CAP and BCAP consultation on references to obesity in advertisements: Individual responses

1 – A Natural Health Therapist

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight-loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so target obese individuals?

No.

CAP/BCAP/ASA aims to lift restrictions around the depiction of obese people in adverts for companies trying to sell products to these very people. It's predictable that such advertising will present obesity and overweight as undesirable. This argument is centred around a belief that overweight is abnormal/unwanted/unhealthy. There are plenty of impeccable data that refute this belief, so caution is needed before jumping to conclusions. Movement and activity seem to be much more important than bodyweight…if advertisers really wanted to help people they'd be pleading to show someone sitting at a computer all day. The premise of "weight-loss equals health" is questionable.

Weight loss is also potentially harmful and stressful for the body (especially if a person is already ill), and most diets/exercise programmes ask subjects to refer to their GP/health provider before starting. This recommendation is included in the NICE guidelines of May 2014. Companies are obliged to link weight loss programmes to health professionals at present, and these restrictions protect people from buying/trying out unsupervised, potentially harmful programmes. If shaming references to obesity/overweight are made in adverts it could stimulate someone into starting an expensive programme in desperation.

There is stigma attached to overweight and obesity felt and experienced by adults (and younger people) in our culture. Being overweight or obese can be compared in its effect to sexism, racism, and classism; enormous prejudice is sometimes experienced. Advertisers and CAP/BCAP/ASA must be very careful not to unwittingly absorb this cultural attitude, which says it's ok to target fat people as abnormal lazy slobs who need help from "normal" people. This attitude is changing with increasing awareness of, and acceptance of, difference in height size shape and colour of our human form. I quote from your consultation document: "Many of those who attend lifestyle programmes, and those who could potentially benefit from them are obese, but such individuals cannot be shown or referenced." This tells me that CAP/BCAP may have bought into the idea that weight-loss is always good, and thus abandoned their objectivity.

In the Communications Act 2003 standard 319(2)(h) advertising on TV/radio may not include misleading, harmful or offensive material. By presenting overweight and obesity as abnormal, unwanted or embarrassing, (for example in "headless fatty" pictures) companies will offend those of us who think this is just part of the natural variation of the human form.

An analogy can be made with adverts for skin-lightening cream, targeted at people of colour.

In summary I think the case for rule-change rests on two arguments:
weight-loss is good and will universally benefit fat people
no psychological harm will come from relaxing advertising rules

Both of these assumptions are dangerous and untrue.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules?

No.

Time
NICE itself admits that most weight-loss programmes result in a total average loss of about 2 kg and cease to be effective after 18 months at the longest. Hence the 3-month to 12-month time-span that is in the re-worded rules is more about selling than providing any real health benefit. In fact such short-term programmes are likely to contribute to weight cycling which is emerging as disastrously harmful to health.

Any lifestyle programme should be effective for 5 years or more, otherwise the description “lifestyle” is inappropriate.

Side-effects
Dangers or side-effects of such programmes should be consulted for, and listed with each advert (for example those side effects associated with weight cycling, obsession, depression, dementia etc). The inclusion of side effects has not even been mentioned.

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible and responsible references to obesity?

No.

The guideline is necessarily one sided, because it tries to make a political decision from a mass of contradictory data. It has chosen data to take notice of, which means there are other data which have been ignored. The NICE guideline should be interpreted with caution, and not used as an irrefutable document. It’s irresponsible to knowingly and cynically do so, just to escape any responsibility or blame, and to be able to bow to pressure from the weight industry.

Questions 4/5: Do you have any comments or suggestions on the drafting of the proposed rules? Do you think advertisers should target people of different size?

Please see my comments in Q 2.

No, I do not think that different categories of “obese” people should be treated differently, I do not think there should be ANY depictions of obese/overweight individuals in weight-loss adverts. The psychological effect of size-perception in this culture is usually harmful.

Question 6: Do you agree with CAP and BCAP’s proposal to maintain the prohibition on the advertising of weight-loss treatments and services to those under 18?

Yes, I think advertising weight-loss to children will result in an even greater raft of weight-loss related health issues (like anorexia) than we deal with already. Having said that I think there is no doubt that obese/overweight/any-weight children will be affected by the proposed advertising and there will be yet more health, growth and psychological problems (such as bullying) for our children as a result of any more relaxation of rules.

2 – A private individual

I am submitting three suggestions as an individual who has intensely studied the dark side of the health marketplace for more than 40 years.

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Your rule 13.2.3 states:

13.2.3 Marketing communications for non-prescription medicines that are indicated for the treatment of obesity and that require the involvement of a pharmacist in the sale or supply of the medicine may nevertheless be advertised to the public.

I see a problem with this because I don't believe that any non-prescription medicines are effective for weight control. If you don't believe me, please ask the appropriate professionals or professional organizations to supply a list.

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The US Federal Trade Commission used an expert team to compile a list of "Red Flag" claims that should not be permitted in weight-loss advertising because they are impossible. They are now called "gut-check claims." I suggest that you incorporate these into your guidelines.

https://www.ftc.gov/tips-advice/business-center/guidance/gut-check-reference-guide-media-spotting-false-weight-loss

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I'm not sure how dietary supplements fit into your regulatory scheme. I have reviewed ads for thousands of supposed "diet pills" (dietary supplements and herbal products). I have never seen one that could live up to the advertised claims and have concluded that all such products are fakes. Consumers would benefit greatly if you simply banned the marketing of nonprescription diet products (or a list of the ingredients of such products) — both OTC drugs and supplements — unless they meet criteria specified by you.

Many years ago, the US FDA banned a long list of useless substances that had been included in nonprescription drugs. The agency has the legal authority to do this. Some of these ingredients are used in dietary supplements because the FDA lacks the legal authority to ban useless ingredients in supplements — it can do this only in drugs.

3 – Beachbody UK LLC

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfill particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

Whilst we agree with the general premise that providers offering lifestyle weight management programmes that meet certain standards should be allowed to make responsible references to obesity in their advertisements, Beachbody has concerns regarding the wording and qualifications which have been arbitrarily used to define standards of a programme.

Beachbody understands the rationale behind the way in which NICE selected thirteen criteria in its Recommendation 9 of PH53. These are sensible approaches to advise commissioners of weigh loss management programmes. Beachbody is concerned that of the thirteen criteria, CAP narrowed these to five rigid criteria and further condensed them into four.

The suggested revision to the Code requires a large amount of efficacy to ensure the programme and claims being made match. While BCAP has a commitment to ensure that advertising does not lead to harm, the commitment to be proportionate is critical to the way this consultation is framed. It should be considered that the Code already ensures that advertisers must not mislead. Therefore, there is a strong argument for allowing the revised Code to be broader than that proposed.

"of at least three months duration"
Beachbody agrees that for long-term weight loss through exercise and dietary control, lifestyle change is most successful the longer the regime is maintained. However, it is not necessary that the same programme be responsible for success over the entire three months and in reality, many people using weight loss management programmes will maintain a healthy lifestyle shift over the course of three months using a mix of shorter programmes, especially as they achieve better fitness and improved health. Even by the current Codes guidelines an 8-week programme would allow 2lb per week weight loss (16lbs). This is a considerable step in moving towards a sustained healthy lifestyle and should not be disregarded.

Moreover, people who wish to change their lifestyle, may be put off making changes that require a long commitment, successful programmes may be better promoted as small steps repeated or expanded upon over a longer period. Programmes may involve several weeks of cycling through increasing advanced steps of different regimes. The end result is the same, but the revised Code does not allow for this.

We recommend the criteria be broadened to suggest that in the advertising. Lifestyle change is understood to be optimised by maintaining a healthy lifestyle over a 3-month period and beyond when starting from a BMI classification of over 30. We appreciate that it is important to ensure 'quick fix', unhealthy programmes are controlled, but not at the expense of short programmes that have a potential long-term benefit when used correctly and repeated over an extended period of time.

"multi-component and developed by a multi-disciplinary team"
Beachbody understands the importance of a weight loss programme that is multi component, indeed it is the core of our business. We are therefore concerned by the subjective nature of these criteria. Whilst multi-component is likely to be understood to include a regime of balanced, dietary control and exercise, it is unclear how the definition of

‘a multi-disciplinary team’, should be interpreted. PH53 recommends input from a registered dietician, registered psychologist and qualified physical activity instructor. The Code should clarify the level of ‘input’ required and in order to allow pre-clearance to be obvious for advertisers. It is also unclear how providers who are developing products outside of the UK should manage to provide the correct level of registration and qualification of those creating programmes. It is not logical or reasonable to believe that a successful programme can be created that does not incorporate the skills of at least one of the team listed in the criteria as essential.

“shown to be effective at 12 months and beyond”
Whilst Beachbody understand the need for public health care commissioners to require a programme to show a return on investment over a twelve-month period, we believe that it is arbitrary to restrict advertisers to this time period as a criterion for a successful weight loss management programme targeting consumers through broadcast advertising. In any case, Beachbody have concerns at the subjective nature of CAP’s use of the term “effective”. Should this criterion be included in the final Code, we would recommend discussion with advertisers, Clearcast and health care consultant specialists in this field to ensure that there is a clear definition of the way in which advertisers will be expected to demonstrate long-term success of a programme. Beachbody suggest that success may look like a reduction and maintenance of BMI values into a healthy range over time.

“provided by staff who are trained to deliver them”
Beachbody understand the requirement in PH53 for health Care commissioners to refer patients to trained teams to deliver community activities. In order to transfer this criteria from a clinical environment to broadcast advertising code, Beachbody recommends that advertisers ‘make qualified staff available’ after purchase.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

As specified within our response to question 1, Beachbody do not agree that CAP and BCAP have identified entirely appropriate criteria to include in the rules. Within PH53, Recommendation 9 suggests several other criteria which Beachbody believe may be a more appropriate qualification for a provider using broadcast advertising:

- Assist in providing achievable goals for weight loss
- Reduce sedentary behaviour
- Include behaviour change methods

We agree the following important criteria should remain:

- Multicomponent

The criteria set out in PH53 is a recommendation and it is not expected that all 13 criteria listed should always be achieved for every weight loss management programme. Beachbody believes that the most reasonable way forward to ensure a successful and reasonable Code would be to request that a provider of a weight loss management programme which is advertised through broadcast is expected to meet at least 3 of the 13 criteria:

- Multicomponent
- Multi-disciplinary team
- Trained staff
- Life long lifestyle change
- Last at least 3 months
- Achievable goals for weight loss

- Dietary targets agreed
- Reduce sedentary behaviour
- Supervised physical activity is led by a qualified PT
- Behaviour change methods
- Tailored programmes
- Monitor weight
- Non-judgemental approach.

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

Beachbody welcome the use of the NICE Guideline PH53. This is a progressive document, which has made fundamental changes to the way in which health care commissioners and professionals are encouraged to consider methods of helping patients who are obese; we especially applaud the new guidelines that encourage self-help ahead of surgical procedures.
We welcome that the scope of the Code may be broadened by this additional sentence but have concerns that it is unclear what the ASA define as having "regard to". It must be understood that in the process of pre-clearance of advertising, there is a requirement that the Code is clear enough for Clearcast to make sense of what an ASA Executive may regard as permissible.

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?

The publication of PH53 was designed for commissioners, health professionals and providers of lifestyle management programmes. It is also suggested that the guide will be of interest to individuals and their families.
The body of evidence provided in the document that has lead to the publication clearly shows there is a need for a different direction in how to direct overweight and obese individuals to help themselves or get help to begin a programme of weight loss. Care should be taken when trying to apply a public health advice document (written predominantly for health care professionals with the aim of helping them advise and communicate with overweight and obese individuals) to advertising code predominantly used by private organisations to communicate directly with consumers mostly through television

Fundamental to the approach advised by PH53 is the need to understand the impact of different approaches on the public purse. PH53 demonstrates a need for value for money in providing a weight loss service.
This approach skews the ultimate advice they would give unhindered by this requirement. (i.e. if they were private company advertisers)

Beachbody have made a number of suggestions within the responses to questions already. Our concern remains that the new Code is clear and easy to understand for pre-clearance executives at Clearcast. Beachbody would recommend that CAP invite advertisers, organisations representing advertisers and Clearcast to talks to ensure that clear guidance notes are agreed and published ahead of the publication of new Code.

As this is a new and complicated area Beachbody recommends that the ASA agree to period of working with advertisers informally in cases of viewer escalations, in the spirit of finding a workable and more durable mechanism for applying the NICE guidelines through retrospectively devised guidance notes.

Question 5: For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):
- **category I,**
- **category I and II, or**
- **category I, II and III**

of obese people?

Beachbody agree that Category I, II and III should be included as being able to be referred to in the new Code.

However, there are a number of well-documented issues with the use of BMI as a measure of personal health. PH53 advocates the use of waistline circumference measurement AND BMI and distinguishes between the BMI of different ethnic groups. Given the make up of the UK in terms of ethnicity, should the Code reasonably ignore this?

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

Beachbody agree that there should be care exercised in the placement of certain advertising and that under-18 year olds should not feature as potential consumers of weight loss treatments and services in advertising. Beachbody are concerned that the current interpretation of the Code has been taken too literally by Clearcast and media owners. If the status quo remains, advertisers of fast-food and food products which may be high in sugar or salt and may promote an unhealthy and unbalanced diet are allowed to be shown next to programming that may be enjoyed by under-18's (including music channels). At this time a product or service advertising healthy weight loss, including the promotion of increased exercise and a shift to a balanced, healthy nutrition plan, may not be advertised on some channels. Given the high number of under-18's in the UK who are now classed as obese. Beachbody believes that it is important that this is reviewed.

