9
. . . remember that they don't have to know all the answers.	100.0	96.4	100.0
. . . try to use "I" statements that are not accusing, such as "I am worried about you", rather than "you" statements such as "You are making me worried".	90.9	89.3	94.4
. . . discuss their concerns with the person in an open and honest way.	81.8	89.3	97.2
. . . be willing to repeat their concerns.	90.9	92.9	88.9
. . . reassure the person that it is safe to be open and honest about how they feel.	90.9	92.9	97.2
. . . allow the person plenty of time to discuss their feelings.	90.9	82.1	94.4
. . . initially focus on conveying empathy, and not on changing the person or their perspective.	90.9	85.7	97.2
. . . allow the person to discuss other concerns that are not about food, weight or exercise.	95.5	92.9	86.1
. . . avoid arguing or being confrontational with the person.	90.9	92.9	88.9
. . . avoid being critical of the person.	100.0	100.0	91.7
. . . not tell the person that what they are doing is "disgusting", "stupid" or "self-destructive".	90.9	96.4	91.7
. . . not speak harshly to the person.	90.9	96.4	86.1
. . . avoid speculating about the cause of the person's problems.	86.4	92.9	91.7
. . . not blame the person or their loved ones for the person's problems.	100.0	96.4	97.2
. . . avoid placing shame or guilt for the person's disordered eating.	100.0	96.4	100.0
. . . avoid making promises to the person that they cannot keep.	100.0	96.4	100.0
. . . avoid giving simple solutions to overcoming disordered eating, such as saying things like "all you have to do is eat".	100.0	85.7	100.0
. . . avoid making generalisations such as 'never' and 'always'. Try not to claim, for instance, that 'you're always moody' or 'you never do anything but exercise'.	100.0	85.7	94.4
. . . not try to solve the person's problems for them.	90.9	82.1	97.2

(*Continued*)

TABLE 4 (*Continued*)

Endorsed statements	Consumers	Care-givers	Clinicians
. . . encourage the person to find someone they can trust to talk to openly about their difficulties, such as a family member, friend, teacher, co-worker etc.	85.7	91.7	92.9
. . . reassure the person that they are deserving of love and concern.	92.9	100.0	82.1
. . . explain to the person that the first aider's role is to assist them in getting the help they need. (Re-rated in Round 2)	92.9	95.8	100.0
. . . not give advice about weight loss, exercise or appearance. (Re-rated in Round 2)	92.9	91.7	100.0
. . . not just focus on weight or food. (Re-rated in Round 2)	85.7	83.3	100.0
. . . not try to force the person to eat. (Re-rated in Round 2)	85.7	83.3	92.9
. . . avoid reinforcing the idea that physical appearance is critically important to happiness or success. (Re-rated in Round 2)	85.7	95.8	89.3
2. The first aider should be aware that . . . . . . they may not agree with what the person says about themselves and food.	95.5	100.0	100.0
. . . they may find it tough to listen to what the person has to say.	100.0	100.0	97.2
. . . there will be times when they don't know what to say. In this instance the first aider should just be there for the person.	100.0	96.4	100.0
. . . the person may have difficulty trusting others.	95.5	96.4	100.0
. . . how they discuss the person's problem will depend on the age of the person and the degree to which their problem has developed.	86.4	96.4	88.9

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clinical experience and case studies from former patients, yet had no systematic analysis of the effect (positive or otherwise) their advice would have on a person with an eating disorder and those trying to assist them.

In contrast, the scientific literature contained a dearth of information on the subject of first aid, even when searched under the broader headings of *help*, *intervention* or *carer*. One notable exception was a study by Smalec and Klingle (2000) who investigated the efficacy of interpersonal messages on persuading women with bulimia to seek help. This study, however, assessed the effect of written messages on the help seeking intentions of women already in treatment, rather than a systematic analysis of the effect of verbal messages on actual help-seeking, and therefore was limited in its utility.

