Platfform
Head Office
Beaufort House, Beaufort Road
Swansea
SA6 8JG

olivertownsend@platfform.org
platfform.org

For mental health and social change
Dros iechyd meddwl a newid cymdeithasol

June 2024

Platfform response to Health and Social Care Committee inquiry into Obesity

Introduction

Platfform welcomes the opportunity to respond to this inquiry into the prevention of ill health with a focus on obesity. For our response, we are bringing our understanding of mental health, and speak from our experience and expertise in supporting people in distress. We also have an established position that aims to shift the way we talk about mental health in Wales, which incorporates a social determinant-led approach. The discourse around tackling obesity is all too often drenched in shame, whether intentionally or not, and our belief is that this underlying approach, when left unchallenged, runs a significant risk of causing great harm to people who struggle with over-eating, or who have been given a diagnosis of binge-eating disorder.

Underscoring Platfform's perspective on mental health, is the need to shift to a rights-based, informed-consent, least-restrictive approach (WHO/UN, 2023), and have been critiquing, respectfully, the reliance on diagnosis-led responses to mental health for a long time now. This has been articulated by the Lancet, in a journal article that argues that responses to the mental health crisis (their term) is "impeded by the dominant framing of mental ill health through the prism of diagnostic categories" (Patel et al, 2023). That same article recommends similar responses as contained within the WHO/UN guidance on mental health legislation and practice, and it is in the spirit of this evidence-led call to change our mental health systems, that we engage with this inquiry.

Key points:

- We would want the Committee to explore the ways in which our primary care services (GPs, for example) approach weight management, so that we lead with compassion, trauma-informed and emotionally understanding interventions as a first step.
- We would want the Committee to clearly explore the need for a social justice understanding of obesity – the contributions that poverty, corporate culture, lack of community resources, and more, have on our communities.
- We would want the Committee to understand the potentially harmful impact that our public health approaches, when uncritically adopted, can

Continued

have. The approach of population level interventions that are based on behavioural science needs to be examined in the context of how it impacts on people in higher levels of distress.

- We would want the Committee to examine the potential liberating impact that shifting away from a "weight-normative" approach, towards a "weight-inclusive" approach would have on people's ability to engage with support.
- We would want the Committee to explore how we can further integrate professions, to address the gap between weight-management professionals and mental health professionals, whose different approaches can cause people who need support, to disengage.
- We would want the Committee to examine the importance of the *time* it takes to create trusted and valued relationships between people and healthcare professionals. Without this trust, no pathway or plan will have as much impact as it could – and we would argue, is much more vulnerable to the risk posed by traditional approaches.
- We also want the Committee to hear the voices of people who are classed as obese, or morbidly obese, and understand the impact that our current systems can have. Only by listening to people in their own voices can we achieve a truly holistic, compassionate approach to obesity that will actively address its harmful impact.
- The Committee will notice that we have not used terms such as 'epidemic' to describe the public health issue of obesity. This is because we believe the social determinants of mental health, as well as the social justice components of obesity, can be tackled and addressed by governmental, corporate and community action, and it is not a situation that we need to passively accept as inevitable.
- In this consultation response, for the first time in my professional experience, I have included my own story, for the Committee, to inform their consideration of this issue. As someone with his own story to tell, I hope this will capture some of the nuance and complexity of this public health – but highly personal – issue. The tone of this contribution (Section 3) might seem jarring compared to the factual content of Section 1 & 2. That is deliberate, as we believe it is hugely important for lived experience to be seen alongside policy and research, at whatever level that experience is held.

About Platfform

Platfform was born in 2019 from Gofal, a mental health charity established in Wales in the late 1980s. Through decades of working across housing and mental health, we gained real insight into the reality of mental health in society, the impact of trauma, and the causes of distress. That work led us to change our focus and become Platfform, the charity for mental health and social change.

Continued

Today we work with over 9,000 people a year. We support people of all ages, across urban and rural communities, in people's homes and alongside other services. Our work spans inpatient settings, crisis services, community wellbeing, supported housing and homelessness, businesses, employment, counselling, schools and youth centres.

Section 1: Obesity and mental health

One of the challenges we see with policymaking to tackle obesity, is the relatively simplistic understanding of obesity and mental health. It is clear that poor mental health can be associated with obesity, and vice versa. The determinants of obesity are complex and cannot be separated out with any success – and so any strategy or approach to obesity needs to be holistic and encompass the interconnected nature of various contributing factors.

