Psychologists for Social Change Cymru

Dros Newid Cymdeithasol Cymru

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Atal iechyd gwael - gordewdra

This response was submitted to the Health and Social Care Committee consultation on Prevention of ill health - obesity

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Psychologists for Social Change Cymru

PREVENTION OF ILL-HEALTH (WEIGHT MANAGEMENT)

Psychologists for Social Change Cymru are part of a network of groups across the UK. The network is made up of applied psychologists, academics, therapists, psychology graduates and others who are interested in applying psychology to policy and political action. We believe that people's social, political, and material contexts are central to their experiences as individuals. We aim to encourage more psychologists to draw on our shared experience and knowledge to engage in public and policy debates.

We strongly support tackling violence in our communities. We believe that such action is an essential part of improving the mental and relational health of the nation and future generations. To do this we believe that a public health approach to violence is essential and that that approach must be trauma-informed, relationally focused and take a whole system view. This is vital if we are to succeed in breaking the vicious cycle of persistent violence, poverty, and poor mental and physical health.

Summary of response

Weight management is a complex public health issue, best understood through a biopsychosocial holistic and rights based lens (WHO, 2023). Weight management is also a mental health inequality issue. The evidence base is clear that overweightness can often be a response to childhood or community adversity, stress and distress. The current strategy takes a somewhat limited view and needs to look at weight management much more holistically and relationally.

Summary of Recommendations

These recommendations can be found within the response in their full context:

1. Inclusion and acknowledgement of the role of all complex factors contributing to weight management.

2. Taking a compassionate approach to public health policies and campaigns about weight.

3. Linking the strategy with mental health, economic and social care strategies.

4. Improving links between physical and mental health services, and social care.

5. Training and supervision for health and social care professionals about weight management, including supporting healthy eating in neurodiverse populations.

6. Raising awareness for the general public about the complex roots of overweightness including weight stigma and its vicious cycle with weight gain.

7. Stepping away from language and messages about healthy or unhealthy, 'good' or 'bad' foods and instead teaching about the reasons we eat or choose foods and focusing on balance in a meal and overall diet.

8. Addressing social and commercial determinants of health, and supporting parents, families and communities to be more connected, responsive and relationally safe.

What's our current understanding of weight management?

Weight management is a complex public health issue, best understood through a biopsychosocial holistic and rights based lens (WHO, 2023). Many adults, children and families in Wales are affected by this and a significant proportion are affected across their lifespan. The roots of weight management begin in pregnancy and develop through childhood, into our adult lives and therefore a lifespan approach feels fundamental to our understanding and addressing the roots of social determinants in physical and mental health (WHO, 2023). It is impacted by many factors including but not limited to how we are fed and cared for early in life, our sense of belonging and connection to others, and our social and economic circumstances.

It's vital that the commercial determinants of health are considered and addressed (WHO, 2023). These influence our social, physical and cultural environments through business and social engagement, and impact young people and particular groups unequally. They include things like our food chain, access to affordable foods, food quality, product design and marketing, and lobbying. Companies shape our environments and by doing so, affect people's abilities to make truly informed decisions about their eating. People's access, rights and the inequality around these factors need to be acknowledged and addressed by policy and strategies.

We also know that the link between weight management and mental health is bidirectional, meaning those living with overweightness are more likely to experience mental health difficulties, likely related to early adverse experiences, stigma and discrimination, and chronic stress; and those experiencing mental health

difficulties are more likely to live with overweightness. In mental health services this often gets labelled and medicalised as 'eating disorder'. The use of certain antipsychotic and antidepressant medications is also a significant contributing factor to weight gain which can exacerbate people's feelings of distress (BPS, 2019).

The evidence base is clear that overweightness can often be a response to childhood or community adversity, stress and distress. Overeating is often a coping mechanism for distress and feeling overwhelmed or unsafe. This can start in childhood when we don't have our relational needs met but can also develop through other stressful, adverse or traumatic experiences at other points in our lives. We all know a version of this experience from during the pandemic when we or other we know we're eating, drinking, shopping, working, and so forth as a means to manage our loss of connection, safety, certainty and structure.