To the authors' knowledge, this research is the first systematic, consensus-based study of how a member of the public should provide assistance to

TABLE 5 Endorsed Statements Concerning "The Person's Reaction" Showing Percentage of Panel Members Who Endorsed Each Statement as Either "Essential" or "Important"

Endorsed statements	Consumers	Care-givers	Clinicians
1. The first aider should			
. . . understand that the person may react negatively because they do not see their eating habits as disordered or problem behaviour.	100.0	96.4	100.0
. . . not take the person's negative reaction personally.	100.0	100.0	100.0
. . . not express disappointment or shock if the person responds with denial, anger, aggression, tears or defensiveness.	95.5	92.9	94.4
. . . remind the person that even if they don't agree, the first aider's support is still offered, and the person can come and talk with them again in the future.	95.5	100.0	94.4
. . . encourage the person to be proud of any positive steps they have taken, such as acknowledging their disordered eating or exercising habits or agreeing to professional help.	90.9	100.0	97.2
. . . explain to the person that even if there are limits to what they can do for the person, they are still going to try and help.	95.5	89.3	91.7
. . . tell the person that they will always be there to listen if the person wants to talk	86.4	82.1	80.6
. . . reassure the person that they are not going to take control over the person's life, but rather will assist them to get help.	90.9	82.1	91.7
. . . tell the person that people with EDs can get better.	90.9	92.9	97.2
. . . understand that the person may react negatively because they are not ready to make a change.(Re-rated in Round 2)	92.9	87.5	92.9
. . . understand that the person may react negatively because they do not know how to change without losing their coping strategies. (Re-rated in Round 2)	100.0	87.5	92.9
. . . assert that they care about the person and are committed to supporting them.	100.0	100.0	92.9
2. The first aider should be aware that . . .			
. . . the person may react in a variety of different ways. For example, the person might be positive and receptive, they might admit that they have a problem, or they may be denying, defensive, angry or aggressive.	100.0	100.0	97.2
. . . they may be perceived by the person as being pushy, nosey, coercive or bullying.	100.0	96.4	91.7
. . . the person may seek to re-assure or convince them that he or she is fine and that there is no problem.	100.0	100.0	100.0

(*Continued*)

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TABLE 5 (*Continued*)

Endorsed statements	Consumers	Care-givers	Clinicians
. . . the person may want time to absorb the first aider's comments and concerns.	95.5	92.9	94.4
If the person gets angry, the first aider should resist the temptation to respond angrily, as this may escalate the situation.	100.0	96.4	100.0

TABLE 6 Endorsed Statements Concerning "Seeking Professional Help" Showing Percentage of Panel Members Who Endorsed Each Statement as Either "Essential" or "Important"

Endorsed statements	Consumers	Care-givers	Clinicians
1. The first aider should . . .			
. . . explain that they think that the person's behaviours or symptoms may indicate there is a problem that needs professional attention.	81.8	89.3	83.3
. . . remember that the sooner the person gets the help they need, the more likely they are to make a full recovery.	95.5	96.4	91.7
. . . encourage the person to find someone they can trust to talk openly about their difficulties, such as a family member, friend, teacher, co-worker etc. (Re-rated in Round 2)	92.9	87.5	92.9
. . . encourage the person to seek help from a professional with specific training in EDs.	90.9	96.4	94.4
. . . know that sometimes it is difficult for a GP or family doctor to recognise an ED.	95.5	100.0	91.7
2. The first aider should be aware that . . .			
. . . if the person is very underweight, the person may not be able to take responsibility for getting professional help.	86.4	96.4	91.7
. . . some doctors are not formally trained in detecting and treating EDs. This means that they may not know how to assess or assist someone who is thought to be developing or experiencing an ED.	85.7	95.8	96.4
. . . even if the person has experienced disordered eating or exercising behaviours for a long time, they are still likely to benefit from professional help.	90.9	100.0	97.2

someone experiencing or developing an eating disorder. By including panel members with a range of expertise, this study was able to develop a set of guidelines on how to manage issues that are expected to confront someone providing first aid for eating disorders. One of the strengths of the Delphi method is the provision, in the first round questionnaire, for participant comments. Encouraging panel members to provide the research team with