To effectively discuss this issue, we need to ascertain what we mean by specific labels. Within policymaking, obesity can be used as a catch-all term that includes people with very different approaches to food. We would distinguish between:

- **Obesity:** a catch-all term based on a largely unhelpful, overly simplistic BMI measurement.
- **Over-eating:** activity that many people will engage in, usually situational (Boyd, 2007, Hetherington, 2007), which can be seen separately, but also as part of the spectrum of behaviours that have been categorised as "binge-eating disorder" (Goldschmidt et al, 2016). Stress, anxiety, overwhelm, loneliness, can all contribute to this activity, and it can be used to regulate ourselves (in a similar way to over-exercising, using substances, etc).
- **Diagnosis of binge-eating disorder (BED):** a diagnosis/label for people who consume a larger amount of food than others in a similar time, *and* who experience a lack of control before, and guilt after, eating (Iqbal and Rehman, 2022). A systematic review (Palmisano et al, 2016) demonstrates that the great majority of studies into obesity and trauma (90%) support an association between trauma and BED in adulthood. Additionally, associations between traumatic experiences and obesity more generally were also identified (85%).
- **A note on language:** At Platfform, we challenge the use of "disorders" as a way of structuring our mental health system, as they too often root the "problem" in the person, rather than allowing us to see the wider, social determinants that have contributed to distress. For the purposes of this inquiry, we will be using the term "binge-eating disorder", so that we can communicate clearly what is needed for Wales to grapple this public health issue – but we still believe it is critical to see this shifted out of a medicalised, diagnosis-led model.

Continued

Research is unclear as to the exact proportion of people who class as obese/morbidly obese are also displaying binge eating behaviours. Some estimates suggest 25-50% of people classed as obese who seek weight management support have ‘problems’ with binge-eating, with community-based studies suggesting 1-2% have ‘serious’ binge eating problems (Bruce and Wilfley, 1996). Even within those categorised as having BED, only around half of people respond to specific treatments (van Riel et al, 2023). The picture that emerges then, is complex, and blurred by an unhelpful focus on people categorised as obese/morbidly obese as an indistinct whole.

Keski-Rahkonen (2021, cited in Bray et al, 2022) notes commonly co-occurring conditions with binge-eating disorder including obesity, diabetes and hypertension. These may seem obvious, but despite that, the link between binge-eating disorder and obesity can be neglected at policymaking level. The temptation is to resort to quick fixes that will not address the underlying determinants of binge-eating behaviours.

We are also clear at Platfform, that using food to self-regulate in periods of distress is widespread, and we saw this playing out throughout Covid-19, where many across society found themselves using different methods to cope with distress, uncertainty and fear. As Palmisano (2016) also made clear, the link between trauma and obesity is almost as well-evidenced as the link between trauma and a diagnosis of binge-eating disorder.

There is also the wider point, which we will address separately (see Section 2) which recognises that obesity is impacted by social factors (economic, political, social, environmental, etc) which need a wider range of interventions and social changes to address. It is these social factors that public health interventions seek to address with policy ideas such as sugar taxes, calories labelling, traffic light systems, early school education and more. Our concern is that those public health interventions have also cut across into our healthcare system and are seen as interchangeable with primary health interventions into obesity. We are clear at Platfform, that introducing behavioural interventions into primary healthcare might work for one part of the ‘obesity’ spectrum, but it is actively harmful and detrimental to another part, due to the very different needs faced by people who are categorised as obese.

Our contention goes further: the interventions that would work for people who are given the diagnosis of BED, would *also* work for other people categorised as obese. What we need to see in the Wales approach to obesity is a complete shift and reversal in how we approach public health, primary health and specialist mental health services.

Continued

We consider two main areas where greater understanding of mental health and its relationship with obesity needs to be considered:

1: Public health / behavioural interventions

Public health campaigns in the UK, and the wider Western world, are often perceived as embracing stigmatization of obesity (Lewis et al, 2010; Vartanian & Smyth, 2013, Dolezal and Spratt, 2022), which seeks to perpetuate shame. In that context, it is extremely important to understand the impact that shame-based interventions can have on people with experiences of trauma. Shame, particularly when connected with PTSD, can be a "potent treatment barrier" (Saraiya and Lopez-Castro, 2016), and further exploration (Lopez-Castro et al, 2019) identifies that "…highlighting shame as an important clinical target may help improve the efficacy of established treatment."