Question 7: Are there any other comments you wish to make, or evidence you wish to submit, in relation to CAP and BCAP's consideration of the issues set out in this document?

The title of PH53 is " Managing overweight and obesity in adults – lifestyle weight management services". CAP's executive summary in the consultation only recognises the impact that PH53 has had on tackling obesity, not the overweight. It is clear that there is a path from overweight to obese that public health bodies are looking to reverse; reasonable advertisers can play a part in this process. The consultation overall only relates to obesity, this seems to ignore overweight being an issue that PH53 set out to tackle.

Furthermore, Beachbody propose that there should not be separate rules for the 'overweight' and the 'obese' regarding healthy weight loss. This is not mentioned in the consultation and is an omission that is out of step with PH53. NICE have changed their guidelines from 2lb per week to a % of baseline weight over a time period appropriate to a programme: PH53 makes it clear that both the overweight and the obese should target a 10% weight loss but that even a weight loss in the 3% to 5% range and 'maintaining a lower weight trajectory' has a significantly better outcome. This suggests a 'cut off' at BMI 30 is arbitrary and not relevant.

4 – British Psychological Society (BPS)

Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

The Society believes that there is no reason to change CAP and BCAP guidelines. We are aware of the revised NICE guidance but that in and of its self is insufficient to legitimise direct marketing to people with obesity. The fundamental problem is that advertising, by the nature of commercial communication in a competitive environment, must emphasise the optimal outcome. This substantiated the false impression that someone with obesity entering a commercial programme would not be obese at its end. Unfortunately, the data as it is, demonstrates that this is not the case. Weight loss in these programmes, for those who complete (a limited number) is, at best, 4-5kg. Looking at the evidence base, the often quoted evidence for effectiveness of a commercial programme is the Lighten up trial (Jolly et al, 2010). In this trial only 11.5% of people with obesity or who were overweight who were invited participated which is an extremely low participation rate. Of these the best results were for Weight Watchers (WW). 46% of participants in the WW group lost 5% (with an average loss of 4.43kg). Only 31% maintained a 5% loss over the next year.

Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

The Society believes that the current criteria are modest and descriptive. They are inadequate to determine if a programme is comprehensive or effective which makes them unenforceable.

Firstly, we believe that the proposed duration of a minimum of three months is inadequate. In that period consumer use and adherence will vary greatly. The intensity and duration of the programme are important determinants of outcome.

Second, the criteria fail to specify the depth of content of the multi-components. Programmes currently vary in content, some maximising in just one area e.g. dietary change. Provision of written advice or even information on a website could be argued as fulfilling the multi-component requirements.

A third issue is the role of the multi-disciplinary team in supervising the programme. The Society recommends that such a team should be delivering the programme. But if that is not the case it needs to be specified how training will be delivered, to what standards, and how skills are maintained and how are programmes and sites are audited to maintain adequate standards.

The fundamental problem is Health Professionals do not yet have enough evidence to specify the most effective components of weight loss interventions. As well as design, the effectiveness of Behaviour Change interventions depends on training and on-going supervision. Evidence demonstrates only the best programmes prove effective for a minority. The unqualified term 'Trained to deliver them' raises a number of questions including who sets the standards for training, accreditation of having been trained, ongoing supervision, continual professional development and so on amongst Facilitators.

Relevant evidence includes Look AHEAD whose primary objective is to examine, in overweight volunteers with type 2 diabetes, the long-term effects of an intensive lifestyle intervention program designed to achieve and maintain weight loss by decreased caloric intake and increased physical activity. The authors of the paper claim success. Those who show response early appear to maintain benefits to 8 years post-intervention.

The headline weight loss was at year 4, intensive lifestyle intervention participants lost an average of 4.7% of initial weight, compared with 1.1% for education controls (DSE) ($P < 0.0001$). More ILI than DSE participants lost ≥5% (46% vs. 25%, $P < 0.0001$) and ≥10% (23% vs. 10%, $P < 0.0001$) of initial weight. Within the ILI, achievement of both the 5% and 10% categorical weight losses at year 4 was strongly related to meeting these goals at year 1. (Wadden et al, 2011)

Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

This question puts regulation very much in the context of NHS provision.

NICE guideline state that 'Lifestyle weight management programmes for overweight or obese adults are multi- component programmes that aim to reduce a person's energy intake and help them to be more physically active by changing their behaviour. They may include weight management programmes, courses or clubs that: 1) accept adults through self-referral or referral from a health or social care practitioner, and 2) are provided by the public, private or voluntary sector. Such lifestyle services are sometimes known as tier 2 services'.

The Society welcomes this pragmatic approach that recognises the provision of effective weight management is beyond the scope of the present NHS, especially in primary care, and that there is expertise in weight management existing in commercial sectors (some not for profit) outside the NHS. This is not in dispute.

Unfortunately within the NHS, what constitutes a tier 2 service remains unclear and how commercial programme relate to wider patient care is confused. The guidance implies that tier 2 services should have significant NHS input. However, advertising creates a direct link with the consumer from which health practitioner is excluded.

Moreover, in the NHS context creates demands that the GP may not be able to meet. The implication of advertising a service nationally if it is not available locally needs to be specified. Therefore, in an NHS context, if a GP and patient decide a structured programme is the way forward it may be more appropriate to send them to comprehensive tier 3 services.

Do you have any comments or suggestions on the drafting of the proposed rules?

The Society believes that regulators should be aware of how poor weight loss results are for the majority undergoing any programme. Individual testimonials are generally unrepresentative of this and should be controlled. The use of these cases is misleading as they are very much the exception to the rule. Most people will not pass from obesity to normal weight.

For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):

- **category I,**
- **category I and II, or**
- **category I, II and III**

of obese people?
Please provide any evidence you consider supports your response.

There is no specific evidence to suggest lifestyle weight loss programmes are any less effective or contraindicated in people with a BMI of 40+. What is clear is these programmes require intensity and longevity of the intervention that far exceed the proposed criteria (see the reference and description of Look AHEAD above. A patient group with morbid obesity are more likely have specific health issues, medical requirements, and possible functional limitations that necessitate personalised approaches and individual motoring that cannot be delivered outside of a multidisciplinary professional setting.

Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

The Society recommends that the 18 year prohibition on advertising treatments is appropriate and is maintained. While current weight loss providers do accept young members (11+) with the permission of their GP and with an adult attending sessions they are not providing dedicated (and proven effective) children's services. There may also be unintended consequences of any campaign targeted at children in terms of stigmatisation and bullying (Puhl et al, 2013; Avery et al, 2012).

Are there any other comments you wish to make, or evidence you wish to submit, in relation to CAP BCAP's consideration of the issues set out in this document?

The Society has concerns about the advertisement of weight management 'solutions' across the sector. The commercialisation of weight management has grown and it will further expand. In particular there is a large unregulated market that offers products presented as medicines with unproven claims. Any loosening of regulation not only allows the exploitation of vulnerable people. Because these products are ineffective, the resulting failure to lose weight will reinforce feelings of personal failure and undermine future weight management strategies and health outcomes.

References

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5 – Cambridge Weight Plan (Cambridge)

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

Cambridge agrees that responsible lifestyle weight loss and weight management providers should be able to refer to obesity in their marketing and to target obese individuals once they have fulfilled specific criteria.

The current CAP code rule against allowing responsible weight loss providers to target obese individuals in their advertising appears to be based on an incorrect assumption: Section 13 of the CAP code (Weight control and slimming) states "obesity is frequently associated with a medical condition and a treatment for it must not be advertised to the public unless it is to be used under suitably qualified supervision." This suggests that, in being frequently associated with a medical condition, obesity qualifies as a medical condition itself. This is not the case. As noted by the NHS, whilst some medical causes may contribute to weight gain, obesity in itself is not a disease. This has been reinforced by recent studies, including one co-authored by a scientist from Harvard University which found that it is possible to be obese and healthy.

Moreover, despite CAP's current rule stating that obesity is associated with co-morbidities, this has not been reflected in Cambridge's experience. Whilst it is true that being obese increases the risk of developing co-morbidities, it is by no means a certainty and a significant majority of individuals who have joined our programmes have not had secondary illnesses and, therefore - in being considered to be healthy - would not require medical supervision. Furthermore GPs and other HCPs may not consider it their responsibility to supervise the weight loss of a patient who is otherwise healthy.

Permitting responsible weight loss providers to advertise to the obese will undoubtedly provide benefits for the nation as a whole. Approximately a quarter of the population are currently obese according to government statistics, with severe repercussions for the NHS' finances and the health of the nation.

Allowing responsible weight loss and weight management providers to advertise to the obese will aid such individuals in making informed decisions about how best to lose weight. This, in turn, will not only help reduce the prevalence of obesity but will ensure that the additional strain placed on the NHS – especially primary care health professionals who assist obese individuals – is reduced.

Finally, revising the CAP code prohibition on weight loss programme advertisements targeting obese individuals would resolve the current conflict between this rule and the EU Nutrition and Health Claims Regulation (1924/2006). As you will know, the Nutrition and Health Claims Regulation regulates the use of nutrition and health claims on commercial communications across the EU, including advertising: only approved claims may be carried, including claims related to weight loss. Currently, however, CAP and BCAP rules mean that companies can go to the time and expense of securing an approved claim for weight loss on one of their products only to find themselves banned from making any reference to the fact that these products form part of a weight loss programme.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

Cambridge agrees that there should be appropriate criteria in place to ensure that those weight management providers advertising to the obese are indeed responsible.

There must, however, be a strict and well thought-through definition for 'multi-component' programmes which takes into account those instances where requirements on increasing physical activity or effecting behaviour change may be ineffective in the short term. For example, specifying that a multi-component programme must incorporate the need for increased physical activity would be of no help to an individual who has gained a significant amount of weight due to a physical disability or arthritis in their joints and must lose this weight before they can exercise. Such rules would therefore prevent advertising aimed at a large number of obese people.

Cambridge also agrees that programmes must have an established minimum duration and should be able to demonstrate that they are effective at one year and beyond. Cambridge is able to provide such evidence to show that our programmes are efficacious at twelve months and longer.

Cambridge would be particularly interested though in any further information regarding how CAP and BCAP intend to assess the manner in which programmes are deemed to be effective by their providers i.e. will such assessment be conducted via peer reviewed presentation or through the use of external scientific experts? And what will be the standard of effectiveness? If someone loses 30kg on a weight loss programme, but their weight increases by 3kg after 12 months, will that be deemed 'effective' or not?

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

Cambridge disagrees with CAP and BCAP's proposal that the ASA have regard solely to NICE Guideline PH53 when assessing whether an advert for a lifestyle weight management programme can make a permissible reference to obesity, though it is a helpful basis.

It is important to note that NICE guidance is designed for the NHS and is not intended to extend to private providers of weight management programmes such as Cambridge. The NICE Guidance Development Group acknowledged in Guidance CG189 'Obesity: identification, assessment and management of overweight and obesity in children, young people and adults' that commercial providers were beyond their remit, indicating strongly that it would be inappropriate to apply criteria formulated by NICE for NHS staff to commercial organisations. We share this view.

Accordingly, when assessing adverts from commercial weight loss providers, the ASA should take into account all satisfactory scientific evidence provided by responsible weight management providers, regardless of whether it is not covered or even conflicts with NICE guidance.

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?

Cambridge are in agreement that CAP and BCAP should be flexible when drafting the suggested rules for marketing to obese individuals and should also ensure that they exercise openness and transparency when doing so.

Due consideration should also be given to any relevant robust scientific evidence submitted to CAP in response to this consultation when constructing the rules. Furthermore, CAP and BCAP should ensure that the criterion on effectiveness in particular is sufficiently broad and encompasses instances where overweight individuals may only need to lose weight in the short term, like when needing to lose weight to qualify for surgery. In that instance, effectiveness would surely be measured in terms of whether the subject was able to qualify for surgery, not whether their weight loss was maintained at 12 months and beyond, when their increased activity after (say) knee replacement would also be a major contributory factor.

Question 5 [on PH53's various classifications of obesity: Healthy weight 18.5–24.9 Overweight 25–29.9 Obesity I 30–34.9 Obesity II 35–39.9 Obesity III 40 or more]: For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):

- **category I,**
- **category I and II, or**
- **category I, II and III of obese people?**

Please provide any evidence you consider supports your response.

Cambridge is of the view that weight management providers should be able to target obese individuals in all of the categories set out above, as having additional information on the effective programmes that exist to help them lose weight is beneficial to all obese people.

Furthermore, in practice, it may be difficult for consumers and advertisers to distinguish between adverts targeting individuals in each of these classifications if such restrictions between categories were created. This is due to there being very little difference in practice between individuals whose BMI is near the borderline between categories.

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

Cambridge agrees that the prohibition on advertising of weight loss programmes to under-18s should be maintained.

6 – Diet Chef

This is the response of Diet Chef to the Committee of Advertising Practice's (CAP) and the Broadcast Committee of Advertising Practice's (BCAP) consultation on proposals to allow providers of certain lifestyle weight loss programmes to refer to obesity in their advertising and therefore target obese people.

