

Productivity Commission Inquiry into the Economic impacts of mental ill-health

The connection between obesity and mental health

I welcome the Commonwealth Government's commitment to promoting the health and wellbeing of Australians at all stages of life, thereby appreciating the opportunity to make an individual submission to the Productivity Commissions Inquiry into the Economic impacts of mental ill-health.

My submission is based on 48 years (from the age of 7) living with the combined impact of bipolar depression, obesity, binge eating disorder, body shaming, trauma, childhood abuse, and surviving several suicide attempts.

I respectfully request that the inquiry takes into consideration the connection for many people, including very young children, between mental illness, being overweight and obesity.

The causes of the rise in overweight and obesity in Australia.

Key points of connection between obesity and mental health

Weight is never simply a matter of food or self-discipline. It is the visible outcome of a complex interaction between biology, nutrition, mental health, life experience, and social and environmental influences. Short-term diets fail to address the underlying causes of obesity. Mental illnesses are described as bio-psychosocial problems and obesity is a bio-psychosocial problem as well. The social drivers of depression have much in common with the social drivers of obesity.

About a quarter of Australian adolescents have experience of mental illness and levels of psychological distress are increasing. One in five people who are obese will also have a comorbid eating disorder (NEDC, 2017). The trigger for eating disorders is dietary restriction. Standard nutritional and exercise advice are not safe or sufficient to address the mental health problems of people with eating disorders and can place people at increased risk of mental illness and suicidality. There is substantial evidence that obesity prevention initiatives increase the risk for eating disorders (NEDC, 2017). The rate of eating disorders in the Australian population is increasing in parallel with the increase in childhood obesity (NEDC, 2012).

The annual economic burden of treating obesity-related diseases is estimated to cost Australia \$21 billion by 2025 (World Obesity Federation, WOF). The financial ramifications of mental illness and suicide are also enormously high (Productivity Commission's issues paper, 2019). These figures need to be considered together as well as independently for the reasons that follow.

The extreme dieting and weight loss strategies used by people with disordered eating perpetuate obesity (Urquhart & Mihalynuk, 2011) and vice versa, the nutritional deficits of

extreme dieting perpetuate binge eating. Few obesity prevention studies assess the interaction between mental health, nutrition and weight gain, or the possible harm obesity prevention initiatives cause to people already affected by mental illness or at risk of eating disorders.

My experience is that mental illness, binge eating and dieting are intertwined.

The impact of fat-shaming on mental health and long-term weight gain

Obesity prevention campaigns inadvertently contribute to “fat shaming” and social isolation of people who are probably already struggling with the isolation of depression and disordered eating. “Fat shaming” is not effective in motivating people for sustained weight loss and places people at increased risk of cardiovascular disease, mental illness and suicidality.

Being overweight is reviled by society. The self-shame and swinging moods with weight loss and then gaining the weight back, is embarrassing. What is wrong with me? The words “I have no willpower” echo in my mind. At one point I was so distressed about my weight and appearance that I physically could not eat in front of anybody else.

Population health messages are interpreted, over-simplified and distorted in popular dialogue and the good intentions are lost in misinformation, shame, stigma and social exclusion. Health messages targeting individuals are unlikely to be effective if they leave the person feeling stigmatised and rejected by society. People who believe these messages that their self-worth is directly related to their weight are at greater risk of obesity related disease and premature mortality.

I have personally been the recipient of harmful commentary from sales assistants when shopping for clothes and from prospective employers who have said I am “too fat” to work for them. This only serves to reinforce and exacerbate my feelings of self-loathing and push me into a retreat from life and contributes to deterioration of my mental health. This is a vicious cycle that many obese people cannot escape; when we try to do the right things for our health, like gaining employment and joining in social activities, we are abused and become further isolated. This triggers the urge to binge eat and our mental and physical health deteriorates further.

Effectiveness of existing policies and programs introduced by Australian Governments to improve diets and prevent childhood and reduce adult obesity.

Evidence can be interpreted in many ways but the reality is that there is no single approach which can be consistently identified as effective in reducing levels of childhood and adult obesity. Adopting one approach will not achieve the Australian Government’s aims.

Learning from practices that do not work

School educational programs have shown mixed results with some researchers finding success (Bauman, Bellew, Boylan et al., 2016) where others find failure (e.g. Adab, Pallan, Lancashire et al., 2018; Hung, Tidwell, Hall et al., 2015). Much depends on the measures used, and on the timing of those measures. Self-weighing, and the community messages which promote regular weight measurement, have been shown to be ineffective for adolescents, contributing to poor self-esteem and disordered eating rather than healthy nutrition (Pacanowski, Loth, Hannan et al., 2015).