These approaches to public health messaging can also trickle down into primary health interventions, setting the tone / parameters for how people are supported. This 'weight-normative' (attaching a values judgement to weight) is often ineffective in treatment settings, and is "not improving health for the majority of individuals across the entire weight continuum" (Tylka et al, 2014).

The issue of weight loss is complex, and instead, we advocate for the idea of weight wellbeing. For people who are vulnerable to shame (particularly those who could be given a diagnosis of BED), a public health campaign approach that leans into stigmatising narratives is actively damaging. Whilst it might help at a general population level, the impact on people with high levels of trauma and shame must be taken into consideration.

Our current system is creating a damaging and dangerous weight bias and prioritising shame in the system, which is ineffective and damaging (Alberga et al, 2016). Alberga et al set out key aspects for consideration and debate, that we would want the Committee to consider in detail. These are:

1) Weight bias is common and has adverse health consequences
2) Shaming individuals for their body weight does not motivate positive behaviour change
3) Internalised weight bias is particularly problematic
4) Public health interventions, if not carefully thought out, can perpetuate weight bias
5) Weight bias is a manifestation of social inequity
6) Action on weight loss requires an upstream, population level approach

Continued

They also share potential examples of interventions to prevent weight bias, which, interestingly, run counter to many of the public health interventions often posited to impact on obesity. These are replicated below:

Government action	Examples in the field of weight bias
Restrict choice.	• Develop legislation to prohibit weight discrimination
	• Implement anti-discrimination laws against bullying in schools and weight discrimination in the employment and healthcare sectors
	• Mandatory post-secondary curricula and appropriate training on weight-related issues for pre-service student teachers, health professionals and public health practitioners
	• Formal training for coaches to prevent eating disorders in sports
	• Mandatory implementation of evidence-based body appreciation, media literacy and eating disorder prevention programs in schools
	• Ban digital modification of images that glamorize thinness in women and muscularity in men in the media
Guide choice through disincentives.	• Implement penalties for evidence of weight discrimination in employment, healthcare and education sectors (e.g., charging schemes in the employment and healthcare sectors, exclusion from extra-curricular activities for youth in schools)
Guide choice through incentives.	• Offer awards, fiscal or other incentives for the promotion of wellbeing and body inclusivity in the education, healthcare and employment sectors (e.g., a school board could offer an award or recognition for schools that implement body inclusivity in their teaching and learning practices)
Guide choice through changing the default policy.	• Devise media and journalism guidelines for prohibiting gender-based and weight-based stereotypes in the media (e.g., stop portraying women of size eating ice cream to cope with mental health issues)
	• Depict positive stereotypes of people living with obesity in the media
Enable choice.	• Modify the built environment to accommodate individuals of all weights (e.g., chairs in waiting rooms, staircases, airplane seats, hospital beds, clothing uniforms and exercise equipment)
	• Offer an evidence-based school program geared towards positive body image, acceptance of body diversity and prevention of weight-related issues
Provide information.	• Create flyers and posters that promote positive body image and body diversity and distribute them in schools

Continued

Government action	Examples in the field of weight bias
	• Disseminate population health campaigns to address weight bias
Do nothing or simply monitor the situation	• Monitor the prevalence of weight bias in different sectors (i.e., education, healthcare, employment)
	• Do nothing

To summarise Platfform's perspective on public health interventions: a balance needs to be struck between the need to raise awareness of the health impacts of obesity, and the damage that can inadvertently do to people who are more vulnerable to stigma and shame. The ideas above need to be consider as a compassionate approach to weight, which we believe will have a much more significant impact on the mental and emotional health of people who struggle with their weight and health.

2: Primary care processes and interventions

We have identified above the clear links between trauma and obesity, and trauma and BED. Despite that, however, the responses in healthcare can often be focused still on the need for nutritional education. Considering the NICE Guidelines on binge-eating (2017, updated in 2020) for example, which includes a recommendation to:

> *"…advise people to eat regular meals and snacks to avoid feeling hungry."*

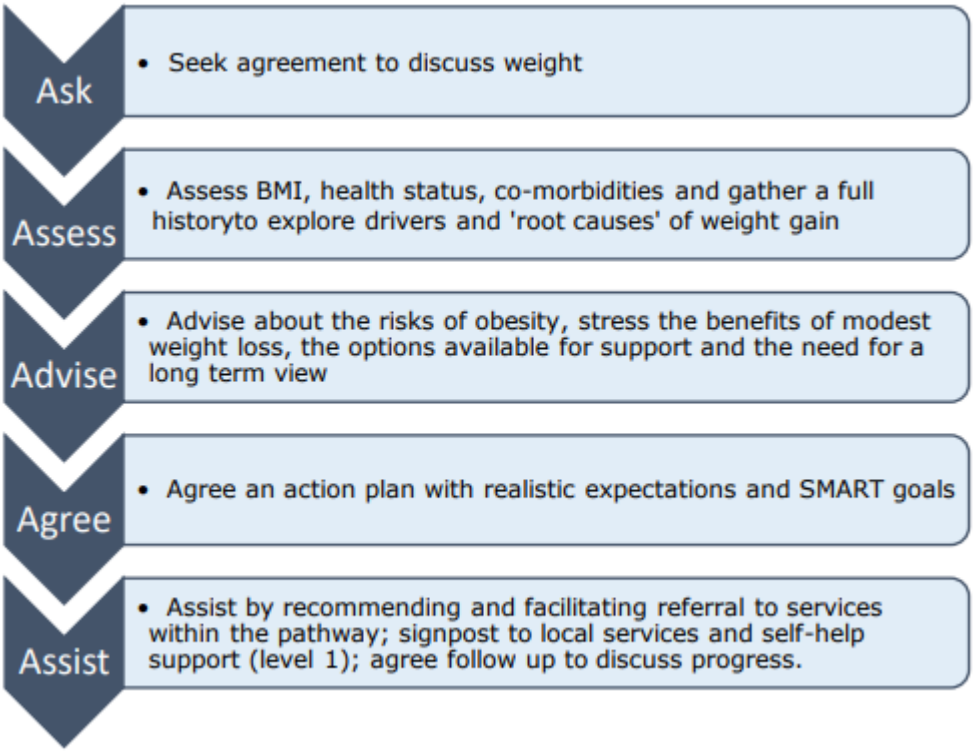
Whilst that is just one part of an overall approach to binge eating within NICE guidelines, it runs the risk of misunderstanding the emotional and relational component to behaviours captured by an eating disorder diagnosis.

We are also concerned with the current Wales adult weight management pathway (Welsh Government, 2021), we would challenge the use of the 5As (from Canada Obesity) as a way to structure treatment. This is where a key tension between a physical health approach, and a mental health (or, ideally, relational) approach can be seen. This approach, as adopted across Wales, would appear to take an approach that does not consider the feelings of shame and trauma that are clearly linked to diagnoses of binge eating disorder.

Continued

Understandably, this approach is a catch-all, but again, it is an example of where the default approach might work for initial approaches, but would cause active harm and distress to someone who is more vulnerable to that distress.

Diagram 1: *the 5As approach as designed by Canada Obesity, and included in the weight management pathway for adults*



Alberga et al (2016) draw attention to this inherent tension. They share the perspective of a Ms. Schafer (New York Times, 2013, cited in Alberga et al, 2016):

> "My therapist tells me not to talk about my weight and that my body is fine. But my doctor keeps weighing me and says that I need to lose weight."

They go on to describe this quote as:

> *"illustrating a traditional disjoint in perspectives between practitioners in the fields of obesity and eating disorders."*

Continued

This tension is directly addressed by professionals, who are articulating a need to shift towards an integrated approach to tackling obesity and eating disorders (Van Riel et al, 2006). In this context, we would want the Committee to explore how different professional perspectives play out across the NHS within Wales – the tension between physical health with a focus on weight loss, often held by GPs, and then emotional health / mental health, often held within other specialist services.

We also believe that our submission today could play a part in reimagining how we tackle obesity. Our logic is based on considering the harm that traditional, current interventions can create for people who have been given a diagnosis of BED, as well as others on the spectrum who are motivated by trauma and stress, to over-eat. In our diagram, we have summarised how the current system works (very broadly), and how we would want to start reimagining it.

This is not a policy recommendation, at this stage – we would want the Committee's inquiry to set in motion a wide-scale review of how we approach obesity policy at a mental health system level, primary care level, and public health campaign level. A national conversation on this issue is long overdue.

