Consultation of RCPsychiS Members – Mandatory Calorie Labelling in Out of Home settings

Question 1. Should mandatory calorie labelling at point of choice, for example, menus, menu boards or digital ordering apps in the Out of Home sector (as listed in paragraph 1.2) in Scotland be implemented?

Paragraph 1.2

○ Yes ○ No ◉ Don't know

Please explain your answer

Introduction (our response to Question 1 follows)

- **Our role** – As a College, we seek to represent the collective views of Scotland's specialist mental health doctors providing essential and potentially life-saving care to those with a mental health condition, including those with an Eating Disorder.
- **Eating Disorders**– Eating-disorders are serious mental illnesses, which can affect people of all ages, ethnicities and backgrounds. 'Eating disorders are characterised by extreme fear of weight gain, driving sufferers to sacrifice other values to focus on weight loss or overactivity. Each requires person-centred support and care, up to and including the specialist mental health care our members provide. '
- **Their impact** – as highlighted in previous research by the RCPsych in Scotland, anorexia nervosa (which is diagnosed when a substantial amount of weight is lost, alongside other ED symptoms) is prevalent among 1% of women and 0.5% of men, and has the highest mortality rate for any type of severe mental illness, with half of these deaths are by suicide. Women are likelier to present with an eating disorder, as are our LGBT communities.
- **The pandemic** – research is starting to emerge that suggests the pandemic has both exacerbated the number of young people presenting with eating disorders, but also the severity of their condition. Research by BEAT also suggested that 61% of adults who received care for their eating disorder had less contact with services as a result of the pandemic.
- **An active voice** – The College has been an active part of the conversation for how we can better provide support, care and treatment for those with an eating disorder. This includes our members, including Dr Stephen Anderson, playing a lead role in the development of a Review into the care and support available to those with an eating disorder, which was published last year.

Our response to Question 1

- **Lack of evidence** – while recognising the intent of the proposals are to improve the overall health and wellbeing of Scots, the evidence base for this policy delivering such benefits is not clear. Looking to the UK Government's evaluation of its impact, the lead study it utilises (https://pubmed.ncbi.nlm.nih.gov/25037558/) explicitly states that calorie labelling did not have a meaningful impact alone, and, while it suggests some

reduction in calories when set alongside wider nutritional information, this would be to the detriment of the patient population who present at eating disorder services.

- The lead study used is actually not the most authoritative work on this matter with the 2018 Cochrane review of this subject being more up to date: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009315.pub2/full. This study found the existing evidence indicating benefits to calorie labelling as weak. This review also makes clear the lack of a clear and coherent understanding of the likely implications of socioeconomic status on the effects of such a policy.
- **Physical activity calorie equivalent** – this metric (where the equivalent exercise to 'burn' of the calories consumed) has been suggested as a alternative, but would suffer the same issues as the 2,000 calories a day average, of making pejorative presumptions of a person's 'average' body, weight and height. It would also likely provoke among those with an eating disorder unhealthy habits and decisions, including over exercise.
- **Social determinants** – The evidence suggests social, economic, and some protected characteristics are determinants for poor diet and obesity rates. This includes those with a severe mental health condition, whose 20-year worse life expectancy versus the rest of the population is partly driven by such factors. Measures such as calorie labelling have very limited evidence to suggest they will have an impact on systemic issue such as these, versus broader interventions to tackle health inequalities. The systematic review previously quoted makes clear that the impact of such a policy on these groups is lacking completely in evidence-the risk of inadvertent, adverse effects or ones that are discriminatory must be considered as present.
- **Wider evaluation of initiatives to tackle obesity** – a clearer effort to evaluate the wider policy landscape and initiatives to address causes of obesity, including through addressing health inequalities, is essential to judging what is currently effective, and what further interventions are needed instead of/in addition to what is proposed.
- **Additional, better evidenced public health measures** – as part of any efforts to implement this policy, we would urge that other, better evidence public health interventions in this pace are considered. This includes policies like breakfast clubs, education initiatives and We would urge that education and support to raise understanding of healthy, balanced diets and food, alongside addressing factors that lead to people eating less healthy food, is considered alongside or, ideally, instead of these proposals.
- **Need for formal review process** – if it is the Scottish Government's preference to continue with these proposals in some form, we would urge it to include a statutory review and renewal process. Replicating the process for Minimum Unit Pricing (which had a significantly stronger evidence base of positive public health impacts at the time of implementation), this would enable the Scottish Government to evaluate whether the policy has a meaningful impact on public health outcomes, as well as to assess the negative implications on those with Eating Disorders among others.
- **In principle cannot support** – with the public health benefits insufficiently evidenced, the stark implications for those with eating disorders who may at some stage need psychiatric support (detailed below) mean we cannot support these proposals. As a College, engaged with this population, we cannot endorse a move that will expand this populations' exposure to calorie labels that will drive unhealthy eating habits.
- **Patient's experience with calorie labelling** – Our members report that those with an eating disorder already find calorie labels and nutritional information in numerical form as a 'trigger' for them. Those who are predisposed to seek information around