Living with chronic stress, adverse or traumatic experiences, and lack of meaningful connection cause alarm and sensitization in our threat systems, leading us to find ways to escape and cope with that pain. Addiction is actually connection seeking. It is the body's threat system trying to help us soothe and escape such experiences. To get us back to a state of regulation and balance. But it is a short cut. Once the thing we are using to escape is no longer accessible or meeting that need we go back to a state of overwhelm, anxiety and/or depression. We can be 'addicted' or in other use many means to escape; food, shopping, chocolate, sex, binge watching TV, work, drugs, alcohol, energy drinks, high risk activities. This, while living in a world with more widely available and accessible highly processed foods manufactured to tap into our dopamine systems and created to be highly palatable means people are of course more likely to use food (particularly these kinds of foods) as ways to soothe and escape.

We know a range of factors influence our mental health and wellbeing, from our relationships with others, our physical health status, previous traumatic experiences, substance misuse, our financial position and wider community, social and environmental factors.

As described in the mental health strategy consultation document fundamental to our mental health and wellbeing is having a sense of connection: a connection to ourselves (being in tune with how we're feeling physically and emotionally and what matters to us), a connection with others (positive relationships, trust and a sense of belonging), and a connection to the world (feeling part of something bigger).

We all experience a wide range of emotions but being able to identify, understand and manage what we're feeling isn't always easy. It requires knowledge and skills that aren't commonly taught but can be learnt and developed. Living in safe, secure and nurturing conditions alongside developing better awareness and reflective capacity can help us to better regulate our own emotions and to understand the emotions of others, enabling us to form healthier relationships with ourselves and with others.

This means that weight management is also a mental health inequality issue. The Senedd Cymru Health and Social Care Committee inquiry Connecting the dots: tackling mental health inequalities in Wales covered this issue in depth, highlighting those in the population who have the greatest risk of mental health inequality and how different groups and communities can experience this inequality. It made a number of recommendations which which suggestion should inform the development of this strategy:

The Centre for Mental Health describes a "triple barrier" of mental health inequality, which affects large numbers of people from different sections of the population:

1. Some groups of people are disproportionately at risk of poor mental health. This is often linked to wider inequalities in society.

2. Groups with particularly high levels of poor mental health can have the most difficulty accessing services.

3. When people do get support, their experiences and outcomes are often poorer.

The right to good mental health and wellbeing is everyone's and yet we know there are a number of societal conditions that put some groups at a greater risk of poor mental health. Weight management is an example of how inequalities can contribute to poor mental health.

We also know that marginalised groups who experience discrimination, racism or exclusion solely based on age, gender, race, sex, sexual orientation, disability or other characteristics protected by the Equality Act 2010 will be disproportionately impacted. This includes asylum seekers, refugees and migrants who may be at greater risk of these issues. We also know that while the mental health system can go some way to mitigate inequalities, there is also evidence that it can exacerbate inequalities. How weight management services are designed and delivered is an example of this. Weight management services that don't take a holistic and whole system approach are part of this problem. We therefore need trauma and relational health informed weight management services that can support a holistic and rights based approach to addressing these issues. This would bring services in line with the Trauma Informed Society Framework for Wales. Furthermore, the make up of weight management services across Wales remains varied depending on local funding, including access to psychologically and relationally informed approaches. With the ever-changing face of weight management in the UK and wider, including recent medications licensed for use, this has increased waiting lists and further reduced accessibility of evidence-based support, and perpetuates a medical and individual view of weight management.

Evidence shows living with overweightness can be incredibly stressful. Those who experience this are more likely to experience stigma and discrimination due to their weight from insidious, harmful narratives absorbed through culture and media (Puhl, 2020). This stigma only serves to add to difficulties through the experiences of chronic stress on our bodies, coping using food to comfort or soothe, and attempts to restrict diet and lose weight (Tomiyama, 2014).