Continued

Diagram 2*: A comparative system to enable discussion*

The current system:

	People who are categorised as overweight / obese / morbidly obese		
Description of the (reductive) spectrum of obesity	People who might benefit from a physical health intervention / education	People who use over-eating to cope with stressful situations	People who could be given a diagnosis of BED – who feel they are uncontrolled
Current intervention examples	GP intervention (flyers, face-to-face discussion, weight management pathway, nutritional classes, gym referral, focus on prudent healthcare and taking personal steps to improving weight. Reinforced by public health campaigning and messaging. Most often, a pathway would then identify whether an individual would need mental health support which is currently very diagnosis led.		
Potential benefits / harms	With less experience of shame, stigma and trauma within this part of the "spectrum" as a rule, these interventions are not directly harmful and there is evidence that these have a positive impact on weight	With mixed experience of shame, stigma and trauma within this part of the "spectrum" (but with those experiences more prevalent here than in the first group), there is a chance that this approach to weight management will help some, be neutral for others, and harm others. For some, who might find their reliance on food for emotional regulation worsening, they would need prompt support to understand what they are experiencing, before they might feel it gets out of control.	With high levels of shame, stigma and trauma, and over-eating likely to feel for people like it is out of control, the traditional approach and pathway is more likely to cause harm and create disconnection, shame and lack of trust. Against a backdrop of public health campaigns that rely still on stigma, there is a significant risk that our public health and primary health systems will continue to exacerbate and perpetuate harm.

Continued

A potential new approach:

	People who are categorised as overweight / obese / morbidly obese		
Description of the (reductive) spectrum of obesity	People who might benefit from a physical health intervention / education	People who use over-eating to cope with stressful situations	People who could be given a diagnosis of BED – who feel they are uncontrolled
Potential intervention examples	We would want the Committee to explore how our physical and mental health systems, and our public health / education systems could start to "flip" this approach round to a trauma-informed approach (in this context we would describe this as "**relational first**" approach). Intervention examples here could include: • Changes to public health narratives and campaigns; • Changes to weight management pathway to make a discussion about emotional eating and ways we use food to cope one of the first steps; • A default approach within services to be trauma-informed, rather than weight-based; • A shift to a "weight wellbeing" rather than "weight management" approach; • An options-based offer, for people, trusting that they know what they need.		
Potential benefits / harms	For people with reduced experiences of shame/stigma/trauma, this approach of "relational first" would allow someone who wants nutritional advice, exercise referrals, etc, to ask for it, and the chances of harm for this group would be unchanged.	With mixed experience of shame, stigma and trauma within this part of the "spectrum", a "relational first" approach would give people the choice about how to ask for help, and for those who might find their relationship with food worsening, they can access more emotional health, relational support.	With high levels of shame, stigma and trauma, and over-eating likely to feel for people like it is out of control, the urgent intervention here is not nutrition classes, or gradual progression through a pathway, but a default assumption, without stigma or shame, that a recovery-based approach is offered.

Continued

Section 2: Obesity and social justice

Platfform is also clear that we need to look more widely than just the mental health system and consider the social determinants that contribute to obesity. Bray et al (2022) explored the perspectives of experts engaged in research into binge-eating disorder, particularly focusing on a social justice perspective. They identified key themes that played a role in contributing to binge-eating disorder *behaviours* (our emphasis). These are:

- Systemic issues and systems of oppression
- Marginalised and under-represented communities
- Economic precarity and food/nutrition security/insecurity
- Stigmatization and its psychological impacts
- Trauma and adversity
- Interpersonal factors
- Social messaging and social media
- Predatory food industry practices
- Research/clinical gaps and directives.

These social justice factors are also directly relevant to people who could be given a BED diagnosis. A recent thematic analysis of over 160 blogs (Kenny, 2020) written by people with lived experience of an eating disorder diagnosis, found that there was widespread acknowledgement of the impact of social justice factors (poverty, etc) on people's experiences and – crucially – chances for recovery from diagnoses of eating disorders.

We would want the Committee to explore this holistically. Our suggestion for discussion above (Diagram 2) does not capture the full complexity of the challenge of obesity. Investing further in communities to tackle poverty, rather than trying to educate people about nutrition, for example, would have a significant impact on obesity without ever touching on the mental health/physical health systems. We also need to have a very open, honest and challenging discussion about *commercial* determinants, which are referred to above by Bray et al as "predatory food industry practices".