Diet Chef acknowledges the growing issue of obesity within the UK. It notes that in 2012, 24% of men and 25% of women aged 16 or older were classified as obese, while 42% of men and 32% of women were classified as overweight. This is in line with the definition of obesity as having a body mass index (BMI) of greater than 30kg/m2, and the definition of overweight as having a BMI in the range of 25 to 30kg/m2. To combat this issue, Diet Chef supports the idea that individuals should have greater access to support, albeit within clearly enunciated guidelines.

Diet Chef notes that the key components of the Code will still operate to ensure that weight loss programmes will be prohibited from misleading consumers or causing them harm. However Diet Chef is vehemently opposed to the approach being taken by CAP and BCAP. It believes that the approach of adopting criteria from Nice Guideline PH53 (PH53) which is predominantly aimed at medical staff and other health professionals commissioning weight loss programmes not only lacks proportionality but is also ultra vires of CAP and BCAP's remit. Furthermore this fundamentally restricts individual choice by prescribing a single model of weight loss, despite the fact that individuals approach weight loss in a variety of ways.

The method of cherry-picking five partial criteria out of a sixty-one page document has led to CAP and BCAP adopting an extremely ambiguous and highly unclear set of criteria. They have also failed to demonstrate why the chosen approach is the least onerous method by which they are able to achieve their aim.

In particular Diet Chef is concerned that by adopting the criteria they have, CAP and BCAP are foreclosing competition. This concern arises due to the requirement in the code that weight loss programmes must be shown to be effective at 12 months and beyond. This effectively restricts the number of advertisers who currently would meet this criterion to incumbents. Despite this clear restriction on competition, CAP and BCAP have not justified why this criterion is necessary in order to meet their statutory duties.

Diet Chef also notes that the approach taken by CAP and BCAP is at odds with the approach taken in other areas (e.g. medicines) and is also at odds with the approach taken in some other EU jurisdictions (e.g. Germany).

In addition Diet Chef notes that the proposal would allow the Advertising Standards Authority (ASA) to have regard to PH53 in its entirety when assessing advertisers' compliance with the CAP and BCAP Codes. This is despite the fact that the consultation itself recognises that PH53 was not drafted with the regulation of advertising as its aim. The consultation therefore implies that it would be wrong for the ASA to adjudicate on the acceptability of an advertisement on the basis of another body's code. This is a contradiction. Diet Chef foresees that there will be confusion, uncertainty and an upswing in the number of complaints to the ASA, all of which could be avoided by an appropriately drafted amendment to the Codes.

In Diet Chef's view, if the ASA have deemed that it is not appropriate for the details of the Guidance to be written into the Code itself because it is not proportionate, then it is not appropriate or proportionate for the ASA to be able to refer to it in their assessment of complaints.

Diet Chef has an alternative proposal. It is proposed that weight loss programmes should be able to refer to and target Category I obesity, defined as having a BMI in the range of 30-35kg/m2. However where such programmes are not carried out under direct medical supervision there must be a reference to obtaining medical advice or supervision. This would align the approach taken to obesity with the approach taken to medicines and would reduce the risk of harm whilst being the least onerous approach and so proportionate. This would mean that advertisers still would not be able to target Category II and III obesity given the greater risk of co-morbidities involved with these categories.

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

Diet Chef strongly disagrees with the approach taken by CAP and BCAP. Its detailed reasons are set out below. As set out in the executive summary Diet Chef believes that the approach taken by CAP and BCAP lacks proportionality and there is a strong risk that by adopting these criteria CAP and BCAP are acting ultra vires. Diet Chef notes that the approach is at odds with the approach presently taken in other cases by CAP and BCAP, including in relation to medicines, and that under the proposals advertisements targeting obesity would be required to satisfy a higher threshold than those advertising medicines.

Diet Chef also notes that the approach taken by CAP and BCAP would not only seem to foreclose competition within the UK (in particular by requiring services to show that they are effective at 12 months and beyond) but is also at odds with the approach taken in some other European jurisdictions such as Germany.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

Diet Chef strongly disagrees with the approach that has been taken by CAP and BCAP in relation to setting the criteria for who may refer to obesity in their marketing. CAP and BCAP have taken a document, PH53, which they recognise "is not designed as a regulatory tool for advertising", and have chosen five seemingly arbitrary criteria out of that sixty-one page document to apply as a means of regulating advertising.

The NICE Guidance is fundamentally premised on the idea that it is addressed towards people working in health services who are addressing obesity issues. It is aimed at assessing the suitability of programmes to be commissioned both from the perspective of those doing the commissioning and the programs being commissioned.

Diet Chef notes that CAP and BCAP have merely cherry picked a series of criteria from Recommendation 9 of the Guidance. Recommendation 9 is entitled *"Commission programmes that include the core components for effective weight loss".* The Recommendation is clearly directed towards commissioners as it says *"Commissioners of lifestyle weight management services (see Who Should take action) should commission or recommend lifestyle weight management programmes that"*. There then follows a series of 14 criteria that these lifestyle weight management programmes should satisfy in relation to

weight loss. Recommendation 10 deals with the criteria that these programmes should satisfy in relation to preventing weight gain.

CAP and BCAP have cherry-picked five of these criteria relating to weight loss and partially applied them in their guidance in a way that fails to consider CAP and BCAP's role and responsibilities in regulating advertising. Ultimately CAP and BCAP's role is to ensure that advertising which may be misleading, harmful or offensive is prevented, not to apply rules that have been developed in other contexts.

Unfortunately however CAP and BCAP have not justified in any detail why they have chosen these five criteria on weight loss and not others, nor have they demonstrated why programmes not offered under medical supervision must be able to demonstrate these criteria in order for the advertisement not to be misleading, harmful or offensive. There is no attempt to demonstrate why in a materially different context these requirements are necessary and why they are the least intrusive remedy to achieve the statutory aim.

It must be remembered that all these rules are doing is preventing advertisers from referencing obesity either visually or verbally. It is difficult to envisage the harm in a weight loss programme that does not satisfy all of these criteria but which encourages participants to seek medical assistance in parallel, showing a picture of a person who might be seen by the public as being overweight but who is in fact Category I obese. Diet Chef notes that there is no evidence to illustrate that the public as opposed to CAP, BCAP and the ASA are able to clearly delineate between the point at which a person has a BMI of 29.9, and thereby making them overweight for the purposes of the Code, and the point where they have a BMI of 30, thereby making them obese for the purposes of the Code.

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

Diet Chef disagrees with the approach of adopting criteria from PH53 and also disagrees with allowing the ASA to have regard to PH53 in its entirety to adjudicate on compliance with the Code.

Diet Chef notes that CAP and BCAP's consultation appears to be extremely inconsistent as regards the ASA's ability to rely on PH53. On page 13 of the consultation, after acknowledging that PH53 is not designed as a regulatory tool for advertising, it says *"its provisions are too extensive for the ASA to reasonably be expected to judge programmes' compliance with them when considering the acceptability of individual advertisements".* They then go on to say that *"Additionally CAP and BCAP do not consider it appropriate for the ASA to make adjudications on the acceptability of an advertisement on the basis of another body's Code or Guideline, particularly given the risk to advertisers of being judged by another body on the same criteria but for other reasons, e.g. the programme's suitability to be commissioned by a local health authority."* A few paragraphs on however, having identified the criteria, CAP and BCAP say that *"there may be occasions when the ASA needs to draw on the wider Guideline to inform its understanding of the key criteria and therefore propose to allow the ASA the discretion to have regard to Guideline PH53 to help judge whether a particular marketing communication for a lifestyle weight loss programme may permissibly refer to obesity."*

Notwithstanding that Diet Chef does not agree with the choice of the criteria, it does not understand how it can be appropriate for the ASA to be able to refer to the wider guideline given the dramatically different purpose of PH53. If it were to be appropriate and proportionate for this wider context to be taken into account then the detail of the provisions

should be built into the code so that advertisers are clear what rules they will be being judged against from the outset. The fact that CAP and BCAP have not done so suggests that they do not believe that to do so would pass the proportionality test. If it is not proportionate to include the requirements in the Code itself, it would not be proportionate to allow the ASA to apply them in its adjudication.

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?

Diet Chef believes that CAP and BCAP's chosen criteria are not only inappropriate and disproportionate but they are also ambiguous. In addition there is ambiguity between CAP and BCAP's consultation document and the proposed changes to the Codes themselves. These ambiguities include:

Of at least three months duration
Diet Chef queries the imposition of this requirement. It notes that individuals approach weight loss in different ways. Stating that only weight loss programmes that are of a duration of three months or greater can make reference to obesity in advertising will reduce the ability of consumers to make an informed choice as to the options available to them. Diet Chef has recommended that all weight loss programmes which make reference to Category I obesity should indicate that customers should seek medical advice or supervision in parallel. Diet Chef believes that it is more appropriate for the individual's medical practitioner in consultation with the individual to suggest an appropriate length of time for the weight loss programme.

Multi component
Diet Chef notes that in the consultation document itself, multi component is referred to "as addressing dietary intake, physical activity levels and behaviour change". In the changes to the CAP and the BCAP Code however, the requirement is for the programme to be "multi component". Even if the wording "addressing dietary intake, physical activity levels and behaviour change" were included in the rules, it is not clear what would be required to satisfy this requirement. Again Diet Chef notes that individuals have different preferences as to how they approach weight loss. By prescribing that in order to reference obesity, weight loss programmes must be multi component, BCAP and CAP appear to be suggesting that there is only one way for individuals to lose weight. Diet Chef believes that this assessment is for the individual, in consultation with their medical professional, rather than for BCAP and CAP.

Developed by a multidisciplinary team
Again there is ambiguity between the consultation document which refers to "developed by a multi-disciplinary team; including input from a registered dietician" and the proposed revised wording which refers to being "developed by a multi-disciplinary team". It is difficult to see what constitutes a multi-disciplinary team in this context. There are questions as to whether it must include a registered dietician; as to why other nutritionists are excluded; whether or not a physical fitness instructor and a registered practitioner psychologist are required, as referred to in the NICE guidelines. Further to this, it is unclear as to what "developed by" means in this context and whether the team must help develop the programme, or whether it is sufficient for them to merely approve a programme that has been developed by a third party, and whether their continuous involvement is required or if their contribution can stop after the initial development.

Shown to be effective at 12 months *and beyond* (emphasis added)
Diet Chef queries the appropriateness of this requirement in the context of regulating advertising for weight loss programmes. Diet Chef notes that this is not one of the criteria set out in Recommendation 9 of PH53 but instead falls under Recommendation 12 which is designed to provide a national source of information on effective weight loss programmes.

Accordingly, the recommendation suggests that providers of lifestyle weight management programmes should demonstrate that their programmes “are effective at 12 months or beyond”. Other requirements in this Recommendation are that the weight loss programme meets best practice for commissioning and meets the core components for weight loss (Recommendation 9) and the core components for the prevention of weight regain (Recommendation 10). Given this context of developing nationwide information and given that CAP and BCAP have not included any of the requirements for the prevention of weight regain in the relevant criteria, Diet Chef queries why this particular requirement is appropriate.

More importantly Diet Chef notes that by including this requirement the effect is the almost certain foreclosure of competition by ensuring that only programmes that can currently demonstrate that they are effective at 12 months and beyond will be able to reference obesity in their advertising. If the ASA were to rely only on PH53 in making an assessment of this criteria, the number of programmes which would be able to satisfy this requirement would be extremely limited and would mean that the vast majority of weight loss programmes operating in the UK would not be able to refer to obesity in their advertising based on the existence of this criteria. Such a foreclosure of competition should not take place without the strongest justification and Diet Chef does not believe that CAP and BCAP have demonstrated why this onerous requirement is required in the context of an advertising code.

In addition Diet Chef notes that this requirement is extremely ambiguous. It is difficult to define “effective” in this context, and it is unclear as to whether the assessment of effectiveness depends on the subjective view of the participant or the objective view of some, as yet unknown, third party. It is also unclear as to how effectiveness will be measured, whether by relation to the level of weight loss, and if so what level of weight loss is considered effective, and whether or not this will need to be proven by mere anecdotal evidence or rigorous scientific trial. The time limits also pose questions as to whether or not the 12 month period as required by PH53 means that the programme must be effective at that precise point in time or whether the reference to “and beyond” adds an on-going obligation to monitor and ensure continued effectiveness. This is especially difficult considering that the requirement for the length of the programme itself is for only a duration of at least three months, and that CAP and BCAP have gone further than PH53 by using the terminology of “and beyond” rather than “or beyond”.

Provided by staff that are trained to deliver them

Diet Chef notes that this requirement is also ambiguous, and they query what it requires. It is not evident whether or not the programmes must be delivered by face-to-face meetings or whether the programmes may be delivered by online or telephone services. It is also unclear as to what level of training the staff providing the programme must have, and whether or not the requirement is an on-going one or whether the requirement applies only at the outset of the programme.

Question 5: For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):

- **Category I;**
- **Category I and II; or**
- **Category I, II and II**

of obese people? Please provide any evidence you consider supports your response.

As Diet Chef has made clear it does not agree with the adoption of the relevant criteria by CAP and BCAP. It believes that a far better approach is to allow weight loss programmes not conducted under medical supervision to refer to Category I obesity provided that advertisers

encourage people to seek medical help. The ban on targeting Categories II and III could remain given the greater risk of co-morbidities at these higher classifications of obesity.

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

Diet Chef supports the maintenance of the prohibition on the advertising of weight loss treatments and services to those under 18.

Question 7: Are there any other comments you wish to make, or evidence you wish to submit, in relation to CAP and BCAP's consideration with the issues set out in this document?