how much they're eating are inevitably likelier to seek this information out, meaning any mitigations will only have a limited effect for this population. Our members have already had patients report they are affected by calorie labels to make unhealthy eating choices, including those with anorexia nervosa.

- **Avoiding labels one of the first steps** - Apps which provide such information are already utilised by this population in a negative manner, acting as a harmful trigger. One of the initial signs of progress for clinicians is to support people off using calorie counting apps, as it leads to harmful malnutrition, and it has changed clinical practice to create a caring, therapeutic environment.
- **Calories not an effective indicator of diet** – While we recognise that calories are a measure that can be used as part of assessing someone's diet, they are an arbitrary measure that does not account for individuals and their calorie needs versus the average population. They give no indications that help the judgement towards a balanced diet, and in fact we contend will act as an unhelpful distraction in the process of decision making towards making good decisions about dietary choices.
- **Eating disorder settings** – This applies to Eating Disorder settings as well. Clinicians engage with dieticians, who engage with patients based on portion size and food groups on the plate, rather than using calories. The notion of using calories may feature in exceptions, but is very rarely used directly when engaging with patients in thinking about how they structure their doet to aid the process of recovery. The focus then is on the principles of what a balanced daily diet contains and how to aid people to build the confidence to regularly make flexible and socially orientated food choices. Calorie labelling will just close down that potential for our patient group.

While we seek to propose mitigations in the event the proposed policy is put into practice, such as a formal review and renewal process akin to that in place for Minimum Unit Pricing, our stance in principle is that this policy does not have evidenced benefits for the public health of Scotland, and would cause significant harm to those with an Eating Disorder to who we provide care for.

Question 2. Should any of the sectors listed in paragraph 1.2 be exempt from mandatory calorie labelling? If yes, please explain why.

List of sectors

◉ Yes ○ No ○ Don't know

Please explain your answer

- **Particular settings of concern** – While we are in principle opposed to the implementation of this, there are particular settings where, in bringing in calorie labelling, those with an eating disorder would be particularly adversely impacted.
- **Hospitals and care settings** – Hospitals and outpatient settings generally should absolutely be exempt. The notion of healthcare settings triggering people with eating disorders in what is supposed to be a caring environment would breach that setting's obligations to its patients, and be wholly unethical. It would fundamentally breach our

obligations as clinicians to provide a caring, person-centred approach. The same applies to care home settings, where those with severe conditions who need support for an eating disorder. It would be far more worthwhile to look at the quality and diversity of food available in these settings, as well as providing accessible information, to help influence choices to ones towards a balanced and healthy diet.

- **Forensic and military settings** – It should also apply to forensic and military settings, as this is a population who would have no choice on whether they are engaged with this information.
- **School settings** – The stipulations on manufacturers, and whether this would translate to labels being provided on food serviced in school settings, is also deeply concerning. Our members are already seeing greater presentations from children and young people, due to a range of factors (many of which are touched on in later responses). We would urge that manufacturers to school settings are exempt from this process.

We would urge that, if this policy is implemented, these exemptions are included to ensure we do not turn caring and supportive environments into places where a person faces continual triggers for their eating disorder.

Question 3. To which size of business in scope of the policy, should mandatory calorie labelling apply:

☐ All businesses ☐ All except businesses with fewer than 10 employees (micro) ☐ All except businesses with fewer than 50 employees (small and micro) ☐ All except businesses with fewer than 250 employees (medium, small and micro) ☑ None ☐ Other ☐ Don't know

Please explain your answer

- **Bigger reach** – While aware that smaller businesses are exempt from the delivery of this in England, our member's perspective is that the bigger the organisation, the bigger the impact of their adoption on the lives of people with an eating disorder.