Understanding the social justice perspective on obesity is important, as it is the surrounding context for obesity. These aspects will absolutely influence our mental health, and we need to ensure that Wales continues to develop an approach to mental health that recognises the social determinants that contribute to people's distress. We also need to ensure that in any inquiry into obesity, we understand the impacts of the above systemic, social justice issues on our wider health.

Continued

Section 3: A personal perspective

I knew that my own experiences were present in my mind as I was writing this response. At Platfform, we believe in the power of sharing our stories, and helping people understand some of the reality on the ground. This is a small part of my story.

I was first told I was overweight when I was nine, after a long and difficult operation. I had started eating more due to earlier difficult childhood experiences, but it became a real source of comfort when I was in hospital. I was often alone in hospital as the treatment was in Sheffield, and my family lived in Newport, South Wales.

From the moment I was told I was overweight, a hospital dietician put me on a healthy eating plan, and that started a journey of being regularly told what was healthy or not, whilst not being able to express to any professional that there was something else driving my weight gain.

My weight always went up and down, but the overall trajectory was upwards. After another surgery aged 15, and another aged 19, my approach to food felt set in stone. I knew how to eat healthily, but when I was emotional, I couldn't control myself. I could feel myself becoming less and less well, I struggled throughout university, and in my first job.

I finally went to a GP in Exeter for some help and was put quickly into a dietician-led healthy eating course. There was one session out of ten, which addressed the catch-all "emotional overeating". We did an exercise for mindfulness, with a raisin, which did absolutely nothing other than make me think about food exclusively, without any benefit. I left the session and lost control of food again that day.

In one of the later sessions, there was a moment I can remember vividly: around half the patients in the room, including myself, expressed feeling emotionally exhausted, and how we felt like we wanted to run away from our responsibilities, and that we couldn't because we had people who relied on us. The person leading the group said they didn't feel confident they could discuss this in detail, they were clearly overwhelmed at the sharing of people's feelings themselves. Their recommendation was that when people got home, they took a bubble bath to relieve stress. People at that moment were articulating, along with me, an emotional need that the system could not address.

When I moved back to Cardiff, my weight continued to climb, and I felt like the

Continued

binge-eating was unstoppable. When my Dad died, I felt very unwell, and so I approached my GP for support. I was referred to another healthy eating class. The first session, the dietician led a discussion about whether chips were healthier than salad. There was one session around emotional over-eating. We did an exercise for mindfulness, again with a raisin. I left the session and lost control again, but this time I was angrier.

I spoke to the dietician, and he tried to cobble something together, based on what I was telling him I needed – but it was impossible, and I didn't trust the service was going to offer what I felt I needed.

I talked to my GP, and said I needed something more specialist, my weight was still climbing, and he said I needed to be heavier before I could be considered for that. I was morbidly obese.

When I moved back to Newport, I went to my family GP, and had the same conversation. Again, they said they couldn't help unless I was heavier, but they could refer me to *another* dietician-led healthy eating course. I refused. I knew what I needed at this stage, and it wasn't raisins, food nutrition booklets, or group discussions about meal planning, TV snacking or calorie deficit. It was someone to listen to what I was experiencing and feeling.

At this point, I was a Policy Manager in a Wales-based charity, leading key projects, submitting reports and responses to Welsh Government, and able to articulate myself well. Despite all of that, I couldn't get myself heard in terms of what I needed. All my knowledge, resilience and communication skills were utterly meaningless in the face of a weight management pathway.

I decided to forget about tackling my food, and instead started talking more about my mental health more generally and was lucky to have a course of EMDR with a brilliant therapist (the key intervention there being the trusted relationship I had with her, not the mode of therapy itself). This intervention had more impact on my relationship with food than any number of NHS groups I've taken part in, or individual dietician sessions.

During Covid-19, my eating spiralled out of control, more than ever. I was diagnosed with diabetes, at the age of 34.

Despite the brilliant support from the EMDR therapist, my eating was still a problem. I was able to get a referral to the local eating disorder team, where group support sessions were offered. I don't do well with group sessions, and I fed that back, but was encouraged to attend whilst waiting for one-to-one DBT

Continued

support. In one of the sessions, we had to bring a piece of food and eat it mindfully. At least it wasn't a raisin that time, I suppose! But despite that, I logged off immediately and didn't engage with that group again.