Diet Chef's view is that the CAP and BCAP consultation needs to be completely rethought. CAP and BCAP's remit is the regulation of advertising with a focus on preventing advertising that is misleading, harmful or offensive.

It has not demonstrated that the advertising of weight loss offerings which do not satisfy the criteria it has set out in this consultation would be misleading, harmful or offensive if they were to refer to Category 1 of obesity and to encourage those to whom they were targeted to seek medical advice. As such therefore CAP and BCAP have not demonstrated why their proposal is the least onerous proposal necessary to achieve their aims.

The lack of proportionality of the approach is heightened by the arbitrary nature of the criteria that have been selected from PH53 and the highly ambiguous nature of those criteria. As such, the proposals will singly fail to achieve the intended outcomes while foreclosing competition in this important area.

7 – Dietitians in Obesity Management UK (domUK)

1: We welcome this consultation and the opportunity to contribute to it.

2: In our view this is a complex area. Obesity is highly prevalent in both adults and children, and despite a multicomponent causal pathway, is highly stigmatised, including by healthcare professionals. Images of obesity are generally negative, and imply negative personal qualities of obese individuals. We are not always aware of our own bias, which may impact upon our treatment of and dealings with, obese individuals.

3: We agree that responsible and evidence-based lifestyle weight management services have an important role to play as part of tier 2 services.

4: We note the concern that ads featuring less noticeably overweight individuals may give the impression that weight management needs to be treated medically only for those with a BMI above 30kg/m2 (p11). In addition, a general prerequisite for accessing specialised weight management services is having tried and failed to lose weight using tier 2 and 3 services. However we are not aware of evidence that obese individuals are deterred from using weight management services because of the current rules on advertising.

5: One of our concerns is the converse; that if images of obese individuals only are used, an unintended consequence might be that overweight individuals perceive these services as being personally irrelevant. The prevalence of overweight is higher than that of obesity, but to impact on obesity prevalence those who are overweight are a key target group. If they can avoid further weight gain or achieve weight loss, they will not contribute to a further rise in obesity prevalence. Anything which has a negative impact on their engagement with weight management does not make sense, from a public health perspective. If however a range of images, including but not restricted to, obesity are used this should mitigate against this risk.

6: Given the stigmatisation of obesity, a major concern for us is the types of images of obesity that would be shown, should the decision to include them be made. This would represent an opportunity to show more positive images of a stigmatised medical condition, but who will decide what constitutes a positive image? Clear guidance on what is, and is not, acceptable would need to be developed and disseminated. In our view, 'before' and 'after' images are not acceptable for example. Who would police images and ensure that the spirit as well as the letter of guidance is being adhered to? This is in our view an important ethical concern. A guiding principle is to first do no harm, and if including images of obesity is likely to add further distress to a vulnerable group with a highly visible condition, then this is not something we could support. If however there was clear guidance and policing, and positive images were shown, this may potentially be beneficial in counteracting some of the negative images already available.

7: We strongly recommend that if the decision is made to include images of obesity, there is consultation on suitable images using appropriate patient groups for example. Consultation should take into account that there may be differing views on acceptability of images at different levels of severity of obesity.

8: We also have concerns that those with a BMI of ≥30kg/m2 are likely to have one or more co-morbidities, which need to be identified and monitored by healthcare professionals. The greater the degree of obesity, the more likely this is. In our view all those with a raised BMI should be screened, especially those with BMI of ≥30kg/m2 for co-morbidities by a healthcare professional. While good quality weight management interventions should already be including this, we would welcome a recommendation to this effect as part of any change to the guidance.

9: In our view, if there is no evidence that the current rules deter obese individuals from using tier 2 weight management services, then there is no need for them to be changed.

10: If the decision to change them is made, we agree with the criteria set out on page 13.

11: We also agree that the proposed changes to the codes (pages 14 and 15) are appropriate, if the rules are altered.

12: We agree that any changes made to the rules should not affect those under the age of 18 years.

8 – Electronic Retailing Association (ERA)

1. Yes, we do agree with CAP and BCAP's proposal to allow certain lifestyle weight-loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals.

2. We would like to make the following comments in relation to the proposed "criteria";

    a. Setting a three-month minimum duration for any weight-loss programme is somewhat arbitrary, unnecessary and may deter some people from engaging in a programme from which they could otherwise benefit. Many people can achieve meaningful weight-loss from programmes lasting less than three months and there is therefore no obvious reason or purpose for disallowing such programmes. Clearly, there is a need to guard against the "get-slim-quick" or "magic-bullet" products and programmes that could be ineffective or potentially dangerous. We feel however that the current requirements for the provision of substantiation and safety/efficacy data at the Clearcast approval process (in relation to broadcast advertisements) are sufficient to prevent such products/programmes from being advertised.
    b. We agree with the proposal that weight-loss programmes targeting the obese may be individual parts of a multi-component approach and that each component may lay claim to contributing to the user's weight-loss (providing that this can be adequately demonstrated). This is important in that, in our experience, Clearcast has not permitted any exercise-based products/programmes from making weight-loss claims in advertising, even if such claims can be substantiated.
    c. The proposed requirement that a weight-loss programme targeting the obese must be developed by a multi-disciplinary team could be problematic and difficult to manage in practice. Advertisers will be asked to provide information on this issue in order to gain Clearcast approval or in response to an ASA intervention. It would not be uncommon for programmes to have been developed outside the UK, so how will Clearcast/ASA be able to determine whether a particular programme-developer's qualifications are acceptable? If an advertiser can provide sufficient evidence to either Clearcast or ASA to justify the advertisement being broadcast, it should not necessarily matter who developed it.
    d. We do not agree with the proposal that weight-loss programmes targeting the obese should be shown to be effective at twelve months and beyond. Our position on this is largely comparable to our views on the three-month proposal. Many programmes will be able to deliver meaningful and clinically beneficial weight-loss outcomes to people in less than twelve months. It is well known that people attempting to lose weight often do so in an episodic manner, in that they undertake a regime which may produce positive outcomes, only to lapse after a period, after which they may return to the regime. So to impose a largely arbitrary twelve-month efficacy criterion would prohibit advertisers who do not have data proving twelve-month efficacy (which is in itself very hard to produce) but whose products/programmes can be shown to deliver beneficial results over shorter periods.
    e. The proposal that weight-management programmes be delivered by "staff who are trained to deliver them" needs careful consideration. For example, who will be

the judge on this? How will Clearcast and/or ASA determine whether a person is adequately trained, or not? In addition, many weight-management programmes are delivered at home, in the absence of a “trainer”. Does this mean that DVD-based programmes that are developed and presented by a suitably qualified individual would be permissible or not? In our view, such programmes should be allowed. There is also the issue of online support. If a person is a member of an online group or community related to the particular weight-management programme, does this constitute adequate “delivery” if there is access to specialist help and advice. Again, our view is that this should be acceptable. We would like to add, however, that ERA UK has no issue with the current requirement that obese people embarking on a weight-management programme should seek medical advice before commencing the programme. This makes absolute sense to us.

f. In summary, we feel that the proposal to implement certain criteria to weight-management advertising to the obese maybe an attempt to limit such advertising to bona-fide programmes and to deter potentially ineffective and/or dangerous programmes. While such an attempt is both laudable and responsible, we believe that most of the criteria currently being proposed are either unnecessary, inappropriate or subjective. This may unduly prohibit certain legitimate programmes from being advertised and cause confusion at Clearcast and ASA as to how to interpret and administer the criteria. We believe that the ultimate test for whether a product/programme aimed at helping obese people lose weight is acceptable or not is whether the programme itself and the advertisement used to promote it is backed by efficacy, safety and other relevant data sufficient to convince Clearcast and the ASA (and their respective specialist consultants) that the programme and its advertising are fit for purpose and conforms to the broadcast codes (see comments in para 4).

3. NICE Guideline PH53 was not intended to be used as a surrogate code or guideline for the regulation of weight-management advertising. We are therefore not in favour of ASA referring to the NICE Guideline in the process of deciding whether an advertisement may or may not contain references to obesity. An advertisement for weight-management services should be assessed in the same way as an advertisement for any other product or service i.e. does it comply with the codes. Is it legal, decent honest and truthful and without misleading claims and statements? If there are claims for efficacy and safety, are they responsible and supported by sufficient and appropriate data and substantiation?

4. As in many other potentially controversial areas, we believe that the interpretation of any new rules by regulators will be of almost as much significance as the rules themselves. The potential for different interpretations of the rules by different bodies and/or individuals will surely lead to confusion, controversy and contradiction among and between advertisers and the regulators. We would therefore urge that in writing new rules for this area, BCAP should aim for maximum simplicity, objectivity and clarity with a view to reducing the potential for different interpretations of the rules.

5. We believe that weight-management programmes should be allowed to target all categories of overweight and obese individuals, provided that that the programme itself is seen to be safe for the user. In this context, our suggestion that advertising for such

services should include a recommendation that the user seeks medical guidance before embarking on the programme is sensible and responsible. There has been a suggestion that weight-management programmes that produce too rapid weight loss (based on actual weight-loss over time) may be inappropriate for some people and potentially harmful. The NICE Guideline now refers to percentage of weight lost over time and if these criteria are met, then there should be no restriction as to whom a weight-management programme may be targeted.

6. We agree that weight-management programmes should not be advertised to and/or targeted at people under the age of eighteen.

7. ERA UK would like to summarise its position on this issue as follows;
    a. There is widespread concern among healthcare professionals, politicians and the public at large about the increasing trend towards obesity in the British population. It therefore seems illogical that suppliers of effective, legitimate weight-management products and services are currently prohibited from advertising them to obese individuals and that current advertisements for such products and services may not feature obese individuals. We believe that the broadcast codes relating to this subject should be amended accordingly.
    b. In terms of compliance with any new codes, weight-loss management products and services (and their associated advertisements) should be judged on their individual merits and not be constrained by potentially subjective, arbitrary or unnecessary pre-determined criteria. If the supplier of such a product or service can provide proper and adequate data supporting its claims for efficacy and safety and can provide valid substantiation for any claims made in the advertisement, then that should be sufficient to permit marketing of the product or service. Any changes to the rules should allow for this. We would however make one important rider here, in that we appreciate that obesity is a potentially dangerous clinical condition. As such, all advertisements targeting obese individuals should contain a recommendation that individuals seek professional medical advice before embarking on any weight-loss programme.
    c. NICE recognises the benefits of a multi-component approach to weight-management, which may include behavioural changes and exercise in addition to (and in combination with) dieting. To date, it has proven virtually impossible to obtain advertising clearance for exercise products and programmes claiming weight-loss outcomes, even if the supplier has been able to substantiate such claims. This situation must surely now change.

9 - Health at Every Size UK and four professional, individual co-signatories (HAESUK)

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

A different approach is needed supports people of all shapes and sizes in healthful behaviours and body respect.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

For any approach it must be stated what criteria constitutes 'being effective at 12 months and beyond' and how the rules are governing how this is proved i.e. what standard of evidence is required. Currently, for medical interventions other than weight management the highest standard of evidence is considered to use data from systematic reviews of randomized controlled trials. This standard should be adopted for weight management.

Adverse effect must be routinely monitored covering at minimum physical health, overall psychological wellbeing and eating disorder symptomology.

Weight fluctuation (yo-yo dieting) must be monitored and treatment stopped immediately where this occurs or there is a risk of occurrence. In addition, people with a history of yo-yo dieting must be screened for and should be advised against starting any further treatment from the same paradigm approach as that associated with previous yo-yo dieting. This is because weight loss from dietary change is usually limited with any weight lost is likely to be regained within two years (BMJ, 2000), constituting weight fluctuation. The British Nutrition Foundation (1999) states that:

> '' a positive association has consistently been observed between body weight fluctuation and all-cause mortality and usually… with coronary mortality in particular. This finding is very robust, further confirmation is found in the British Regional Heart Study (Wannamethee & Shaper, 1990), in the Seven Nations Study (Peters et al., 1995) and in the Iowa Women's Health Study (French et al., 1997) (p 137).''

The SIGN (2011, p18) guidelines also warn against yo-yo dieting as a health risk:

> " Weight cycling is a common condition as only a minority of people who lose weight through weight management interventions are able to maintain their weight loss.115,116 . . . Weight cycling is a risk factor for all-cause mortality and cardiovascular mortality (hazard ratio (HR) approximately 1.8 for both).118,119
>
> This risk cannot be ignored.

We believe that a different approach to provide for a change in the rules is required altogether.

Our rationale is:

- that traditional scientific beliefs on BMI are outdated and it is unethical to use BMI categories as a basis for treatment for individuals
- the current approach focusing on weight change is associated with adverse effect on eating disorder symptomology that is routinely ignored
- the current approach focusing on weight change is associated with yo-yo dieting which is strongly linked to health risk
- the current approach focusing on weight change is associated with size stigma
- the current approach focusing on weight change is associated with poor body image
- a different approach focusing on healthy behaviours and body respect for all is ethical and scientific
- We base this claim on findings that change in health behaviours can improve health outcomes with or without weight change*. We also note the impact of stress on hypertension, diabetes, and heart disease. Living with stigma, including size stigma, is a stress. Promoting body respect for all supports healthy behaviours for every body and reduces psychological distress related to size discrimination. We note the best available evidence i.e. systematic review of randomized controlled trials of weight loss treatment at two years shows the intervention to be ineffective for most and with high risk of adverse effect.