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TABLE 7 Endorsed Statements Concerning "What If the Person Refuses Help?" Showing Percentage of Panel Members Who Endorsed Each Statement as Either "Essential" or "Important"

Endorsed statements	Consumers	Care-givers	Clinicians
1. The first aider should . . .			
. . . be sensitive towards the person's fears about the process of seeking help.	100.0	92.9	100.0
. . . not threaten to end their relationship with the person but rather continue to be supportive.	81.8	82.1	86.1
. . .not give up on the person.	86.4	96.4	94.4
. . . recognise that EDs are long-term problems that are not easily overcome.	95.5	82.1	94.4
2. The first aider should be aware that . . .			
. . . they cannot force the person to change their attitudes, behaviours, or to seek help. (Re-rated in Round 2)	92.9	87.5	96.4
. . . the symptoms of an ED can affect the person's ability to think clearly.	86.4	100.0	94.4
. . . it is common for a person with an ED to resist seeking help because they believe that there are benefits to their disordered eating or exercising behaviours. For instance, controlling their weight may make the person feel better about themselves, or give them a sense of accomplishment.	90.9	89.3	97.2
. . . the person may resist seeking help for a number of reasons; these may include feeling ashamed, fear of gaining weight or fear of losing control over their weight.	90.9	100.0	97.2
. . . the person may resist seeking help because they are afraid to acknowledge that they are unwell or do not think that they are ill.	95.5	100.0	94.4
If the person resists seeking professional help, the first aider should . . . Seek advice from an organisation which specialises in EDs.	95.5	89.3	94.4
When speaking with the person, the first aider should acknowledge that recovery is hard but many people have done it. (Re-rated in Round 2)	92.9	87.5	85.7

their ideas not only allows the researchers to refine ambiguous, insensitive or contentious statements, it also ensures that the experience of eating disorder experts can be mined for pertinent issues that may not have been uncovered by the initial literature search.

Feedback from the panel after the first round, for instance, indicated that many statements were being given a *Don't Know/Depends* rating because their utility varied depending on the age of the person receiving the first aid. For example, the statement "*To respect the person's privacy, the first aider should not talk to someone close to the person about their disordered eating behaviours*" received many comments such as *"This depends on the*

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TABLE 8 Endorsed Statements Concerning "How to be Supportive Until the Person Seeks Help" Showing Percentage of Panel Members Who Endorsed Each Statement as Either "Essential" or "Important"

Endorsed statements	Consumers	Care-givers	Clinicians
1. The first aider should . . .			
. . . encourage the person to surround themselves with people who are supportive of them.	100.0	100.0	83.3
. . . be positive, supportive and encouraging towards the person.	100.0	100.0	100.0
. . . be encouraging of the person's strengths and interests that are unrelated to food or physical appearance.	95.2	92.9	88.9
. . . acknowledge the person's positive attributes, successes and accomplishments.	90.5	82.1	88.9
. . . view the person as an individual rather than just someone who has an ED.	100.0	100.0	100.0
. . . tell the person that past unsuccessful attempts to get better do not mean that the person cannot get better in the future.	95.2	89.3	88.9
. . . continue to suggest the person seek professional help. (Re-rated in Round 2)	85.7	95.8	96.4
. . . let the person know that they want the person to be healthy and happy. (Re-rated in Round 2)	92.9	87.5	92.9
. . . avoid conflict or argument with the person over food. (Re-rated in Round 2)	92.9	83.3	96.4
2. The first aider should not . . .			
. . . overwhelm the person with information and suggestions.	100.0	91.7	96.4
. . . expect the person to immediately follow their advice, even if the person has asked for it.	95.2	92.9	100.0
. . . let issues of food dominate their relationship with the person.	85.7	85.7	94.4
. . . comment positively or negatively on the person's weight or appearance, for instance by saying "you're too thin" or "good you have gained weight."	85.7	82.1	88.9
If the first aider becomes aware that the person is visiting pro-ana or pro-mia websites, the first aider should discourage further visits, as the websites can encourage destructive behaviour. (Re-rated in Round 2)	85.7	87.5	85.7