My one-to-one DBT support started as helpful, but personnel changes left me without support halfway through. But at this point, I was starting to understand more about how my emotions were impacting me, how I needed to focus on my relationships, start to understand the trauma that had taken place around me, and make real progress. To do that, I have had to really think about how to create safety for myself, and I have been incredibly lucky to work alongside mental health professionals within my current role that have supported me on that journey in their individual ways.

I still struggle with food and bingeing, but I also have hope for the first time in twenty-six years. It will be a long road for me, as I work through the different experiences and find a better way to cope. And there's a big part of me that is angry, about the lack of support I had when I was younger. I am still morbidly obese, my diabetes fluctuates, and I had a letter two weeks ago that said I had early (hopefully repairable) diabetes-related retinopathy. I often feel like I am holding on with my fingertips, that if I let go, I might not know how to keep hold of myself. I also sometimes feel people don't understand what it feels like to struggle with food control. Buffets in work, snacks, they are a constant nightmare for me, because I can sit in a room with food and it will be all I can think about, for the whole time I am there. I can't let my guard down once; is how it can feel sometimes. The shame that makes me feel is huge.

That should help to explain why, at no stage on this journey, did any public health intervention help me – I would react to leaflets about healthy eating with shame; I would only retreat from discussions about my health. Even now, when I read research reports, or policy responses, or Government plans on intervening with obesity, I feel a deep sense of shame as I feel I am impossible to help. The same public education, or calorie labelling, or sugar taxes, that might help a proportion of the general population, actively makes my situation worse – and I know this is a perspective shared by people I talk to with binge eating behaviours.

What would have made my situation better? GPs that understood the emotional context of my binge eating – without judgement. Professionals that didn't try to "fix" how I looked, however indirectly. Sessions that didn't try to give me huge levels of nutritional information as if assuming I was stupid, or a child who couldn't cook. But also, sessions that recognised the experiences I had had over the course of my life. What we need, if we are to truly address obesity/morbid

Continued

obesity within our health services, is a kinder, more holistic approach that responds quickly to people and their distress – whilst not losing sight of the community and societal factors around them.

I still carry some anger and despair about the system as it has been experienced by me, and as I know it is for others. But the longer I go, with a better understanding of what my feelings are, why I react in certain ways, and how to step back from that brink, I think I am starting to build my hope for the future. Now, I want to make sure others in my position can have that same hope.

Conclusion

We welcome this opportunity to response to the inquiry. We know that across Wales, great strides have been made to tackle the challenge of obesity. However, we also know that across the Western world, obesity rates are climbing, our populations are becoming more unwell, and our public health and healthcare systems are struggling to cope. The temptation with this context is to lean heavily on a 'prudent healthcare' approach, which we know the current Welsh Government favours.

Whilst not opposed to prudent healthcare as a concept, we at Platfform are unequivocal in our belief that we need to understand the reasons behind people's decisions, but also recognise with humility the social conditions we have created around people. In areas of poverty, where cheap food is available that worsens people's health, where we have people working long hours and unable to cook, or where we build over green spaces, or have unsuitable housing, or if we create systems that don't recognise distress or emotional complexity, or if our public narratives embed shame and blame… it is no wonder that our obesity rates remain high.

We would conclude with a clear statement: obesity is *not* a disease in and of itself, but a symptom of personal and community distress, and results from a system that, despite many professionals trying their hardest, cannot take action to tackle these structural challenges. We hope our response to this inquiry sets out our perspective on what needs to change and encourages open discussion and humility as we seek answers – and we would be happy to expand on any of the information we have provided today.

Submitted by Oliver Townsend
Head of Connections and Change
olivertownsend@platfform.org

Continued

References

Alberga, A. (2016). *Weight bias: a call to action.* Journal of Eating Disorders. 4. Available at: https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-016-0112-4

Boyd,. J. (2007). *Developmental and Situational Factors Contributing to Changes in Eating Behaviour in First-Year Undergraduate Women.* UWSpace. http://hdl.handle.net/10012/3384

Bray, B., et al (2022). *Binge Eating Disorder is a Social Justice Issue: A Cross-Sectional Mixed-Methods Study of Binge Eating Disorder Experts' Opinions.* International Journal of Environmental Research and Public Health. 19(10). Available at: https://www.mdpi.com/1660-4601/19/10/6243

Bruce, B and Wilfley, D. (1996) *Binge Eating Among the Overweight Population: A Serious and Prevalent Problem.* Journal of the American Dietetic Association. Volume 96, Issue 1. Available at: https://www.sciencedirect.com/science/article/pii/S0002822396000168#BIB10