In contrast, therapy and counselling have been linked to improvements in diet and levels of exercise (Hadley, Hair and Dreisbach, 2010). Clinically supervised weight-loss, and psychological interventions have been shown to consistently improve symptoms of binge eating disorder as well as contributing to modest weight loss (NEDC, 2017). A key is ensuring that the people who administer weight loss interventions are adequately trained in mental health and in the risks associated with unhealthy dieting behaviours.

Training the people who administer obesity prevention and intervention strategies

The people relied on to implement prevention initiatives, particularly in children and adolescents are not qualified in nutritional science, psychology or medicine. A teacher commenting on the nutritional value of a child's lunch, or weighing a child in front of their peers, is not expected to have the knowledge and skills to understand how this impacts on mental health and motivation for change. **Despite popular representation of GPs as experts in health, most medical professionals are not experts in nutrition and psychology and are influenced by the wider social dialogue about nutrition and weight.**

Targeting strategies to specific populations

People who are overweight and people who are obese are not a single homogenous group. There are identifiable sub-groups distinguished by biomarkers, psychological profile and social environmental influences. People need strategies that are right for them with their physical and mental health needs and in their social contexts (Rizk, 2013). Models of intervention are required that take into consideration the measurable differences both within and between groups of people who are overweight and those who are obese.

There isn't one way of eating well that will work for everyone. There are many health conditions which require dietary modification; there are many different cultural, social and religious expectations that may affect dietary behaviours. When you promote one way of doing things (e.g. 5 portions of grains a day) you invite people to ignore the advice or misinterpret it with devastating consequences for themselves and their children.

My relationship with food has been disordered since I was a child, growing up with very confused messages about "good and bad food, my appearance, and health. On one hand my mother either took meals away from me or wouldn't allow me to leave the table until I finished everything. As I grew older I was placed on very low "calorie" diets and medications. In the background, my grandparents indulged me with the heavy food traditional in my

culture and chocolates. During this time, with further family turmoil, I turned to “secret binge eating” as my head filled with growing self-loathing and regular suicidal thoughts – all at 7 years of age.

Regulating the non-medical weight loss industry

The lack of regulation of the weight loss industry, particularly in regard to the promotion of ‘quick fix’ diet products and diet plans raises considerable concern. Unlike pharmaceuticals, diet products do not have to prove their effectiveness. Failure to lose weight leads product users to blame themselves rather than the product leading to low self-esteem and the potential for increased health risks (NEDC, 2012). Regardless of the strategy adopted, stigmatisation does not work and should be avoided.

For decades I have restricted my food intake and exercised in the belief that this is what I needed to do to be well and to be socially acceptable. I have been seesawing from great weight loss only to gain greater weight later. It’s a cycle I can’t get off. The daily invisible psychological struggle is hidden in plain sight behind the mask of being overweight. The diets that I followed were not right for my physical or psychological health needs but provision is made for individual need and no-one made the connection between mental and physical health.

Solutions

When choosing strategies to reduce obesity it is just as important to ensure that they do no harm as to ensure that they achieve their narrowly defined purpose of short-term weight loss. The long-term consequences of mental illness are no better for the individual or the costs of health-care than the long-term consequences of obesity.

It is always more effective to deal with the systemic issues sustaining behaviours rather than focussing on the individual’s responsibility to change. Without systemic change, the factors that influence behaviour will remain the same and the outcomes – in this case obesity – will remain the same as well.

- Include safe guards into all obesity prevention interventions and measure unintended consequences (Bauman, Bellew, Boylan et al., 2016).
- Integrate mental health and obesity prevention strategies, addressing the shared risk factors of body dissatisfaction, depression and disordered eating. I agree with the National Eating Disorder Collaboration that “there is an urgent need to develop integrated prevention initiatives which encourage body esteem, healthy eating and lifestyle behaviours without prompting engagement in fad diets, weight loss attempts and the diet-binge cycle”. (NEDC, 2012)
- Train the people responsible for delivery of obesity related messages in mental health. Whether they are school teachers, doctors or weight loss coaches, it is

essential that these professionals are skilled and supported to carry out prevention initiatives without placing young lives at risk.

- Make sure that when young people go to the internet for dietary advice the information they find is safe and evidence-based and includes ways to seek help not only for weight loss but for any underlying mental health contributors to weight gain.
- Make sure that all community messages around dieting and weight are safe and effective. Obesity prevention initiatives should avoid:
 - Emphasising weight as the only measure of health. Good health is as a state of physical, social, and mental well-being and absence of disease. Emphasising weight promotes weight stigmatisation, body dissatisfaction, and disordered eating, and may increase the risk of weight gain, depression and eating disorders in adult life.
 - Labelling foods as ‘good’, ‘bad’, ‘junk’, and food choices as ‘right’ or ‘wrong’. This detracts from the development of a healthy and relaxed relationship with food, increases feelings of guilt and shame and the risk of disordered eating.
 - Cues to engage in any type of dieting, including fad dieting. Sensible healthy eating is quite different to the diets promoted through popular media. These are unsuitable for growing children.