age of the person. If they are a child the caregiver should be informed." In order to overcome this difficulty, the statements which attracted the most comments from the panel were qualified in the second round by allowing participants to rate the statement in three scenarios—when assisting an adult, an adolescent, or a child. This qualification resulted in a further two statements being endorsed and, importantly, the exclusion of some

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TABLE 9 Endorsed Statements Concerning "When the First Aider is a Parent of a Child or Adolescent With an ED" Showing Percentage of Panel Members Who Endorsed Each Statement as Either "Essential" or "Important"

Endorsed statements	Consumers	Care-givers	Clinicians
1. The parent should. . .			
. . . express their love and support for the child no matter how upsetting their behaviour is.	100.0	96.4	97.2
. . . take responsibility for getting professional help for the child.	85.7	100.0	91.7
. . . always be clear and honest with the child about what to expect from any professional treatment that the parent may seek for them.	90.5	82.1	97.2
. . . maintain a caring and supportive home environment.	100.0	100.0	100.0
. . . understand that the child's resistance to eating, seeking treatment or gaining weight is motivated by fear and anxiety rather than a desire to be difficult.	92.9	100.0	100.0
. . . not let empathy for the child inadvertently lead them to supporting their child's disorder.	85.7	96.4	94.4
. . . accept disordered eating behaviours as "normal adolescent behaviour."	90.5	100.0	97.2
. . . let the child always be the one to decide when, what and where the family will eat.	90.5	100.0	86.1
2. The parent should be aware that. . .			
. . . a child who has disordered eating habits does not have to meet all the clinical criteria for an ED in order to suffer from the long-term negative effects of disordered eating and weight control behaviours.	90.5	92.9	94.4
. . . if the child is underage, the parent can legally force their child to attend an appointment with a GP or family doctor, psychiatrist or other appropriate professional.	85.7	92.9	83.3
. . . if disordered eating behaviours are left untreated in young people, the behaviours can quickly develop into serious disorders that are difficult to overcome.	95.2	100.0	94.4
. . . because disordered eating in children can have long-lasting negative consequences on their growth and development, it is particularly important that the parent does not delay seeking help.	95.2	100.0	94.4
3. If the parent . . .			
. . . and child attend an appointment, and the parent is worried that the professional is ignoring the child's condition, or has not correctly diagnosed the ED, the parent should seek a second opinion.	100.0	100.0	94.4

(*Continued*)

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TABLE 9 (*Continued*)

Endorsed statements	Consumers	Care-givers	Clinicians
. . . suspects that their child may be experiencing an eating disorder, the parent should seek advice from a professional or organisation specialising in EDs.	92.9	100.0	100.0
. . . suspects their child is developing an eating disorder, the parent should observe the child's behaviour for any warning signs.	92.9	100.0	96.4
. . . is concerned about intruding on their child's privacy, the parent should remember that it is their right to ensure that their child is safe and healthy.	92.9	95.8	96.4
When initiating discussion with the child, the parent should stress how much the child is loved, and that the parent's concerns for them, stem from that love.	100.0	96.4	91.7
If the child becomes harmful to themselves or others, the parent must be prepared to move them to a safe environment, such as a hospital.	85.7	96.4	100.0

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first aid actions that may have been age-inappropriate for children or adolescents, such as maintaining a respect for privacy above the need for health care.

