edhit
Eating Disorder Health Integration Team

Activity notes: small group discussion around priority areas, using research talks as inspiration - brainstorm solutions / design projects to address priority areas

Priority areas: early intervention and services for all (removing barriers)


Flipchart paper 1 feedback

Access to services shouldn't be linked to BMI requirements (high or low).

Educate parents not to reward with food (however some cultures express love through food - so reframe this message based on culture).

A programme to help kids be aware from a young age and make it part of the very normal conversation.

Food poverty, over representation of fast-food outlets, food bank contents, perception of affordable food, e.g. veg.

Higher-level interventions – smaller fast-food meal sizes, less BOGOF, king-size everything. Meal deals are with large bars not the small bar.

Ingredients causing food cravings, excessive salt and sugar.

Make healthy cooking simple, home cooking that's easy to understand/access – especially for young people.

Tackle intergenerational impact.

Identify chronic constipation etc., try GF/DF diet to improve restricted eating – optimise/supplement B vits, magnesium, probiotics.

Chemicals in foods lead to cravings to eat more – Pringles is a prime example.

What is it in mental health medication such as quetiapine which releases a chemical or cause people to crave food and gain weight. Significant stigma linked to weight gain when on this medication and unable to work (+ side effects of other medications).

Understanding breadth of eating disorders, especially binge eating and yo-yo dieting.

Long-term initiatives, built on past work - e.g. 1. Jamie Oliver in schools. 2. Increasing planning restrictions on fast food outlets in disadvantaged areas.

Flipchart paper 2 feedback

Recognition of the problem - GPs + Primary Care + Family

Education for surgeries.

What to look for? When to seek help? When to refer? (for individuals and families).

No jargon. Listen.

Tool, scale or checklist for GPs – when to worry? When to refer?

Where it doesn't 'look like a typical eating disorder'.

Diversity – gender, neurodiversity, ethnicity (normal weight range | weight/hip ratio | WHO guidance), weight behaviour.

Inclusive – how to share this.

Coproduction – carers, parents, people with eating disorders, diverse groups.

Flipchart paper 3 feedback

Wider understanding

- Cultural interpretations of eating disorders
- Eating disorder services not representative, e.g. BMI – racist and sexist
- Societal – barriers to access to education

Communities

- Seeking support in different places
- i.e. religious spaces
- Professionals etc. exploring understanding
- Parents / families

Research into communities

- Understanding of eating disorders
- Preventative measures
- Families – parents / support system
- Dietary advice for babies / parents
- Cultural differences – what is healthy?
- Baby groups? Family hubs – free childcare
- Coping strategies / emotional understanding

Schools

- Which routes to support within schools

- Resilience building workshops (adapting versions of the body project workshops culturally, lived experience training and workshops)
- Age of services to access
- Curriculum
- Schools don't work for everyone though
- Research with people working in schools - training
- Referrals from schools
- Language

GPs

- Cultural competence
- Barriers from primary to secondary care
- Language

Flipchart paper 4 feedback

Prevention - Community | Early relationship and attunement in communities | Isolation

How do we break the denial in protected family situations?

How can we break the taboo, e.g. childhood sexual abuse, the family secret or is it family norm? or denial?

BMI and different cultures, go to them to consult:

- Don't use formal language
- Use existing services for the consultation (carers, social workers, health or mental health services etc)
- Remember some medical/technical terms cannot be translated

Multi-agency approach - So many specialisms working in isolation. What about multi-dimensional therapeutic approach?

Have holistic approach, not just the disorder – community, sub cultures mirroring – copying and competing.

Can we change the narrative about change? Can we offer tools for change? (e.g. 12 step approach is useful for mental health self-harm)

ED in males is different – need to change our approaches, emotional connection, "eat my feelings". Do men share emotions in the same way?

So many influences but it's individual – sexual, neurodivergent systems, coping mechanisms, internal anxiety issues, unhappy, insecurity. Self-love / self-care? Person-centred.

Research design – who will be involved? Focus: multi-agency, structured recovery plan (e.g. 12 step).

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Discussion summary, feedback collated from all groups

Notes taken by HIT Academic Director Christine Ramsey-Wade during the event

Feedback from discussion:

- Level of understanding of EDs
- Cultural interpretation
- Community spaces
- Schools – resilience building, teaching for teachers, parents, families
- Religious spaces
- Parenting around food/body image – parent and baby groups, health visiting
- Healthy eating – educating parents not to reward through food
    - Important in certain cultures – how to address?
    - Portion sizes – US v UK
    - Unhealthy food in disadvantaged areas
    - BOGOFs
    - Food poverty
    - Lack of cooking skills in young people
    - Lack of awareness of digestive issues
- Access to services should not be linked to BMI
- General mental health
- Food as comfort – disordered eating as a symptom
- Early relationships
- Isolation in communities
- Abuse, neurodivergence – eating issues can come from lots of places
- 12 step approach to disordered eating?
- Copying unhealthy patterns in cultures / communities
- More collaboration with services
- Going to ethnic minority communities – go to where they are
- Breaking down taboos
- EDs in men – lack of emotional expression
- Structured multi professional approach – looking at the big picture – a wider position – more holistic
- Lack of psychological support in prisons for EDs – disparity / health inequality
- Normalising diversity of appearance in EDs – public health campaigns – can't tell if someone has an ED from how they look
- Do we know how many people seek help, rather than someone seeking help for them? Low levels of self-referral
- Lack of appropriate help available
- Recognising the problem in the first place

- GPs / primary care – doesn't always look like 'typical' - not accessing current guidance around diversity
- Tool / checklist / scale for GPs that is inclusive and up to date
- How do families / carers / know when to worry
- Co-producing this – what needs to be included, making it accessible
- Needs to be jargon free
- Working with families – forget the labels
- Using WHO guidance – waist to hip, not BMI
- Schools – PSHE – teaching people about healthy eating – and a whole school approach around mental health

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