Question 4 . We are considering including food provided for residents and/or patients within the following public sector institutions within the scope of the policy. Should food in these settings be included within the scope of the policy?

	Yes	No	Don't know
Hospitals	○	◉	○
Prisons	○	◉	○
Adult care settings	○	◉	○
Military settings	○	◉	○

Please explain your answer

Please see our response to question 2

Question 5 . The intention is that pre packed for direct sale (PPDS) foods would fall within the scope of the policy. Do you agree with that proposal?

○ Yes ○ No ◉ Don’t know

Please explain your answer

Please see our response to question 1.

Question 6 . Should the foods and drinks listed below be exempt from calorie labelling? (please state your view for each of the above)

	Yes	No	Don't know
Non-standard menu items prepared on request	○	◉	○
Alcoholic drinks	○	◉	○
Menu items for sale 30 days or less	○	◉	○
Condiments added by consumer	○	◉	○

Please explain your answer

Please see our response to question 1.

Question 7 . Should menus marketed specifically at children be exempt from calorie labelling?

◉ Yes ○ No ○ Don't know

Please explain your answer

- **Formative experiences** – As stated previously, children and young people need to be given an environment where their formative experiences are impacted by an arbitrary measure of calories would distort the value of eating, the wider need for nutrition and potentially create additional risk factors of an potential eating disorder. Given the existing evidence gives no guidance on age-related effects, we would be deeply concerned if menus for children contained calorie labelling.
- **Increase in eating disorders** – Our members are already reporting greater presentations of eating disorders among young children. Our fear would be this would only increase if children were continually provided calorie labelling.

- **Misinterpreted** – We would question how and whether calorie labelling would be meaningfully explained to a child or young person, and the ways it could be misinterpreted and lead to negative eating habits forming form an early age.
- **Healthy relationship with food** – We fully support a healthy relationship with food should be nurtured, but that this should be sensitively done, with clear expectations set that healthy eating is a substantive and balanced diet. This is to ensure their physical growth and development is healthy, and not compromised by a focus on calories instead of wider nutritional factors.

Question 8. Should businesses be required to provide calorie information about options on children's menus to parents and carers on request?

○ Yes ◉ No ○ Don't know

Please explain your answer

- **Lack of support** – There are concerns that sufficient support is not in place for adults and carers to support their child/young person with understanding calorie labelling information as part of wider nutritional markers.
- **Supporting parents/carers** – Prioritising this support, information and education to adults/carers to identify what is and isn't unhealthy for their child, and how a balanced diet needs to include food from across the spectrum of nutrition including fats and sugars, and this could be implemented to positive effect without resorting to calorie labelling.

Question 9. What are your views on the proposed requirements shown below for the display of calorie information?

a) Calorie information should be provided at all points of choice

As previously stated, we oppose its introduction.

b) Calorie information should be displayed in the same font and size as the price

This implies the cost is as important as the calories, which is a gross misrepresentation of the causes of unhealthy eating.

c) Calorie information should be provided in calorie only and not also kilojoule

As previously stated, we oppose the introduction of labelling.

d) Calorie information should include the reference statement of "adults need around 2,000 calories a day"

- **Generalisation** – To have such a reference statement would provide a generalisation across age groups and the profile of individuals without context. The 2,000 calorie daily total can lead to a number of false assumptions being made, resulting in unhealthy eating decisions. This is a very arbitrary figure, and does not reflect individual needs.
- **Unhealthy decisions** – This would also encourage people with an Eating Disorder to believe that 'they only need' x number of calories, when based on their activities/lifestyle they need significantly more. It also leads to those people who go over the 2,000 calories who will then engage in forced bulimia to reduce their intake.
- **Heathy eating advice** – We would again refer to the work of dietitians to identify healthy food choices, portions and food groups.

Question 10. Should businesses be required or provide the option to have menus without calorie information available on request of the consumer?

◉ It should be a requirement for businesses ○ It should be an option for businesses

○ Don't know

Please explain your answer

- **Minimise exposure** – We should minimise the exposure of calorie labelling triggers where possible, and any levers which are available should be used. This should therefore be in place.
- **Assume menus are provided without labels** – We would suggest a step further, which would be that menus without calorie labelling are provided unless explicitly requested.
- **Healthy advice** – Regardless of menu choice, menus should list healthy diet expectations, and key food groups that a young person should be consuming.