Although the experts were able to reach consensus on a wide range of issues, there were also important points of disagreement between the panels. Statements that were rejected due to strong disagreement revealed differences in the beliefs consumers, care-givers and clinicians had about the first aid process. These statements appeared to cluster around three themes. The first theme involved the conditions in which it is acceptable for a first aider to break confidentiality and start talking to others about the person's problem. This theme appeared to represent a tension between the rights of the person with the eating disorder to privacy and the rights of the first aider to seek help on behalf of the person. For instance, the Round 2 statement, *"If the person is an adult the first aider should respect the person's right to privacy and confidentiality when it comes to their eating and weight-loss behaviours, except where the person is placing their health at risk"* received a relatively high level of endorsement from consumers and clinicians, yet a relatively low level of endorsement from the care-giver panel. This may indicate a desire among the care-givers to discuss their loved one's problem in specific detail before health is placed at risk, while clinicians and consumers are perhaps more desirous of upholding privacy until a risk has become apparent. The second theme involved statements about active intervention by the first aider. This theme appeared to represent a tension between the care-givers and clinicians, who preferred early action from the first aider, and the consumers,

TABLE 10 Endorsed Statements Concerning "If the First Aider is a Young Person Helping a Friend With a Suspected ED" Showing Percentage of Panel Members Who Endorsed Each Statement as Either "Essential" or "Important"

Endorsed statements	Consumers	Care-givers	Clinicians
1. If the friend . . .			
. . . is hiding their behaviours from their family or loved ones, the young person should encourage the friend to tell them.	81	92.9	91.7
. . . hiding their behaviours from their family and loved ones, the young person should encourage the friend to find a responsible adult they can trust and talk to about what's going on.	100.0	89.3	97.2
. . . hiding their behaviours from their family and loved ones, the young person should tell a responsible and trusted adult, even if it is against the friend's wishes. (Re-rated in Round 2)	85.7	100.0	92.9
. . . refuses to tell an adult, the young person should then tell a trusted and responsible adult themselves, even if it is without the consent of the young person.	85.7	100.0	89.3
2. The young person should be aware that . . .			
. . . a responsible and trusted adult could be a parent, teacher, coach, pastor, school nurse, school counsellor, GP/family doctor, psychologist or nutritionist.	95.2	100.0	97.2
. . .telling the family or responsible and trusted adult about the friend's eating and exercising behaviours may make the friend angry, but it may also save their life.	95.2	100.0	94.4
. . .eating disorders are serious illnesses, they should not be kept secret.	85.7	100.0	100.0
If the young person feels unable to approach the friend's parents/trusted adult by themselves, the young person should ask for help and support from their own parents or loved ones.	90.5	96.4	97.2
If the young person has told an adult about their friend's eating and exercise behaviours, and the adult has not helped the friend, the young person should talk to another responsible and trusted adult or a professional who is trained in assessing and treating EDs.	100.0	100.0	82.1

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who preferred for the first aider to remain more distant. For instance, clinician and care-giver panels endorsed the item "*If the first aider suspects that the person has an ED it is important that they do something about it*" much more strongly than the consumer panel. Finally, a small group of items appeared to represent the desire of care-givers to be involved in the first aid process. Items that were about the first aider enlisting the help of the person's family were more highly endorsed by care-givers than by the consumer and clinician panels.

TABLE 11 Endorsed Statements Concerning "During an Emergency" Showing Percentage of Panel Members Who Endorsed Each Statement as Either "Essential" or "Important"

Endorsed statements	Consumers	Care-givers	Clinicians
1. The first aider should . . .			
. . . know the symptoms that indicate a crisis or advanced disorder.	100.0	100.0	91.7
. . . be aware that the person has a right to refuse treatment, except under specific circumstances described in local relevant legislation (e.g., if the person's life is in danger).	95.2	92.9	94.4
. . . understand that the person does not have to be underweight in order for the person to require emergency medical assistance.	100.0	100.0	100.0
If the person is admitted to the Emergency Department/Room for any reason, the first aider should tell the medical staff that they suspect the person has an ED.	85.7	82.1	91.7

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TABLE 12 Endorsed Statements Concerning "What is a Medical Emergency"

