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The impact of body image on mental and physical health

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Report, together with formal minutes relating to the report

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Health and Social Care Committee

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Executive summary

1. How people think and feel about their bodies and the steps they take to make perceived improvements has changed significantly in recent years. The advent of social media and rise in online advertising have both increased exposure to certain idealised body types. With a Mental Health Foundation report in 2019 finding that 31% of teenagers and 35% of adults feel ashamed or depressed because of their body image,[1] these pressures are directly impacting the health of the population.

2. Our survey found that 80% of respondents agreed or strongly agreed that their body image had a negative impact on their mental health, with 61% agreeing or strongly agreeing that their body image negatively impacts their physical health.[2]

3. Body image dissatisfaction and its associated health impacts can affect anyone regardless of gender, sexuality, ethnicity, or age. Body image issues can also result in increased health risks for specific groups, from the increased risk of suicide[3] in those suffering from body dysmorphic disorder (BDD)[4] to the total suppression of testosterone and its cardiovascular risks in those taking long-term anabolic steroids.[5] There is little evidence that the Government is doing enough to understand the scale of these risks or to provide the necessary services for those seeking help. A more thorough understanding of the causal mechanisms between body image and health issues in these groups is needed. We recommend that the Department of Health and Social Care, along with the National Institute for Health Research, commission and fund new research to understand the causal pathways that are leading to a rise in body image dissatisfaction across the population including the impact of social media. This is of particular importance in relation to certain groups known to be vulnerable to body image concerns including adolescents, people with disabilities and LGBT people. However, it is also vital for groups in relation to which the understanding of body image dissatisfaction is less clear, such as those from BAME communities and older people.

4. In July 2021, one in six children aged five to 16 in England were identified as having a probable mental health issue.[6] We received worrying evidence pointing to rising body dissatisfaction contributing to poorer mental health in young people,[7] particularly but not only girls.[8] The health implications of this are wide-reaching. One example is the rise in the rates of eating disorders, with the proportion of children and young people with possible eating disorders increasing since 2017 from 6.7% to 13% in 11 to 16-year-olds and from 44.6% to 58.2% in 17 to 19-year-olds.[9]

5. We heard much evidence about the potential harm from online content that promotes an idealised, often doctored and unrealistic, body image and the link to developing low self-esteem and related mental health conditions. We acknowledge the complexities

1 Mental Health Foundation, Body image: How we think and feel about our bodies, May 2019
2 See annex
3 Dr Georgina Krebs IBI0029
4 The Body Dysmorphic Disorder described BDD in their evidence submission as ' a mental health condition characterised by excessive preoccupation with perceived flaws in physical appearance.'
5 Q70
6 NHS Digital, 'Mental Health of Children and Young People in England 2021', 2021
7 CLOSER IBI0043
8 Girlguiding IBI0013
9 NHS Digital, Mental health of children and young people in England, 2021: Wave 2 follow up to the 2017 survey, 2021

surrounding the debate on digitally altered images, and the progress that has been made with the Online Safety Bill. However, we believe further action is needed in terms of both culture and legislation. We call on the Government work with advertisers to feature a wider variety of body aesthetics, and work with industry and the ASA to encourage advertisers and influencers not to doctor their images. We believe the Government should introduce legislation that ensures commercial images are labelled with a logo where any part of the body, including its proportions and skin tone, are digitally altered.

6. 31% of those who completed our survey said they had accessed, or tried to access, health services for issues relating to body image in the past. Of these, 64% felt that their experience of accessing services was either negative or strongly negative, with only 14% saying their experience was positive or strongly positive. Perhaps most worryingly 55% of these respondents felt that they had been stigmatised when they accessed, or tried to access, these services.[10] One survey respondent described having gone "to the doctor for help. I was dismissed, I was diminished."[11] These findings are extremely worrying and highlight the need for further awareness and training among all healthcare staff. We urge Health Education England, the General Medical Council and the Nursing and Midwifery Council to collaborate with third sector organisations that are currently educating people about and promoting awareness of body image issues, and after a period of assessment, integrate the most effective existing training and resources into all training programmes within the medical, nursing and midwifery fields within the next two years.