What are the gaps in the Welsh strategy?

The current Welsh Weight Management strategy outlines adult and child weight management pathways and services in Wales, as well as the long term plans to improve the health of people, environments and settings in Wales. It is positive that the strategy is integrative of environmental climate change and food promotion policies. However it focuses mainly on the over simplistic and damaging narrative about weight of calories in/calories out. Policies that do not include consideration of the deeper, complex interplay of factors in weight management, including adverse childhood experiences, socio-economic differences, stigma, mental health and social justice can perpetuate the issues that lead to weight management problems in society. It also does not acknowledge the difficulties of people with additional needs such as neurodiversity or disabilities, who are significantly more likely to experience weight management and health difficulties. The current policies and strategy largely focus on the surface level behaviours around weight management, and although these are important to consider, they are in no way the whole picture, and ignore deeper trauma and distress responses and understanding of the root causes of weight issues.

It's also positive the current strategy includes responsive feeding and some acknowledgement of increased funding for those from more deprived areas but it could go further - focusing on other issues that impact responsive feeding and food choices such as parental hardship and stress.

The current strategy also mentions reformulation of foods to be healthier, however research suggests reformulation of foods are more highly processed and therefore contribute to greater weight gain, through speed and convenience of accessibility, easier digestion, and dysregulation of our hunger and fullness system. Research suggests that it is since reformulation and higher processing of foods that weight has

become a public health concern, and therefore a focus should be to increase use of minimally processed whole foods, and cooking and eating in ways that connect us to our traditions, cultures, and communities.

We also need to be careful with narratives about health and weight in schools, as these could contribute to both weight management and disordered eating. The current strategy talks about promoting healthy eating in schools. It's positive to help everyone, including children (in an age-appropriate way) to be educated and informed on making food choices. However this ignores the fact that children exert limited power over what to buy and cook within their household. Children can influence some habits and as they grow older are likely to become more independent in these ways. In young childhood parents are often the ones in charge of these things. Children's brains are also still developing and so they may have less control over impulses and see things in a binary way. Furthermore, young people are disproportionately affected by the commercial determinants of health such as advertising and marketing of foods and the quality of school dinners served to them, especially if they receive free school meals. Therefore targeting children with 'healthy eating' messages, often given by individuals who may not have a background in this complex area, puts undue pressure on children to be more aware of their bodies, choices, and health when they lack the power and capabilities to do this by themselves. This leads to extra stress and potentially eating related issues in young people, and contributes to a diagnosis of eating disorder in the long-term if not these messages are not more carefully considered.

How can we better support weight management in Wales?

With this in mind, we would recommend the following:

1. Inclusion and acknowledgement of the role of adverse childhood and community experiences, additional needs, social determinants of health, stigma and mental health.

2. Taking a compassionate approach to public health policies and campaigns about weight.

3. Linking the strategy with mental health, economic and social care strategies.

4. Improving links between physical and mental health services, and social care through shared ICT systems, creating easy pathways for consultation and liaison between services, and supporting staff to have time for these.

5. Training and supervision for health and social care professionals about a person-centred, trauma informed and relational understanding and treatment of weight management, including supporting healthy eating in neurodiverse populations.

6. Raising awareness for the general public about the complex roots of overweightness including weight stigma and its vicious cycle with weight gain. Making clear the links between our mental and physical health including talking about using food to cope with distress, and the role of chronic stress and adversity.

7. Stepping away from language and messages about healthy or unhealthy, 'good' or 'bad' foods and instead teaching about the reasons we eat or choose foods and focusing on balance in a meal and overall diet. Talking about or more and less nutritious foods or those higher in fat/sugar/salt foods; using non-stigmatizing and more person-centred language when talking about bodies and overweightness (e.g. referring to individuals as obese rather than living with obesity or overweightness). Lessons not just focusing on individual diets and choices but recognising commercial determinants of health and eating.

8. Addressing social and commercial determinants of health, including the cost of living crisis and supporting parents, families and communities to be more connected, responsive and relationally safe.

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