Endorsed statements	Panellists*
The first aider should call for emergency medical assistance if the person . . .	
. . . is suicidal.	100
. . . has disordered thinking and they are not making any reasonable sense.	80.0
. . . is disoriented; doesn't know what day it is, where they are or who they are.	100
. . . is throwing up several times a day.	86.7
. . . is experiencing fainting spells.	100
. . . is too weak to walk or collapses.	100
. . . has painful muscle spasms.	92.9
. . . is complaining of chest pain, or having trouble breathing.	100
. . . has blood in their bowel movements, urine or vomit.	100
. . . has a BMI of less than 16.	80.0
. . . has a BMI of less than 15.	86.7
. . . a very low heart beat (less than 40 beats per minute).	100
. . . a very low heart beat (less than 50 beats per minute).	86.7
. . . an irregular heart beat.	86.7
. . . a body temperature of less than 35 degrees centigrade/95 degrees Fahrenheit.	93.3
. . . cold or clammy skin indicating a low body temperature.	80.0

*Only those panel members who had training in emergency medicine were required to answer these questions in Round 1.

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TABLE 13 Statements Rejected Due to Strong Disagreement Between Panels

Statements with strong disagreement	% of Consumers (1)	% of Care-givers (2)	% of Clinicians (3)	Difference b/w 1 & 2	Difference b/w 1 & 3	Difference b/w 2 & 3
When seeking information about EDs from a health professional, the first aider should maintain the confidentiality of the person by not disclosing information that may identify the person.	77.3	39.3	63.9	38.0	13.4	–24.6
The first aider should reassure the person that they are likely to benefit from discussing their problems with the first aider.	72.7	39.3	58.3	33.4	14.4	–19.0
*If the person is an ADULT the first aider should respect the person's right to privacy and confidentiality when it comes to their eating and weight-loss behaviours, except where the person is placing their health at risk.	85.7	45.8	67.9	39.9	17.9	–22.0
*The first aider should try to demonstrate that they care about the person, for example by offering encouraging words or a hug. (Re-rated in Round 2)	78.6	91.7	53.6	–13.1	25.0	38.1
*If the person is an ADOLESCENT the first aider should respect the person's right to privacy and confidentiality when it comes to their eating and weight-loss behaviours, except where the person is placing their health at risk.	78.6	41.7	64.3	36.9	14.3	–22.6
*If the person is an ADULT the first aider should respect their right to privacy and confidentiality when it comes to their eating and weight-loss behaviours, except where the person is placing their life at risk.	78.6	41.7	64.3	36.9	14.3	–22.6

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TABLE 13 (*Continued*)

Statements with strong disagreement	% of Consumers (1)	% of Care-givers (2)	% of Clinicians (3)	Difference b/w 1 & 2	Difference b/w 1 & 3	Difference b/w 2 & 3
*If the person is an ADOLESCENT the first aider should respect their right to privacy and confidentiality when it comes to their eating and weight-loss behaviours, except where the person is placing their life at risk.	71.4	41.7	60.7	29.8	10.7	−19.0
*If the first aider suspects that the person has an ED it is important that they do something about it.	57.1	91.7	82.1	−34.5	−25.0	9.5
*If the first aider is concerned that the person's ED is severe, and the first aider has tried to talk to them about treatment without success, the first aider should enlist the support of other loved ones.	50.0	83.3	71.4	−33.3	−21.4	11.9
*If the first aider is having trouble finding a time when the person is not angry, emotional or frustrated, it is best that the first aider approach the person as soon as possible.	35.7	70.8	64.3	−35.1	−28.6	6.5
*The first aider should encourage the person to get their family involved in helping them find appropriate professional help	28.6	79.2	42.9	−50.6	−14.3	36.3
∞Social and behavioural warning signs - Changes in clothing style (e.g. wearing baggy clothes to disguise the figure).	83.3	63.0	50.0	20.4	33.3	13.0
∞If the young person is worried about the friend, the young person should seek support or advice from a professional or organisation that specialises in EDs.	54.2	77.8	85.7	−23.6	−31.5	−7.9

Panels were considered to have substantial disagreement (large effect size) if the difference in endorsement between the panels was ≥30%.
*Results shown are re-ratings occurring in Round 2.
∞Results shown are re-ratings occurring in Round 3.