7. Kim Booker, one of our lived experience witnesses who suffers from BDD, told us of her experience of seeking procedures that ended up in "filthy" rooms and taking only "10 to 15 minutes," comparing the process to "a conveyor belt … without any questioning at all".[12] We welcome the Government's decision to include the power to introduce a licensing regime for non-surgical cosmetic procedures in the Health and Care Act. With a consultation on what the new licensing regime should look like now awaited, we urge the Government to make this a priority and to introduce the licensing regime by July 2023. This licensing regime ought to include a commitment to a two-part consent process for anyone considering having a non-surgical cosmetic procedure, including, at a minimum, a full medical and mental health history, a mandatory 48-hour cooling off period between the consent process and undergoing the procedure. There should be minimum training and qualifications standards for practitioners, to bring an end to the situation in which anyone can administer non-surgical cosmetic procedures. We also call for dermal fillers to be made prescription-only substances, in line with Botox. We welcome the ban on advertising for cosmetic procedures directed at under 18s and recommend further regulation of advertisements on social media. This should include the requirement that advertisements for treatments within the licencing regime's scope must display a kitemark and a warning logo. Existing and new regulations must be properly enforced by the relevant bodies. Complaints about a practice can span a number of different regulators, and so a new 'Non-Surgical Cosmetic Procedures' safety taskforce of regulatory bodies should ensure a coordinated approach exists to checks that practitioners are complying with the law.

8. We acknowledge the difficulty in striking the right balance between effective messaging on the health risks related to obesity and the potential to provoke weight

10 See annex
11 Survey respondent 399
12 Q42, Q44

stigmatising attitudes and further health issues. With obesity rates continuing to rise, the morbidity from the increased risk of associated long-term health conditions such as type 2 diabetes, cardiovascular disease, strokes and some cancers will, if left unchecked, result in an unhealthier population and rising costs for the health service.

9. We have heard evidence stressing the importance of education about body image for young people both in terms of critical thinking and appraising images, but also self-worth. The Government should look to strengthen these areas in education settings.

10. We propose that in line with the introduction of Integrated Care Systems, which are intended to tackle health inequalities and focus on prevention, the Department ought to bolster the Healthy Child Programme. We propose that the Government introduce annual holistic health and wellbeing assessments for every child and young person, using the existing workforce of school nurses and health visitors, as well as those in associated roles such as community paediatrics and primary care. These assessments should monitor a range of physical and mental health markers including, but not limited to, weight and mental wellbeing. They should provide an opportunity to explore the context in which the young person and their family live, how these circumstances can relate to their health and should aim to engage the wider family (if appropriate, depending on age) to ensure early detection of potential health risks, with signposting to appropriate services if required.

11. We urge the Government to implement population-level policies that ensure healthier choices and lifestyles are made a priority in tackling obesity rates, rather than schemes that focus solely on weight loss which can engender adverse health outcomes including stigma and even weight gain. We were disappointed by the Government's delay in restricting multibuy deals for foods and drinks high in fat, salt, or sugar–including buy one get one free. We urge the Government to reconsider this decision and to implement this measure immediately.

12. We recommend that the Government undertakes an urgent review of its current campaigns related to obesity and alters any language or media used, to stress that being underweight is a risk to health just as being overweight. We also recommend that training on weight stigma is integrated into undergraduate and trainee curricula in all medical, nursing and other allied professional programmes to address stigma early on. This requires professional bodies and Health Education England to update their curricula and training standards, coupled with training offered to all current clinical staff, on how best to discuss weight and health.

13. In short although the impact of body image on mental and physical health is wide-reaching, we are unconvinced that it is a sufficient priority for the Government. With 72% of our survey respondents answering 'No' to the question 'Do you think the topic of body image and its related health impacts is receiving sufficient attention from national policymakers?' and only 8% answering 'Yes,' the public agree.

14. ***We urge the Government to immediately initiate a comprehensive cross-government strategy that brings together, at the very least, the Department of Health and Social Care, the Department for Digital, Culture, Media and Sport, and the Department for Education to tackle the current growing problem of body dissatisfaction and its related health, educational and social consequences. This strategy should include, but not be limited, to education about self-worth, body positivity, critical thinking and appraising***

images, as well as wider health advice such spotting signs and symptoms of eating disorders, anxiety and depression and body dysmorphia, within educational, health and online/media settings.