Dolezal, L, and Spratt, T. (2022) *Fat shaming under neoliberalism and COVID-19: Examining the UK's Tackling Obesity campaign.* Sociology of Health & Illness. Volume 45, Issue 1. Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/1467-9566.13555#shil13555-bib-0051

Goldschmidt, A. et al. (2016). *Overeating and binge eating in emerging childhood: 10-year stability and risk factors.* Developmental Psychology. 52(3). Available: https://psycnet.apa.org/record/2015-56716-001

Haines, J., and Neumark-Sztainer (2006). *Prevention of obesity and eating disorders: a consideration of shared risk factors.* Health Education Research, Volume 21, Issue 6. Available at: https://academic.oup.com/her/article/21/6/770/608683?login=false

Hetherington, M. (2007) *Individual differences in the drive to overeat.* Nutrition Bulletin, Volume 32, Issue S1. Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1467-3010.2007.00601.x

Iqbal, A. and Rehman, A. (2022) *Binge Eating Disorder*, National Library of Medicine. Available at: https://www.ncbi.nlm.nih.gov/books/NBK551700/

Kenny, T., at al (2019). *#recovery: Understanding recovery from the lens of recovery-focused blogs posted by individuals with lived experience*. International Journey of Eating Disorders. Volume 53, Issue 8. Available: https://onlinelibrary.wiley.com/doi/abs/10.1002/eat.23221

Keski-Rahkonen, A. (2021) *Epidemiology of binge eating disorder: prevalence, course, comorbidity, and risk factors.* Current Opinion in Psychiatry. 34(6). Available at: https://journals.lww.com/co-psychiatry/abstract/2021/11000/epidemiology_of_binge_eating_disorder__prevalence,.3.aspx

Lewis et al., (2010) *"I don't eat a hamburger and large chips every day!" A qualitative study of the impact of public health messages about obesity on obese adults.* BMC Public Health. Volume 10. Available at: https://link.springer.com/article/10.1186/1471-2458-10-309

Lopez-Castro at al (2019). *Association Between Shame and Posttraumatic Stress Disorder: A Meta-Analysis*. Journal of traumatic stress. 32(4). Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7500058/

Continued

NICE (2017, updated 2020). *NICE Guideline [NG69]. Eating Disorders: recognition and treatment.* Available at: https://www.nice.org.uk/guidance/ng69/chapter/Recommendations#treating-binge-eating-disorder

Palmisano, G, at al. (2016) *Life adverse experience in relation with obesity and binge eating disorder: A systematic review*. Journal of Behavioral Addictions 5(1). Available at: Life adverse experiences in relation with obesity and binge eating disorder: A systematic review in: Journal of Behavioral Addictions Volume 5 Issue 1 (2016) (akjournals.com)

Patel, V., et al (2023) *Transforming mental health systems globally: principles and policy recommendations.* The Lancet. 402. 10402. Available: https://www.sciencedirect.com/science/article/abs/pii/S0140673623009182

Saraiya, T. and Lopez-Castro, T. (2016) *Ashamed and Afraid: A Scoping Review of the Role of Shame in Post-Traumatic Stress Disorder.* J. Clin. Med. 5 (11). Available at: https://www.mdpi.com/2077-0383/5/11/94

Tylka, T., et al. (2014). *The Weight-Inclusive versus Weight-normative Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss.* Journal of Obesity. Volume 2014. Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1155/2014/983495

Van Riel, L, et al. (2023) *Exploring effectiveness of CBT in obese patients with binge eating disorder: personality functioning is associated with clinically significant change.* BMC Psychiatry, 23. Available at: https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-023-04626-x

Vartanian, L. and Smyth, J. (2013) *Primum Non Nocere: Obesity Stigma and Public Health.* Journal of Bioethical Inquiry. Volume 10, pages 49 – 57. Available at: https://link.springer.com/article/10.1007/s11673-012-9412-9

Welsh Government (2021). *All Wales Weight Management Pathway 2021*. Available at: https://www.gov.wales/sites/default/files/publications/2021-06/all-wales-weight-management-pathway-2021.pdf

World Health Organisation and the United Nations. (2023). *Mental health, human rights and legislation: Guidance and practice.* Available: https://www.ohchr.org/sites/default/files/documents/publications/WHO-OHCHR-Mental-health-human-rights-and-legislation_web.pdf