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Statements that were rejected with a strong consensus by all three panels were also revealing. These focused on the first aider trying to change the person's behaviour or attitude in some way (e.g., *The first aider should try to convince the person that they are not fat)* or first aid actions that were inappropriate for children (e.g., *If the professional recommends hospitalisation the parent should agree, but only if the child agrees also*), which again reflected a concern of the experts that the guidelines should not advise the first aider to allow age-inappropriate autonomy.

While this research gave equal weighting to the opinions of the three different panels, a limitation in the findings is that the sample size of the consumer panel in particular was small (n = 22 Round 1, n = 14 Round 2, n = 14 Round 3). It is therefore possible that some individuals on the consumer panel had a greater effect on the exclusion of some items than on other panels. For instance, with a panel size of 14, 1 person constitutes 7.14% of the panel. This means that only 3 people need to rate a statement below the *Essential* or *Important* ratings and the statement will not meet the criteria for endorsement. By contrast, with a panel size of 27 (the clinician panel in Round 3), 6 or more people are needed to rate the item below the *Essential* or *Important* ratings before it will fail to meet the criteria for endorsement. While it is possible that the consensus process was disproportionately affected by the small sample size of the consumer panel, this effect can only *exclude* items from the guidelines. The requirement for all three panels to reach 80% consensus ensures that if the rating of one panel is inflated by a few individuals, the other two panels will balance the effect of idiosyncratic views. The occurrence of this phenomenon in Delphi studies makes a strong case for setting a high consensus level criterion, especially when working with smaller samples; other Delphi studies have required as little as 51% of panel member agreement (McKenna, 1994).

Research investigating the efficacy of clinical practice guidelines has often suggested that guidelines have little implication for practice unless they are heavily publicized and their uptake monitored (Bloch, Saeed, Rivard, & Rausch, 2006; Kosecoff et al., 1987). The economic cost of implementation has also been cited as a negative implication of guideline research (Grimshaw et al., 2004). While this phenomenon may be true of *clinical practice* guidelines there is some evidence to suggest that *first aid* guidelines are not subject to the same fate. For instance, consensus-based guidelines developed by previous Delphi studies have generated significant international public interest on the Internet. Since being made available on the World Wide Web for free download in 2007 (see http://www.mhfa.com.au/Guidelines.shtml), the guidelines on providing first aid for depression, for psychosis, for assisting a person who is suicidal, and for assisting someone who is deliberately self-injuring, have each attracted over 2,000 views. In total, this group of guidelines have been viewed 9,862 times by web-users. Mental health promotion organisations, such as *CAN (Mental Health)* a mental health consumer network in Australia, have also shown a keen interest in the guidelines by supporting and publicising the documents. It

is therefore likely that many members of the public who require information on how to help someone developing or experiencing an eating disorder will be made aware of and have access to these guidelines at no cost.

In addition, the first aid guidelines developed by this study will have direct implications for the MHFA training course. This public education program, which in Australia alone has been presented to over 85,000 people, is set to revise all its teaching materials to reflect consensus on best practice techniques, as developed by the Delphi studies. Furthermore, the MHFA training program has now been established in America, Canada, England, Finland, Hong Kong, Japan, Northern Ireland, New Zealand, Scotland, Singapore, Thailand and Wales, which means teaching of the guidelines-based MHFA training program will eventually be world-wide.

While there is evidence to suggest that the guidelines produced by the current study will have direct implications on the practice of first aid for eating disorders, only further evaluation of first aid outcome will be able to elucidate whether or not the information developed by this research is effective in increasing health service utilization and therefore helpful in reducing the burden of eating disorders. Future public health interventions and policies aimed at improving the uptake of services by those with a mental illness, such as an eating disorder, would certainly benefit from such an analysis.

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