* " ….correlational analyses . . . uncovered no clear relationship between weight loss and health outcomes related to hypertension, diabetes, or cholesterol, calling into question whether weight change per se had any causal role in the few effects of the diets. Increased exercise, healthier eating, engagement with the health care system, and social support may have played a role instead." (Social and Personality Psychology Compass 7/12 (2013): 861–877, 10.1111/spc3.12076)

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

No. NICE Guideline PH53 relies on a common, convenient, but outdated scientific stance on BMI and health. The recommendations in NICE PH53 do not appear to be informed by any literature from critical weight science. The use of BMI is widely critiqued as an unreliable indicator of health at the level of an individual. It is therefore misleading to rely on NICE and to use BMI categories to indicate health. In addition, the NICE guidelines are further criticized for their lack of scientific integrity (Healthwatch May 2015).

It is wholly inappropriate to use BMI at an individual level as a reliable health indicator. Interventions should target promoting health behaviours and body respect for people of all shapes and sizes.

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?

The rules must be transparent about what evidence is being relied on.

Images used in adverts should not cause offence by stereotyping fat people as unhealthy, lazy, greedy and lacking self-regard and should avoid stereotyping thin people as superior to others by virtue of their size.

Images must not dehumanize by chopping people's heads off or showing images of bodies in whole or part designed to provoke a negative emotional response. People of all shapes, sizes and health status should be portrayed with dignity and respect.

Question 5: For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):

- **category I,**
- **category I and II, or**
- **category I, II and III**
  of obese people? Please provide any evidence you consider supports your response.

This question becomes redundant with a scientific scrutiny of BMI categories.

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

Traditional services should not be advertised to those under 18. A different approach based on health-gain and body respect for all could be advertised to those under 18 as it is not associated with adverse effect. It also has a role in eating disorder prevention.

Question 7: Are there any other comments you wish to make, or evidence you wish to submit, in relation to CAP and BCAP's consideration of the issues set out in this document?

Currently advertisers must make efficacy claims for treatments that are substantiated. We note that the ASA says a recommended weight loss is 2lb per week. We call on the ASA to corroborate this claim in conjunction with the requirement for efficacy and no harm at 12 months and beyond. The best available evidence is held to be systematic reviews of randomized controlled trials. Such a review, with data at 2 years, shows "The benefits of dieting are simply too small and the potential harms of dieting are too large for it to be recommended as a safe and effective treatment for obesity." (Mann et al 2007 Am Psyc Vol. 62, No. 3, 220–233)
It is unethical to recommend dieting unless the ASA has good quality evidence to refute this finding. By good quality evidence we refer to a systematic review of relevant randomized controlled trials of at least 2 years duration. To ensure scientific integrity and hence consumer protection it is inappropriate to rely on NICE, or other guidelines, to underpin the claim that dieting that leads to 2lb weight loss a week is effective and safe.
To clarify, we are not engaging with the statements about the prevalence of high BMI or statements linking high BMI and health outcomes. We note that regardless of the prevalence of fatness or any link between weight and health, for a treatment to be recommended it must proven to be safe and effective.

We note that the validity of the British Dietetic Association's claims on the benefits of dieting were recently questioned. As a result of this enquiry, the group Sense About Science who campaign for quality evidence, have indicated their intention to alter the wording on dieting on their website.

Signatories:

Personal Capacity
Dr Lucy Aphramor
Dietitian, member of the British Dietetic Association and member of the specialist interest group Dietitians in Obesity Management.
I hold a PhD in weight science. My interest is in challenging the use of poor quality science that has become routinized in weight management.
I am also committed to championing equality and diversity and ensuring size discrimination is recognised as a source of stigma. To this end I have worked as a Size Awareness Consultant with the Welsh Assembly Government. Thirdly, I am interested in preventing eating disorders and preventing widespread body image problems. For these reasons I advocate an approach based on quality science that promotes health-gain and respect for all.

Diana Newson PhD – see other personal submission

Wasilat Daniju
Person-centred counsellor; registered member of BACP
I am an advocate of the HAES (Health At Every Size) approach, in both my personal and professional life. As such, I cannot support the pathologising and stigmatisation of certain body types. I believe the BACP and CAP have a responsibility to support healthy behaviours, rather than further encouraging weight and eating disorders through the services they advertise and the language used in marketing such services.

Maria Jose

Linda Bacon PhD
U.S. based health advocate and research scientist.

Groups
HAESUK
We are a voluntary group campaigning for ethical, effective and scientific healthcare for people of all shapes and sizes. We work to promote dignity and respect for all and especially to raise awareness of, and challenge, stereotypes and stigma around size.

10 – LighterLife

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

LighterLife strongly agrees with the fundamental principle underpinning CAP and BCAP's proposal, namely that certain lifestyle weight loss and weight management providers, having fulfilled specific criteria, are able to refer to obesity in their marketing and to target obese individuals. The vast majority of clients who are referred onto our programme do not have any obesity-related co-morbidities and as such the current requirement mandating supervision of an otherwise healthy person is at best confusing and at worst utterly pointless.

In addition, obesity in itself it not a medical condition: recently published data clearly states that 'although the BMI is a simple method to estimate adiposity at a population level, it is relatively inaccurate within an individual and provides little-to-no indication of overall health status or disease severity.' As such, obesity is not in and of itself a disease and an individual can be both obese and perfectly healthy.

Roughly a quarter of the UK population, according to UK Government statistics, are currently obese and this will have considerable implications for the health of the nation and for the financial health of the NHS if this rate is not lowered.

It is worth noting too that the prevalence of obesity amongst adults has steadily increased over the last 25 years and the current percentage of adult obesity is nearly double that in 1993. The ASA enforced CAP code prohibition on advertising to the obese has also been effective for the last 25 years.

Reforming this long-standing rule which banned advertising to the obese will undoubtedly assist with reducing obesity levels. Allowing responsible weight loss and weight management providers to target obese individuals will help these individuals make their own decisions, allowing them to make informed choices about how they can best help themselves to lose weight. This will also help to lessen the burdens placed on the NHS – particularly GPs – as well-informed consumers look to help themselves, rather than turn to their primary care physicians. This, together with establishing and maintaining appropriate rules to ensure that only programmes shown to be effective are able to advertise to the obese, is the sensible way to help address the increasingly worrying obesity crisis with which we are faced.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

LighterLife agrees with the general thrust of the criteria that CAP and BCAP have identified to change the rules in terms of the holistic approach (behaviour, physical activity and diet) in dealing with the obesity crisis. Certainly LighterLife understands that there is the need to have appropriate criteria in place when looking to advertise to the obese and we would like to comment on each criterion on its own:

- *They are of at least three months duration*

LighterLife agrees that there is a need for a programme to have a minimum duration and we suggest that an initial 12 week intervention is a more appropriate objective as it is the industry standard.

- *are multi-component; address dietary intake, physical activity levels and behaviour change*

LighterLife agrees once again that a programme must be multi-component and address all the criteria CAP and BCAP have identified. LighterLife would, however, like CAP and BCAP to bear in mind that those who are physically disabled by their obesity will not be able to undertake physical activity until they have lost considerable amounts of weight

- *have been developed by a multi-disciplinary team; including input from a registered dietician registered practitioner psychologist and a qualified physical activity instructor*

Although LighterLife's programmes have been developed by an expert board, including input from medical professionals, we are slightly concerned at the need to include a practitioner psychologist. Many programmes that use CBT to help people identify and change unhelpful behaviours have been shown to be efficacious in changing behaviours and are not devised with input from psychologists. LighterLife would be keen to hear CAP and BCAP's justification for this inclusion.

- *are shown to be effective at 12 months and beyond, and*

LighterLife agree that a programme should be shown as being effective at one year and beyond and has the evidence to back up LighterLife's efficacy at this period. We would be interested in hearing how CAP and BCAP intend to assess how programmes are judged to be effective: Will this assessment be through peer reviewed scientific presentations and will the assessment process be open and transparent?

- *are provided by staff who are trained to deliver them*

Again, LighterLife agree that this is important. We would like to highlight that all of LighterLife's Counsellors are trained and LighterLife have proper procedures in place to refer customers to their GP should they be suffering from select conditions.

We would, however, be interested in hearing CAP and BCAP's definition of "training". Who will judge what level of training is appropriate? Will nationally recognised academic qualifications be required, and if so, what criteria will be used to measure these qualifications?

Additionally, there are currently an insufficient number of trained health professionals to deliver weight management programmes: to illustrate, one health professional working a 30 hour week and counselling obese people on a standard 12 week course could see fewer than 100 patients a year. Yet, as highlighted above, 64% of the population are obese. With obesity levels ever growing, this is a problem that is likely to increase. More than 100,000 health professionals dedicated solely to counselling obese people would therefore be required as a result of this new criterion.

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

LighterLife broadly agree that the ASA should have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible, responsible references to obesity.

There are caveats, however. NICE's guidance should not become a bible that the ASA will not deviate from; instead, it should form the basis for any decision. Moreover, it is important to keep in mind that NICE provides guidance for organisations operated by the NHS, not for private providers. It follows that if responsible private weight management providers can supply adequate scientific evidence that is not covered in NICE guidance then the ASA should take due account of this evidence, even if it conflicts with or supersedes NICE guidance.

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?

As touched upon above, LighterLife would strongly encourage CAP and BCAP to be as flexible as possible when drafting the proposed rules, having due account of any good quality scientific evidence that providers are able to supply even if it conflicts with NICE guidance.

Question 5 [on PH53's various classifications of obesity: Healthy weight 18.5–24.9 Overweight 25–29.9 Obesity I 30–34.9 Obesity II 35–39.9 Obesity III 40 or more]: For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):

- **category I,**
- **category I and II, or**
- **category I, II and III of obese people?**

Please provide any evidence you consider supports your response.

LighterLife believe that responsible weight management programmes should be able to target all categories outlined above. All obese people will benefit from having further information on effective programmes that are available to help them lose weight.

Realistically, it may also be difficult for advertisers and consumers to differentiate between advertisements aimed at people assigned these classifications: there is little practical different between an individual with a BMI of 39.8 and an individual with a BMI of 40.1.

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

LighterLife does indeed agree that the prohibition of advertising of weight loss treatments and services to those under 18 should be maintained.

11 - National Institute for Healthcare and Clinical Excellence (NICE)

Question 1
NICE agrees with the proposal given recommendations 3, 4 and 5 in PH53 re raising awareness of lifestyle weight management services.

Question 2
P13 of the document outlines key criteria as:
- of at least three months duration
- multi-component; addressing dietary intake, physical activity levels and behaviour change
- developed by a multi-disciplinary team; including input from a registered dietitian registered practitioner psychologist and a qualified physical activity instructor
- shown to be effective at 12 months and beyond, and
- provided by staff who are trained to deliver them

NICE suggest an additional key criteria is added - that advertisers should not present / suggest unrealistic weight loss. Recommendation 7 in PH53 states that providers should: Discuss realistic weight-loss goals. People should be aware that:
- The more weight they lose, the greater the health benefits, particularly if someone loses more than 5% of their body weight and maintains this for life.
- On average, people attending a lifestyle weight management programme lose around 3% of their body weight, but this varies a lot.
- Preventing future weight gain and maintaining a lower weight trajectory leads to health benefits.

NICE welcomes the comment that 'CAP and BCAP consider that there may be occasions when the ASA needs to draw on the wider Guideline to inform its understanding of the key criteria and therefore propose to allow the ASA the discretion to have regard to Guideline PH53 to help judge whether a particular marketing communication for a lifestyle weight loss programme may permissibly refer to obesity.' We would encourage this statement to be stronger to indicate that programmes should aim to meet the wider recommendations in the guideline. The wording on page 14 section 13.2.2 and 12. 11.2 could be amended along the following lines:

13.2.2 Lifestyle weight management programmes which meet the following standards may make responsible references to obesity in their marketing communications. These programmes should be:
- of at least three months duration
- multi-component and developed by a multi-disciplinary team
- shown to be effective at 12 months and beyond, and
- provided by staff who are trained to deliver them
- Marketing communications should not suggest unrealistic weight loss.

In assessing whether a particular marketing communication may permissibly refer to obesity the ASA may have regard to NICE Guideline PH53. Programmes should therefore aim to adhere to wider recommendations in PH53.

Question 3
We agree that PH53 is the primary guideline. However, it may be helpful to note that related guidelines (such as PH46 and CG189) may be considered as appropriate.

Question 4
The document should be clearer that it applies to programmes for adults only (age 18 and over).

Question 5

- NICE guideline PH53 covered overweight and obesity; some consideration needs to be given as to whether the proposal also covers overweight. PH53 did not have an upper BMI limit but the majority of evidence available was for BMI 30 to 40 and recommendations were aimed 'tier 2' services.
- The definition of obesity is given on page 4.2; please note that this definition should include a reference to NICE guideline PH46. The following text could be added: The use of lower BMI thresholds to trigger action to reduce the risk of conditions such as type 2 diabetes has been recommended for black African, African–Caribbean and Asian groups. The lower thresholds are 23 kg/m2 to indicate increased risk and 27.5 kg/m2 to indicate high risk. (See'BMI and waist circumference – black, Asian and minority ethnic groups', NICE public health guidance 46).

Question 6
NICE strongly agrees with the CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18. Please note that NICE has issued guideline PH47 on lifestyle weight management in children and young people.