(Source: Evaluating the Risk of Harm of Weight-Related Public Messages, Watson, 2010)

My binge eating disorder was finally diagnosed early 2018 when I had the opportunity to participate in an inpatient Binge Eating Disorder program with The Melbourne Clinic, the only one of its kind in Australia. I was fortunate to be able to afford this unique type of private health care. Many others do not have access to this basic essential evidence-based treatment.

Treatment was not what I expected. This initiative was based on my relationship with food, mood and sleep. No-one put me on a diet or shamed me. I am not calorie counting or weighing myself, but rather have acclimatized to a new way of being. Eating regularly, in a balanced way and walking. My “set-point” has still not settled, it may take a year or 18 months (Bacon, 2008).

It has been a life-changing program. Though traumatic in some ways, I have learnt strategies to curb my urges to binge and haven’t binged since. I am eating and moving in a way I could not a year ago and feel the healthiest I ever have. I want to make sure that the roughly 25% of people who are overweight who also have binge eating disorder have access to successful treatment. If as a country we care about health, productive and participating lives, and

reducing health care costs long-term, then we need to provide access to the right type of treatment when it is needed, early in illness.

I want to make sure that children are not exposed to the conflicting diet messages, weight shaming, social isolation and profound psychological distress that I had to endure from the age of 7. No child should want to take their life because of their weight.

Ingrid Ozols

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References

Peymane Adab, Miranda J Pallan, , Emma R Lancashire, , Karla Hemming, , Emma Frew, , Tim Barrett, Raj Bhopal, , Janet E Cade, et.al. (2018). Effectiveness of a childhood obesity prevention programme delivered through schools, targeting 6 and 7 year olds: cluster randomised controlled trial (WAVES study). *BMJ* 2018; 360:k211.

Bacon L, (2008), "Healthy at Every Size" <https://healthateverysizeblog.org>
www.lindabacon.org & www.HAESCommunity.org as cited on www.aedweb.org

Bauman A, Bellew B, Boylan S, Crane M, Foley B, Gill T, King L, Kite J, Mhrshahi S. Obesity Prevention in Children and Young People aged 0-18 Years: a Rapid Evidence Review brokered by the Sax Institute. Full Technical Report. Prepared for the NSW Ministry of Health: Sydney. Physical Activity Nutrition Obesity Research Group, The University of Sydney, 2016.

Alena M. Hadley, M.S., Elizabeth C. Hair, Ph.D., and Nicole Dreisbach (2010). WHAT WORKS FOR THE PREVENTION AND TREATMENT OF OBESITY AMONG CHILDREN: Lessons from Experimental Evaluations of Programs and Interventions. Child Trends.

Ling-Shen Hung, Diane K.Tidwell, Michael E.Hall, Michelle L.Lee, Chiquita A.Briley, Barry P.Hunt (2015). A meta-analysis of school-based obesity prevention programs demonstrates limited efficacy of decreasing childhood obesity. *Nutrition Research*, 35(3); 229-240.

National Eating Disorders Collaboration (NEDC) (2012). *Eating Disorders Prevention and Early Intervention: A Review of Evidence Based Approaches and Opportunities to Implement Effective Strategies*. Canberra, Commonwealth of Australia.

National Eating Disorders Collaboration (NEDC) (2017). *Eating Disorders & Obesity Treatments A systematic review of the physical, psychological and eating disorders outcomes from obesity treatments*. A National Eating Disorders Collaboration Report prepared for the Commonwealth Department of Health. <http://www.nedc.com.au>

Pacanowski CR, Loth KA, Hannan PJ, Linde JA, Neumark-Sztainer DR. (2015). Self-Weighing Throughout Adolescence and Young Adulthood: Implications for Well-Being. *J Nutr Educ Behav*. 2015 Nov-Dec;47(6):506-515.e1. doi: 10.1016/j.jneb.2015.08.008.

Rizk, J.K. (2013). Profiling Obesity: Four Distinct Clinical Subtypes of High-BMI Australians. Doctoral, Thesis, June, 2013. https://www120.secure.griffith.edu.au/rch/file/e33a1ef4-9e30-4529-aadd-eb0d50b6cdd9/1/Rizk_2014_02Thesis.pdf

Urquhart, Christie & V Mihalynuk, Tanis. (2011). Disordered Eating in Women: Implications for the Obesity Pandemic. Canadian journal of dietetic practice and research : a publication of Dietitians of Canada = Revue canadienne de la pratique et de la recherche en diététique : une publication des Diététistes du Canada. 72. e115-25. 10.3148/72.1.2011.50.