Question 11. If businesses are required to also have menus without calorie information available on request of the consumer, what practical implications would this have for businesses?

- **Implications of implementation** – Whatever practical implications are nothing compared to the initial imposition of calorie labelling on menus in the first instance.
- **Health versus economic costs** – Any economic implications should be counterweighted by the potential health implications for the population who engage in unhealthy eating as a result of calorie labelling.

Question 12. What other mitigated measures could be adopted for consumers who may find calorie information upsetting?

- **Population drawn to triggers** – We would return to the principle of minimising those with eating disorders facing triggers. Nonetheless, they will be drawn to triggers as well as come across them in day-to-day life.

- **Mitigations unlikely to be impactful** – Options of mitigation, such as creating an additional step to access calorie information, f(or example a QR code) or to make it only available on request, would therefore only have a limited effect on a population who, if this information is available, will seek it out.
- **Education critical** – There must be an obligation to provide education to establishments to help them understand the policy and how ir may affect those with eating disorders detrimentally.

Question 13 . Please list any costs to businesses in addition to those listed that you think need to be considered in our economic evaluation.

The additional societal cost to society of increased eating disorders should be weighed against any business implications of divergence in Scotland.

Question 14 . What support, in addition to detailed written guidance, would businesses need to implement calorie labelling effectively?

We do not offer comment.

Question 15 . From the publication of relevant guidance, what length of time would businesses need to prepare to implement calorie labelling effectively ahead of legislation coming into force?

○ 6 months ○ 12 months ○ 18 months ○ 2 years ○ Other ◉ Don't know

Please explain your answer

We do not offer comment.

Question 16 - Please comment on our proposals for enforcement and implementation outlined in section 10.

- **Monitoring** – We would urge that in any implementation phase, extensive monitoring is utilised to evaluate a) the impact of the proposals on obesity rates and living choices and b) the impact on the eating disorders population. c. Impact on the development of new EDs among children and adults This should be commissioned alongside the implementation of the legislation, to enable a formal review and renewal process.
- **Sunset clause** – Looking to other health promotion initiatives like MUP (which had a significantly stronger evidence base at the time of delivery), we would urge a formal review process, following by formal renewal process (including a 'sunset clause') by which the proposals should be evaluated. This would reflect that MUP had significantly stronger evidence base, but that it was nonetheless required to have such a sunset clause to enable a consideration of it's impact prior to continuing with this intervention.

Question 17 - How could any requirements be enforced, in a way that is fair and not overly burdensome?

Please see previous responses around weighing economic versus health outcomes.

Question 18 - What impacts, if any, do you think the proposed policy would have on people on the basis of their: age, sex, race, religion, sexual orientation, pregnancy and maternity, disability, gender reassignment and marriage/civil partnership?

- **Severe and enduring mental ill health** – The experiences of those with severe and enduring mental ill health (falling under 'disability' in equalities leg) should be explicitly acknowledged, including for those with a eating disorder like anorexia nervosa.
- **Children** – The particular impacts on children and young people are concerning. The impact on a developing body of a failure to consume enough food is potentially severe and life altering.
- **LGBT** – The LGBT community, and its predisposition to eating disorders, needs to be considered. This group is 50% likelier to develop an eating disorder.

Question 19 - What impacts, if any, do you think the proposed policy would have on people living with socio-economic disadvantage? Please consider both potentially positive and negative impacts and provide evidence where available.

- **Does not address socioeconomic factors** – The wider evidence base indicates causes of obesity are driven by socio-economic disadvantage. This would be legislation that does not meaningfully engage with those from disadvantaged backgrounds, as it would not address decisions taken around price rather than nutrition. It also does not address the prohibitive cost and access sisues to fresh produce.

Question 20 – Please use this space to identify other communities or population groups who you consider may be differentially impacted by this policy proposal. Please consider both potentially positive and negative impacts and provide evidence where available.

See our response to question 1.

Question 21 - Please tell us about any other potential unintended consequences (positive or negative) to businesses, consumers or others you consider may arise from the proposals set out in this consultation

- **Negative associations** – There are potential negative implications for businesses engaging with their communities, as they would become negative spaces for those in their community with an eating disorder.
- **Waste of resources** – It was also suggested that those in public sector settings would see significant time and staffing given to develop calorie analysis that could instead be spent improving delivery provision with better evidenced, less harmful initiatives.