Question 7 – additional comments
We note paragraph 5.4 re 'depictions and references to obese people'. The code could include reference to PH53 recommendation 2 and the core components of programmes (recommendations 9 and 10) that providers and programmes should 'adopt a respectful, non-judgemental approach'. Please also see the comment above about not suggesting unrealistic weight loss. The code could also encourage marketing communications to take a 'person first' approach (in this instance for example 'people who are obese' rather than 'obese people'.

An outstanding issue may be what 'effective' means in practice. PH53 recommendation 12 states that:

Public Health England and other national agencies with an interest in the effectiveness of lifestyle weight management programmes should:

- Work together to establish a national source of information on programmes suitable for commissioning. Any national database should be regularly updated.
- Work with providers and commissioners of lifestyle weight management programmes to agree a standard format and process for providing robust, consistent and regularly updated information on programmes.

Providers of lifestyle weight management programmes (public, private or voluntary organisations) should demonstrate that their programmes:

- Are effective at 12 months or beyond. (The following programmes currently available in the UK have been shown to be effective at 12 to 18 months: [in alphabetical order] Rosemary Conley, Slimming World and Weight Watchers.)
- Meet best practice criteria for commissioning (see recommendation 13).
- Meet the core components for weight loss and the prevention of weight regain (see recommendations 9 and 10).

12 – Public Health England (PHE)

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

Yes

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

Yes. We agree that it should be specified that a 'multi-disciplinary team' should include input from a registered dietician, registered practitioner psychologist and a qualified physical activity instructor; also that 'multi-component' addresses dietary intake, physical activity levels and behaviour change.

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

Yes – this is an up-to-date and comprehensive guideline.

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?

It is good to see that interventions need to be shown to be effective at 12 months and beyond.

Question 5: For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):

- **category I,**
- **category I and II, YES**
- **category I, II and III NO**

of obese people?

They should be able to refer to and therefore target categories I and II of obese people as there are increased morbidity and mortality risks with increasing BMI. However we do not agree that advertisers meeting the criteria should be able to refer to or target category III obese people. Extreme images of morbid/severe obesity (category III) could be used to illustrate overweight and obesity in a voyeuristic fashion and it is important to prevent this (for example in 'before' and 'after' images). Also such images contribute to the normalisation of obesity within society.

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

Yes.

13 – Rosemary Conley CBE (RosemaryConley.com)

Question 1:
I agree with the proposal

Question 2:
I agree with the proposal

Question 3:
I agree with the proposal

Question 4:
I have no comment to add

Question 5:
Category I, II and III of obese people

Question 6:
I agree with the proposal

CAP

14 – Royal College of Physicians (RCP)

General comments on CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing

The RCP supports in principle a review of advertising regulations to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing. NICE guidelines and other good practice guidance on obesity services have made clear that lifestyle weight management programmes are an important service in supporting obese people to manage their weight. We therefore recognise the valuable role that lifestyle weight management programmes can play in helping overweight and obese people to manage their weight.

However, NICE guidelines and good practice guidance make clear that lifestyle weight management programme should constitute 'tier two' obesity services only. This means some obese people will need to access support from medically-qualified health professionals (as detailed in the NICE guidelines).

It is therefore critical that any changes to regulations do not impede obese people from accessing suitable medical services for obesity if and when their health requires it (e.g. if complex co-morbidities are present). These services include 'tier three' physician-led multi-disciplinary obesity care teams and 'tier four' bariatric surgery services for those patients who have not been able to maintain a healthy weight through other means.

Moreover, we are concerned that if images of obese individuals only are used to promote lifestyle weight management services, then an unintended consequence may be that overweight individuals could perceive these services to be inappropriate for their needs. It is important that overweight people are engaged and encouraged to seek support to manage their weight (and thus prevent obesity) and thus any changes to advertising practice must be careful not to discourage their participation in lifestyle weight management programmes.

Comments on the proposed criteria to include in the rules

The criteria should be expanded to include recognition of the need to review patients' progress and refer them on to 'tier three' services if appropriate. As stated in the NICE guideline (PH53):

If it has not been possible to resolve someone's difficulties with the programme (for example, their attendance or participation), agree what should happen next. For example, they could be referred to another service, leave the programme at an agreed time, or think about being re-referred at a future date.

Lifestyle weight management programme providers should be permitted to refer to obesity in their advertisements only if they can demonstrate that they will refer their service users to support from medically-qualified health professionals if/when additional support is required. This could be necessary if, for example, an obese person has not been able to maintain a healthy weight through their participation in a lifestyle weight management programme alone, or if an obese person has complex co -morbidities that are not being managed appropriately under the supervision of a qualified health professional.

The proposed criteria also include a requirement that lifestyle weight management programmes be delivered by 'trained staff'. The RCP strongly recommends that the criteria specify what is meant by 'trained staff': what type or level of training is considered sufficient to meet this criterion?

Comments on the use of NICE guidelines

All advertising regulators must refer to NICE guideline PH53 in making their judgements and developing guidance. The RCP strongly recommends that the ASA and other regulators have due regard to closely related NICE guidelines, including:

- CG189 - Obesity: identification, assessment and management of overweight and obesity in children, young people and adults
- PH47 - Managing overweight and obesity among children and young people: lifestyle weight management services
- PH29 - Weight management before, during and after pregnancy.

Comments on stigma and the portrayal of obesity in advertising

Obesity and overweight carry significant social stigma. Therefore, any changes to advertising regulations must consider how obesity is permitted to be portrayed (visually or otherwise). A change to the rules could be an opportunity to show more positive images of obesity, but this requires clear guidance on what is, and is not, acceptable. Therefore, if the decision is made to permit lifestyle weight management programme providers to refer to obesity in their advertising, then the RCP strongly recommends that obese and overweight people are closely engaged in drawing up regulations to help ensure that the portrayal of obesity helps to tackle (rather than perpetuate) stigma.

15 – Royal College of Psychiatrists (RCPsych)

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

Yes this seems clear and proportionate.

The College recognises the importance of obesity to health and well-being and the scale of the problem we as a society now face. We understand the association of obesity with depression, diabetes, dementia, stroke, heart disease, cancer, arthritis, pain and sexual dysfunction. We acknowledge the key drivers of cheap and easy access to calories through alcohol, sugary soft drinks and foods with high fat content.

We welcome providers of these products demonstrating responsible marketing and sales practice whilst finding healthier alternatives for the market. We share concern that the number of people affected by overweight and obesity is now beyond the capacity of the health service alone to address and therefore understand the need to widen to a whole-society approach to its management.

In this context loosening the regulations around use of the term obesity seems appropriate and safe in relation to advocating for health and well-being programs and products that have an evidence base and do not lead to harmful behaviour.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

The identified criteria are appropriate.

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

Again, this seems a useful benchmark.

Question 5: For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):

- **category I,**
- **category I and II, or**
- **category I, II and III**

of obese people?
Please provide any evidence you consider supports your response.

Targeting the full range of obesity categories ensures that all those who could benefit are included.

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

There may be value in considering earlier intervention for adults and young people with obesity, however this should be balanced with the need for continuing safeguards for children. We support the continued prohibition on advertising of weight loss services for under-18s.

16 – Royal College of Surgeons in Edinburgh (RCSEd)

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

RCSEd believes that the minimum standards for the entitlement to use the term obesity in advertising have been clearly laid out in NICE guideline PH53 and that CAP & BCAP should not be allowed to accept any advertisement which falls below these minimum standards. The current proposal appears to suggest the standards are too rigorous and state a wish to lower the threshold by accepting lower standards, and as such RCSEd cannot support this position. PH53 also recommends that clients must be referred either by direct medical or social services referrals thereby excluding the self-referral route to the lifestyle weight loss providers being considered by these new proposals. Few programmes can achieve the required standards and the cost of policing them would probably not make the proposed change cost effective.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

RCSEd believes that all the following criteria must be achieved by the lifestyle weight loss providers. The programmes must be delivered by multidisciplinary teams and be covered by indemnity insurance. The trained dieticians must not only be fully qualified but must also ensure that specified dietary targets are given to each client. The qualified psychologist must be able to offer a variety of behavioural change methodologies which can be adapted to support the individual client's needs and finally the physical exercise instructor must be on the register of Exercise Professionals at or above the level 3 Standard. The lifestyle weight loss providers must provide audit data to demonstrate an average program weight loss of 3% and confirm that at least 30% of their clients lose 5% of their initial weight in order to substantiate their efficacy claims. They must also be able to provide documentary evidence that their staff have undertaken regular professional development which includes training in tailoring the client interactions to individual needs; the provision of constructive feedback and most importantly a knowledge of common medical conditions.

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

As stated we believe NICE guideline PH53 in its entirety must be the minimum standard.

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?

To ensure that the ASA does not open the floodgates and become swamped by applications the rules need clearly state the minimum standard and documentary evidence required before an organisation can be considered for permission to use responsible references to ensure that only applications of an appropriate standard come forward for review. There needs to be a clear strategy and process for appealing against the ASA decision as there is no doubt that private companies will go down this route.

Question 5: For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):
- **category I,**
- **category I and II, or**
- **category I, II and III of obese people?**

Please provide any evidence you consider supports your response.

RCSEd believes that if this is allowed to progress it makes sense to be able to refer to all categories from 1 (BMI >30) to 3 (BMI >41).

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

Yes. The ASA must ensure that vulnerable teenagers with eating disorders are not encourages to self-refer to avoid the medical route.

Question 7: Are there any other comments you wish to make, or evidence you wish to submit, in relation to CAP BCAP's consideration of the issues set out in this document?

RCSEd would caution the ASA against the decision to relax the current rules and allow permissible responsible references to obesity. The lifestyle weight loss programme providers mentioned such as Weight Watchers and Slimmer's World are already well known for their weight controlling strategies and do not need to include the term obesity in their marketing. There is a real risk that vulnerable obese patients may not seek the necessary medical help and common medical conditions could go untreated if they are lured into self-referral to these programmes by advertising.

17 - Saatchi & Saatchi

Saatchi & Saatchi fully support the Weight Watchers point of view and submission in response to the consultation (below).

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

Obesity has reached epidemic proportions and its prevalence is increasing. Obesity is a major risk factor for diseases such as type 2 diabetes, cancer, liver and heart disease, in addition to mental ill health. It costs the NHS £5bn each year, and costs the wider economy billions more.
The government's obesity strategy 'Healthy lives, Health People: a call to action on obesity in England' (Department of Health 2011) aimed to reduce, 'the level of excess weight averaged across all adults by 2020'. It advocated a range of local interventions that both prevent obesity and treat those who are already obese or overweight.
Currently a situation exists where those who most need to and would benefit from losing weight – those who the government and UK health authorities are most keen to see take personal responsibility and enrol on lifestyle weight management programmes cannot be targeted or depicted in advertisements for such programmes. This results in misleading media images, with advertisers being limited to showing individuals with a BMI of less than 30kg/m2. Lifestyle weight management programmes, who want to be credible, accurate and truthful in their advertising, and who want to make significant contributions to improving public health, are therefore left in an uncomfortable position.
The unrepresentative images currently used in advertising risk skewing the collective perception of weight and weight loss issues generally, potentially having a negative effect on public health. The current CAP and BCAP Code regime results in;

(a) Advertising that disproportionately depicts people who need weight management programmes less than those who are obese. This sends an implicit message to consumers who are unaware of the CAP and BCAP code restrictions; perhaps adding to negative body image issues in those who are at healthier weights than the obese.

(b) Advertising that may lead obese individuals to believe that healthy lifestyle weight loss programmes are not appropriate or indeed effective for them, and that higher risk and/or more invasive interventions such as surgery, VLCDs (very low calorie diets) and pharmaceuticals are their only viable options.

Social norms have a powerful impact on collective population behaviours, and can impair our ability to recognise unhealthy weight in ourselves and others. The current CAP and BCAP regime may be contributing to this, as it is not possible for obese individuals who have successfully lost weight to be featured in mass market advertising. The code is contributing to a dearth of positive examples that others can be inspired by and follow.
The proposed change would bring CAP and BCAP rules into line with government policy and clinical practice. More importantly, it would make a vital and meaningful contribution to the increasingly important national ambition of tackling obesity.
The current inconsistency in linking images of the obese with weight loss surgery and medications, and linking less noticeably overweight people with lifestyle weight management programmes, goes against the evidence of effectiveness which is comparable for medication and effective lifestyle regimes. The distinction of a BMI of 30 as a cut-off is unrelated to the efficacy of treatments. Importantly, this approach cements in the public's eye a false impression that weight management for those with a BMI over 30 somehow requires medical treatment. This risks widening existing health inequalities by deterring access to appropriate self-help support. We believe that it is wrong that surgery clinics and pharmaceuticals are

permitted to target and depict obese individuals in advertisements, but safe, proven and often equally effective lifestyle weight management programmes can not. Indeed there is no suggestion in the National Institute for Health and Care Excellence (NICE) guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (Guideline PH53) that the level of individual medical supervision required under the current CAP and BCAP regime should be seen as necessary or desirable.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

We believe that the following criteria are appropriate to include in the rules,

- multi-component and developed by a multi-disciplinary team
- shown to be effective at 12 months and beyond, and
- provided by staff who are trained to deliver them

See response to Question 4 for a detailed response to this question.

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

It is appropriate that the ASA should have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity. The aim of the Guideline is to help meet a range of public health goals. These include helping reduce the risk of the main diseases associated with obesity. The Guideline provides guidance on the management of overweight and obesity in adults and children and specifically makes recommendations on the provision of lifestyle weight management programmes for the treatment of overweight and obese adults. While the Guideline was intended for commissioners and providers of lifestyle weight management programmes and health and social care professionals who advise or refer people to these programmes, it is an authoritative and independent reference point for the ASA. The Guideline acknowledges the positive role that public, private or voluntary providers, can play in supporting an individual who wishes to lose weight. It identifies best practices recommending that commissioners of services should commission or recommend programmes that can demonstrate that they are effective at 12 months or beyond and meet the core components of effective weight loss and the prevention of weight regain.

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?

While we agree with CAP and BCAP that the most effective and proportionate way to merit a conditional change to the rules is to identify a small number of the criteria that the NICE Guideline PH53 identify as relevant criteria, we would advocate that including the criteria that, [lifestyle weight management] programmes should be “of at least three months duration”, as one of those criteria is unnecessary.

We note that CAP and BCAP consider that this criteria helps ensures that the programmes are sufficiently long to have an impact. While it is true that in order to lose weight at a rate that is compatible with good medical and nutritional practice and move from a BMI of 30 to a BMI in the healthy weight range (BMI 18.5 to 24.9) it will be necessary to follow a weight loss programme for a sufficiently long period. This can be seen in the illustrative examples below.

Height	Start & End Weight	BMI	Weight loss period at rate of 2lbs a week
5'9	203 lbs (14st 7 lbs)	BMI 30	
	168 lbs (12st)	BMI 24.9	
Weight loss	35lbs		17.5 weeks
5'6	186 lbs (13st 4lbs)	BMI 30	
	154 lbs (11st)	BMI 24.9	
Weight loss	32 lbs		16 weeks
5'3	170 lbs (12st 2 lbs)	BMI 30.1	
	140 lbs (10st)	BMI 24.8	
Weight loss	30 lbs		15 weeks

However it is not necessary to introduce the specific criteria that the programmes should be "of at least three months duration", as there are already CAP and BCAP rules in place that restrict advertisers from encouraging weight loss over periods of time that are not compatible with good medical and nutritional practice.

The CAP and BCAP Codes (at Rules 13.10 and 12.9 respectively) impose restrictions on advertisers making claims that individuals can lose weight at a faster rate than is compatible with good medical and nutritional practice. Both, Rule 13.10 and 12.9 state, "For those who are normally overweight, a rate of weight loss greater than 2 lbs (just under 1 kg) a week is unlikely to be compatible with good medical and nutritional practice. For those who are obese, a rate of weight loss greater than 2 lbs a week in the early stages of dieting could be compatible with good medical and nutritional practice."

While many individuals will follow lifestyle weight management programmes for at least 3 months there are those who will choose to follow the programme for shorter periods of time and that doesn't make the programme any less relevant or beneficial as a tool for obese individuals to lose weight. Indeed any weight loss for an obese individual during that period will have a positive impact on that individual's physical and mental well-being.

Accordingly our proposal would be to amend the proposed rules to delete the criteria "of at least three months duration". Alternatively, if CAP and BCAP were not sufficiently persuaded by this argument a middle ground might be to include as a criteria the following, "intended for use over a period of months."

Question 5: For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):

- **category I,**
- **category I and II, or**
- **category I, II and III**

of obese people?

Please provide any evidence you consider supports your response

We believe that for advertisers meeting the criteria, they should be able to refer to (and therefore target) obese individuals regardless of their BMI, as there is no evidence to suggest that to do so would be harmful to the individual.

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

We are comfortable with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18.

Question 7: Are there any other comments you wish to make, or evidence you wish to submit, in relation to CAP BCAP's consideration of the issues set out in this document?

While we cannot speak on behalf of other lifestyle weight management programmes the Weight Watchers programme has been specifically designed with the latest nutritional scientific research and consumer insights to create a safe energy deficit for a healthy rate of weight loss, whilst encouraging healthier, more satisfying food choices, enabling flexibility to learn skills for sustaining weight loss and integrating physical activity. There is a wealth of good quality, peer-reviewed published scientific evidence (over 80 papers to date) that demonstrates the efficacy, effectiveness and sustainability of Weight Watchers' methodology and weight loss plans; demonstrating consistent outcomes from international data and data derived from the UK, both in populations who self-refer and in those referred by health professionals - and in both overweight and obese individuals. Weight Watchers has been shown to be effective at 12 to 18 months . See A-I below for a non-exhaustive selection of references to relevant papers.

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F. Weight Watchers on Prescription: An Observational Study of Weight Change among Adults Referred to Weight Watchers by the NHS. AL Ahern, AD Olson, LM Aston, SA Jebb. BMC Public Health 2011; 11:434.
G. Patient Weight Counseling Choices and Outcomes Following a Primary Care and Community Collaborative Intervention. DB Wilson, RE Johnson, RM Jones, AH Krist, SH Woolf, SK Flores. Patient Educ Counseling 2010; 79(3): 338-343.
H. Changes in Cardiovascular Risk Factors with Participation in a 12-week Weight Loss Trial Using a Commercial Format. V Milsom, R Malcolm, G Cronan, S Pechon, K Miller-Kovach, S Rost, PM O'Neil. Obesity Reviews 2010; 11 (Suppl 1):S244.
I. Changes in Dietary Energy Density With Participation in a 12-Week Weight Loss Trial Using a Commercial Format. P O'Neil, G Cronan, T Turner, L Nance, R Malcolm, S Pechon, S Rost, K Miller-Kovach. Obesity 2010; 18 (Suppl 2):S96.

18 – Slimming World

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

Slimming World is in full support of CAP and BCAP's proposal for a rule change with regard to reference to obesity in advertisements.

We have been concerned for a number of years that that the current codes are outdated and could lead people with a BMI over 30 - those who are at the greatest risk of potentially life-threatening diseases including type 2 diabetes, heart disease and cancer – to believe that support from evidence based commercial weight loss companies is not an option available to them and as a result seek out more drastic weight loss methods.

We fully understand, and support, the need for strict regulations to protect the public from harmful practice and unscrupulous operators within the commercial weight loss industry. However, the current situation of grouping all organisations in the sector under a single banner is harming the very people who most need help in tackling their weight problems.

Recent NICE guidance for obesity management does not suggest requirement for medical supervision within weight management programmes for people with a BMI over 30. The existing Codes do not seem to take into account current obesity management policy and practice and we, like so many health professionals, welcome this review.

In November 2013, Slimming World conducted a poll of health professionals (including GPs, consultants, dietitians, obesity specialists, midwives and nurses from all disciplines) about what they thought about the existing guidelines and the response was unequivocally that they want to see change.

- 100% of respondents felt that the CAP code for promoting evidence based weight management solutions is out-of-date and should be reviewed.
- 96% felt that the current code could encourage people with an obese BMI to seek surgery or other medical procedures as the best way to lose weight, rather than trying evidence based weight management support first.
- 98% felt that the CAP Code should be amended to allow evidence-based weight management companies to refer in their marketing materials to the effectiveness of their programmes for obese people, even if they are not directly supervised by a healthcare professional at an individual level in line with NICE guidelines.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

We are broadly in agreement with the criteria CAP and BCAP have identified to include in the rules which we understand as being that programmes not carried out under medical supervision should be:

- of at least three months duration
- multicomponent; addressing dietary intake, physical activity levels and behaviour change

- developed by a multi-disciplinary team; including input from a registered dietician registered practitioner psychologist and a qualified physical activity instructor
- shown to be effective at 12 months and beyond, and provided by staff who are trained to deliver them

We would like to question the criteria and wording of being ‘at least three months duration’. We would suggest that the wording should be changed to be clearer and say ‘available for at least 3 months duration’ as a programme should be available for someone to access for as long as they wish/need to and not necessarily 3 months in duration.

While we audit for effectiveness at three months and longer, and Slimming World on Referral, a long-established partnership scheme with health professionals, ordinarily works in multiples of three months, we strongly feel that for a programme to be effective it should not be time limited and should provide an individual with support for as long as they need it in order to develop new healthy lifestyle behaviours. Like smokers, people who struggle with their weight may need to make several attempts to change their behaviour and develop new habits so the emphasis should be as much on the range of available support and accessibility as the length of time for which it is available.

Our groups are open 52 weeks of the year and members attend for as long as they wish. Groups include a confidential weigh-in followed by a support session to facilitate learning and behaviour change. Members continue to be supported in between groups by a series of resources including personal support from a Consultant and other group members and free online support from the member website. However, we do not state nor consider it is appropriate to state that our programme is for 3 months participation. Members can choose to pay for their attendance either weekly or in blocks of three months, which allows choices based on their income and preference.

In addition to the proposed rules we feel some areas which are covered in the NICE guideline have been omitted and we question whether they should be included in the new rules.

In addition to a programme simply being available for at least 3 months duration we suggest there should be specific criteria regarding the level of support given over the programme duration to support its effectiveness as specified in the NICE guidance. Within the NICE guidance it is specified that at least fortnightly sessions should be offered which include a weigh in. We feel that regular support is a vital part of any effective weight management programme and question why this has not been included in the rules.

Likewise, throughout the NICE guidance it is made clear through a strong theme and recommendation that a respectful and non-judgemental approach be taken. We feel this is a fundamental criterion for any lifestyle weight management programme and should be embedded in the rules and likewise in any advertising to this group.

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way - please provide your comments.

To ensure quality of the overall lifestyle programme including the dietary advice, physical activity support and behaviour change techniques used we feel it is appropriate for the NICE Guideline PH53 to be used in this way as this provides a thorough outline of what a suitable lifestyle programme should entail.

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?

We would welcome the opportunity to contribute further comment and feedback on the new rules during the drafting and development process.

Question 5: For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):
•category I,
•category I and II, or
•category I, II and III of obese people?
Please provide any evidence you consider supports your response.

We feel strongly that advertisers meeting the criteria should be able to refer to (and therefore target) all the stated categories.

Slimming World's data, looking at a representative sample of over 1.2 million group members[1], shows that almost two thirds (60.5%) of its members are classified as obese (BMI of 30+) when they join a Slimming World group. In fact, over 12% of our membership joins with a BMI over 40 and the evidence base shows that our programme is just as effective in supporting those with high BMIs to lose weight as it is for those who are moderately overweight (see table below)

	n	Percentage of sample	Mean weight change in kg (SD)	Percent weight change (SD)
<30kg/m^2	499,496	39.5	-3.4 (2.7)	-4.5 (3.6)
30-34.9kg/m^2 (category I)	390,642	30.9	-4.2 (3.4)	-4.8 (3.8)
35-39.9kg/m^2 (category I and II)	219,404	17.4	-4.8 (4.0)	-4.8 (3.8)
>40kg/m^2 (Category III)	154,749	12.2	-5.7 (4.8)	-4.7 (3.8)

Likewise, our programme is accessed by people with a range of BMI's via NHS referral into our groups. In an audit[2] looking at over 34,000 patients referred to us via the NHS it showed that:

- 11% had a BMI <30kg/m^2
- 34% had a BMI 30-34.9kg/m^2 (category I)
- 29% had a BMI 35-39.9kg/m^2 (category II)
- 26% had a BMI >40kg/m^2 (category III)

This research has also shown that primary care referral to Slimming World is as effective for people with high BMIs as for those who are less overweight.

In an independent study recently published in the British Journal of General Practice[3], 86% of patients referred to Slimming World had a BMI>30kg/m^2. In this study, longer term follow up data showed that Slimming World led to greater weight loss at 12 months when compared to other providers.

The fact that day-to-day a huge majority of our members fall within these groups warrants the inclusion of them all in advertising.

References
1. Stubbs, R.J.et al. ((2013). Weight outcomes as a function of BMI in 1.2 million members of a commercial weight management programme. *Obesity Facts,* 6(1):189. *(This data has also been submitted for full scientific publication).*

2, Stubbs, R.J et al. (2013). Service evaluation of weight outcomes as a function of initial BMI in 34,271 adults referred to a primary care/commercial weight management partnership scheme. *BMC Research Notes,* 6:161

3. Madigan, C et al. (2104). Which weight-loss programmes are as effective as Weight Watchers? Non-inferiority analysis. *British Journal of General Practice*, 64(620):e128-e136.

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

Slimming World supports under 18s within our group environment (11-15 year olds with the support of their parent/guardian and the support and advice of a health professional).

This is a group for whom support to manage their weight is vital. We wish the review to be mindful of the fact that, as child obesity is a growing problem, responsible organisations should be able to offer support to whole families which may include young people under the age of 18 while not necessarily wanting to advertise directly to this group.

Question 7: Are there any other comments you wish to make, or evidence you wish to submit, in relation to CAP BCAP's consideration of the issues set out in this document?

Slimming World was the first weight management company to actively work with the NHS to tackle obesity through our Slimming World on Referral scheme; a highly successful partnership with health professionals to provide overweight patients with effective community-based weight loss support.

For over a decade, we have worked with GPs, health professionals, the NHS and local authorities who promote and advertise the partnership. As local authorities take on increased public health responsibility for managing obesity in their communities they are finding that they need to promote effective weight management programmes. Without changes to the current advertising guidelines they will be unable to advertise and thus fail to engage people which will inevitably encumber any programme to tackle and reduce obesity.

19 - Very Low Calorie Diet Industry Group (VLCD)

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

The VLCD Industry Group agree with CAP and BCAP's proposal to allow certain lifestyle weight loss and weight management providers, having fulfilled specific criteria, to refer to obesity in their marketing and to target obese individuals.

Weight management programmes, such as those provided by VLCD Industry Group members, are safe, effective and specifically designed to be appropriate for the overweight and obese. They are based around formula foods that are nutritionally balanced with key vitamins, minerals, high quality protein, essential fats and fibre and other nutrients, and are designed to replace more traditional meals to facilitate optimal weight loss.

They have been available in the UK for over 30 years and are aimed at those who are obese but otherwise perfectly healthy. It is worth emphasising this point: obesity is not a disease nor a disorder nor any other form of medical condition. Therefore the strict protections that are rightly in place to regulate advertising to individuals suffering from a medical condition should be considerably more liberal in the case of advertising to the obese.

A further consideration for CAP and BCAP when it comes to reviewing the rules around obesity should be that a quarter of the UK population, according to British Government statistics, are obese. It is widely acknowledged that this will have considerable implications for the health of the nation and for the financial health of the NHS if we cannot bring down this level of obesity.

One way of lowering this percentage - whilst still ensuring that burdens on the NHS are kept to a minimum - is to allow people to make their own choices about what responsible weight management programmes they choose to use. These choices must be informed, hence the need for a change in the rules about advertising to the obese.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

The VLCD Industry Group members agree weight management programmes should fulfil a number of criteria before they are able to advertise to the obese.

We believe that these criteria should include complying with and following NICE guidance and all applicable legislation; ensuring there is oversight by in-house medical professionals; providing sufficient safety guarantees; and providing the evidence on effectiveness and safety of weight management programmes that is already required by the advertising codes.

The Industry Group also agree that programmes should be of an approximately three month minimum duration, which is the industry standard.

CAP and BCAP's suggested criteria generally reflect the Industry Group's beliefs. We do have some concerns with certain elements of the criteria that CAP and BCAP have suggested however.

As already highlighted, Industry Group members agree that programmes should be shown effective at one year and beyond. Members have this evidence but would urge CAP and BCAP to clarify how this evidence will be assessed, who will be doing the assessment and how this process will be fair, public and transparent.

Finally, VLCD Industry Group members provide all of their weight management programmes through trained representatives, who are encouraged to continually refresh and update their training.

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

The VLCD Industry Group do broadly agree that the ASA should consult NICE Guideline PH53 when making decisions about whether an advertisement for a weight management programme is responsibly referencing obesity. As noted above, VLCD Industry Group members comply with NICE guidance where relevant.

The Industry Group is keen to emphasise that NICE guidance should only form the basis of any decision and not become the ASA's sole reference point. There have been huge strides in the quality and quantity of scientific research into how best to tackle obesity in recent years and the subject is a fast moving one, whereas NICE guidance is updated irregularly every few years. Therefore if a responsible weight management provider can supply the ASA with well-conducted scientific research to support any references to obesity it is making, then the ASA should weigh this up carefully - even if such research is not included in the most recent NICE Guideline.

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?

VLCD Industry Group members believe that CAP and BCAP should be flexible when drafting the proposed rules, taking into account any good quality scientific evidence provided and being as open and transparent as possible when drawing up these rules.

Question 5 [on PH53's various classifications of obesity: Healthy weight 18.5–24.9 Overweight 25–29.9 Obesity I 30–34.9 Obesity II 35–39.9 Obesity III 40 or more]:
For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):

- **category I,**
- **category I and II, or**
- **category I, II and III of obese people?**

Please provide any evidence you consider supports your response.

The VLCD Industry Group believes that all responsible weight management companies should be able to target all categories outlined above. All obese individuals will benefit from access to more information about how they can help themselves to lose weight and live healthier lives.

Putting restrictions on advertising to different classifications may also be impractical: how, for example, will the ASA decide which advertising is aimed at someone with a BMI of 34.9 and someone with a BMI of 35.1? Furthermore, there is very little actual difference between someone with the first BMI and someone with the second: forbidding advertising targeted to one but not the other does seem arbitrary.

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

VLCD Industry Group members agree that CAP and BCAP should maintain the prohibition on the advertising of weight loss treatments and services to the under 18s.

20 - Weight Watchers UK Ltd (Weight Watchers)

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

Obesity has reached epidemic proportions and its prevalence is increasing. Obesity is a major risk factor for diseases such as type 2 diabetes, cancer, liver and heart disease, in addition to mental ill health. It costs the NHS £5bn each year, and costs the wider economy billions more.
The government's obesity strategy 'Healthy lives, Health People: a call to action on obesity in England' (Department of Health 2011) aimed to reduce, 'the level of excess weight averaged across all adults by 2020'. It advocated a range of local interventions that both prevent obesity and treat those who are already obese or overweight.
Currently a situation exists where those who most need to and would benefit from losing weight – those who the government and UK health authorities are most keen to see take personal responsibility and enrol on lifestyle weight management programmes cannot be targeted or depicted in advertisements for such programmes. This results in misleading media images, with advertisers being limited to showing individuals with a BMI of less than 30kg/m2. Lifestyle weight management programmes, who want to be credible, accurate and truthful in their advertising, and who want to make significant contributions to improving public health, are therefore left in an uncomfortable position.
The unrepresentative images currently used in advertising risk skewing the collective perception of weight and weight loss issues generally, potentially having a negative effect on public health. The current CAP and BCAP Code regime results in;

(a) Advertising that disproportionately depicts people who need weight management programmes less than those who are obese. This sends an implicit message to consumers who are unaware of the CAP and BCAP code restrictions; perhaps adding to negative body image issues in those who are at healthier weights than the obese.

(b) Advertising that may lead obese individuals to believe that healthy lifestyle weight loss programmes are not appropriate or indeed effective for them, and that higher risk and/or more invasive interventions such as surgery, VLCDs (very low calorie diets) and pharmaceuticals are their only viable options.

Social norms have a powerful impact on collective population behaviours, and can impair our ability to recognise unhealthy weight in ourselves and others. The current CAP and BCAP regime may be contributing to this, as it is not possible for obese individuals who have successfully lost weight to be featured in mass market advertising. The code is contributing to a dearth of positive examples that others can be inspired by and follow.
The proposed change would bring CAP and BCAP rules into line with government policy and clinical practice. More importantly, it would make a vital and meaningful contribution to the increasingly important national ambition of tackling obesity.
The current inconsistency in linking images of the obese with weight loss surgery and medications, and linking less noticeably overweight people with lifestyle weight management programmes, goes against the evidence of effectiveness which is comparable for medication and effective lifestyle regimes. The distinction of a BMI of 30 as a cut-off is unrelated to the efficacy of treatments. Importantly, this approach cements in the public's eye a false impression that weight management for those with a BMI over 30 somehow requires medical treatment. This risks widening existing health inequalities by deterring access to appropriate self-help support. We believe that it is wrong that surgery clinics and pharmaceuticals are permitted to target and depict obese individuals in advertisements, but safe, proven and often equally effective lifestyle weight management programmes can not. Indeed there is no suggestion in the National Institute for Health and Care Excellence (NICE) guidance on the

prevention, identification, assessment and management of overweight and obesity in adults and children (Guideline PH53) that the level of individual medical supervision required under the current CAP and BCAP regime should be seen as necessary or desirable.

Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.

We believe that the following criteria are appropriate to include in the rules,

- multi-component and developed by a multi-disciplinary team
- shown to be effective at 12 months and beyond, and
- provided by staff who are trained to deliver them

See response to Question 4 for a detailed response to this question.

Question 3: Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

It is appropriate that the ASA should have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity. The aim of the Guideline is to help meet a range of public health goals. These include helping reduce the risk of the main diseases associated with obesity. The Guideline provides guidance on the management of overweight and obesity in adults and children and specifically makes recommendations on the provision of lifestyle weight management programmes for the treatment of overweight and obese adults. While the Guideline was intended for commissioners and providers of lifestyle weight management programmes and health and social care professionals who advise or refer people to these programmes, it is an authoritative and independent reference point for the ASA. The Guideline acknowledges the positive role that public, private or voluntary providers, can play in supporting an individual who wishes to lose weight. It identifies best practices recommending that commissioners of services should commission or recommend programmes that can demonstrate that they are effective at 12 months or beyond and meet the core components of effective weight loss and the prevention of weight regain.

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?

While we agree with CAP and BCAP that the most effective and proportionate way to merit a conditional change to the rules is to identify a small number of the criteria that the NICE Guideline PH53 identify as relevant criteria, we would advocate that including the criteria that, [lifestyle weight management] programmes should be "of at least three months duration", as one of those criteria is unnecessary.

We note that CAP and BCAP consider that this criteria helps ensures that the programmes are sufficiently long to have an impact. While it is true that in order to lose weight at a rate that is compatible with good medical and nutritional practice and move from a BMI of 30 to a BMI in the healthy weight range (BMI 18.5 to 24.9) it will be necessary to follow a weight loss programme for a sufficiently long period. This can be seen in the illustrative examples below.

Height	Start & End Weight	BMI	Weight loss period at rate of 2lbs a week
5’9	203 lbs (14st 7 lbs)	BMI 30	
	168 lbs (12st)	BMI 24.9	
Weight loss	35lbs		17.5 weeks
5’6	186 lbs (13st 4lbs)	BMI 30	
	154 lbs (11st)	BMI 24.9	
Weight loss	32 lbs		16 weeks
5’3	170 lbs (12st 2 lbs)	BMI 30.1	
	140 lbs (10st)	BMI 24.8	
Weight loss	30 lbs		15 weeks

However it is not necessary to introduce the specific criteria that the programmes should be “of at least three months duration”, as there are already CAP and BCAP rules in place that restrict advertisers from encouraging weight loss over periods of time that are not compatible with good medical and nutritional practice.

The CAP and BCAP Codes (at Rules 13.10 and 12.9 respectively) impose restrictions on advertisers making claims that individuals can lose weight at a faster rate than is compatible with good medical and nutritional practice. Both, Rule 13.10 and 12.9 state, “For those who are normally overweight, a rate of weight loss greater than 2 lbs (just under 1 kg) a week is unlikely to be compatible with good medical and nutritional practice. For those who are obese, a rate of weight loss greater than 2 lbs a week in the early stages of dieting could be compatible with good medical and nutritional practice.”

While many individuals will follow lifestyle weight management programmes for at least 3 months there are those who will choose to follow the programme for shorter periods of time and that doesn’t make the programme any less relevant or beneficial as a tool for obese individuals to lose weight. Indeed any weight loss for an obese individual during that period will have a positive impact on that individual’s physical and mental well-being.

Accordingly our proposal would be to amend the proposed rules to delete the criteria “of at least three months duration”. Alternatively, if CAP and BCAP were not sufficiently persuaded by this argument a middle ground might be to include as a criteria the following, “intended for use over a period of months.”

Question 5: For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):

- **category I,**
- **category I and II, or**
- **category I, II and III**

of obese people?

Please provide any evidence you consider supports your response

We believe that for advertisers meeting the criteria, they should be able to refer to (and therefore target) obese individuals regardless of their BMI, as there is no evidence to suggest that to do so would be harmful to the individual.

Question 6: Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

We are comfortable with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18.

Question 7: Are there any other comments you wish to make, or evidence you wish to submit, in relation to CAP BCAP's consideration of the issues set out in this document?

While we cannot speak on behalf of other lifestyle weight management programmes the Weight Watchers programme has been specifically designed with the latest nutritional scientific research and consumer insights to create a safe energy deficit for a healthy rate of weight loss, whilst encouraging healthier, more satisfying food choices, enabling flexibility to learn skills for sustaining weight loss and integrating physical activity. There is a wealth of good quality, peer-reviewed published scientific evidence (over 80 papers to date) that demonstrates the efficacy, effectiveness and sustainability of Weight Watchers' methodology and weight loss plans; demonstrating consistent outcomes from international data and data derived from the UK, both in populations who self-refer and in those referred by health professionals - and in both overweight and obese individuals. Weight Watchers has been shown to be effective at 12 to 18 months . See A-I below for a non-exhaustive selection of references to relevant papers.

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E. Weight Loss from Three Commercial Providers of NHS Primary Care Slimming on Referral in North Somerset: Service Evaluation. K Dixon, S Shcherba, and R Kipping, J Public Health (Oxf). 2012 Dec; 34(4):555-61. doi: 10.1093/pubmed/fds034. Epub 2012 May 18.
F. Weight Watchers on Prescription: An Observational Study of Weight Change among Adults Referred to Weight Watchers by the NHS. AL Ahern, AD Olson, LM Aston, SA Jebb. BMC Public Health 2011; 11:434.
G. Patient Weight Counseling Choices and Outcomes Following a Primary Care and Community Collaborative Intervention. DB Wilson, RE Johnson, RM Jones, AH Krist, SH Woolf, SK Flores. Patient Educ Counseling 2010; 79(3): 338-343.
H. Changes in Cardiovascular Risk Factors with Participation in a 12-week Weight Loss Trial Using a Commercial Format. V Milsom, R Malcolm, G Cronan, S Pechon, K Miller-Kovach, S Rost, PM O'Neil. Obesity Reviews 2010; 11 (Suppl 1):S244.
I. Changes in Dietary Energy Density With Participation in a 12-Week Weight Loss Trial Using a Commercial Format. P O'Neil, G Cronan, T Turner, L Nance, R Malcolm, S Pechon, S Rost, K Miller-Kovach. Obesity 2010; 18 (Suppl 2):S96.