1 What drives poor body image and who does it impact?

15. The Mental Health Foundation describe body image as "how we think and feel about our bodies."[13] As a society, we tend to place a great deal of importance on our body image. Nearly half of adults (47%) in the British Social Attitudes Survey in 2014 felt that 'how you look affects what you can achieve in life' and nearly one third (32%) felt that 'your value as a person depends on how you look'.[14]

16. With such existing cultural attitudes, and in a world with ubiquitous social media use and exposure to online advertising, it is no surprise that we received much written and oral evidence that outlined the growing scale of body image issues that exist across the population. There is clear evidence that poor body image is common and has a negative impact on wellbeing. The Good Childhood Report in 2021 highlights appearance as a leading cause of unhappiness among young people and indicates that appearance concerns are increasing year on year.[15] A survey by the Mental Health Foundation similarly found that 37% of teenagers felt upset and 31% felt ashamed of their body image, and just over one third of adults said they had felt anxious (34%) or depressed (35%) because of their body image.[16]

Causes of body image issues

17. There is no single cause for body image dissatisfaction and the causes often differ depending on the characteristics and/or circumstances of the individual. The Women and Equalities Committee's 2021 report, Changing the perfect picture: an inquiry into body image[17] found the most persistent causes of body image dissatisfaction to be:

- Colourism–discrimination affecting people of colour where lighter coloured skin is viewed as more desirable.
- Weight stigma–those with a higher body and lower body weight than the average can be subject to prejudice and discrimination.
- Exposure to media depicting unrealistic and narrowly defined appearance ideals.
- Appearance-related bullying and/or sexual harassment.
- The emphasis on the importance of image/beauty in society.

13 Mental Health Foundation IBI0046
14 Government Equalities Office, Body confidence: Findings from the British Social Attitudes Survey, 2014
15 The Children's Society, The Good Childhood Report, 2021
16 Mental Health Foundation IBI0046
17 Women and Equalities Committee, Sixth Report of Session 2019–21, Changing the perfect picture: an inquiry into body image, 2021

Who do body image issues affect?

18. We heard throughout the inquiry of the number of different ways that body image issues can manifest in individuals, groups and populations. Certain groups were identified in the evidence as most vulnerable to suffering from body image dissatisfaction. These included:

- Adolescents–we received evidence that body dissatisfaction is increasing for both teenage boys and girls, however, the motivations behind this may differ.[18]
- Underweight and overweight individuals–the latter group largely due to weight bias.[19]
- LGBT individuals (particularly gay men and transgender individuals).[20]
- People with disabilities or living with a visible difference.[21][22]

19. The complex relationship between body dissatisfaction and ethnicity was highlighted by the Children and Young People's Mental Health Coalition. They noted that research has shown that Black British girls are more likely to have higher satisfaction with their body image than their White British counterparts. However, they suggested that, as body image research predominantly focuses on factors related to weight and rarely considers those aspects of appearance that may be of more concern for young people from BAME communities or from different cultural groups - for example, hair texture and skin tone - current research outputs may be missing key risk factors relating to poor body image within certain communities.[23]

Body image issues in women and girls

20. We received a wealth of written and oral evidence that detailed the different ways that poor body image can develop in women, particularly young women,[24] BAME women,[25] older women,[26] transwomen,[27] women suffering from breast cancer,[28] and post-partum women.[29]

21. We learnt that poor body image develops early, establishes itself in female adolescence and is becoming more common. Girlguiding told us that results from their survey showed that in 2011, 73% of girls aged seven to 21 were happy with how they looked, falling to 70% in 2018.[30] However, this masks some of the differences across the age groups, including a

18 CLOSER IBI0043
19 Obesity Health Alliance IBI0041
20 Mermaids IBI0010
21 Changing Faces IBI0024
22 Dr Emily Hunt & Dr Charlotte Kerner IBI0031
23 The Children and Young People's Mental Health Coalition IBI0015
24 Girlguiding IBI0013
25 Q3
26 CLOSER IBI0043
27 Mermaids IBI0010
28 Breast Cancer Now IBI0026
29 Dr Alison Owen IBI0001
30 Girlguiding IBI0013

significant decline for the 17–21-year age group (69% were happy with how they looked in 2009 compared to 57% in 2018). In addition, they found that at age seven to 10, 51% of girls say they are "very happy" with how they look. By age 11–16, this has decreased to 16%.

22. The development of poor body image at a young age for girls aligns with what one of our lived experience witnesses, Kim Booker, told us:

> I have had issues with my body image from as young as I can remember, since about the age of five. That is the body dysmorphia. It would be as minute as me not liking the arrangement of freckles on my knees or the way that my toes were shaped. At that young age—it was the early '90s—I was growing up in an environment where it was very much the Disney ideal. It was the princess look. As a child, seeing that and being bombarded with those images, I felt that I needed to fit the template of the big eyes, the small nose, the flowing hair and the tiny waist. That has grown with me through my teenage years, into adulthood.[31]

Body image issues in men and boys

23. While women and girls are often more likely to report being unsatisfied with their bodies, men and boys also experience body image dissatisfaction. The Mental Health Foundation told us that 28% of men aged 18 and above had felt anxious about how their bodies looked while 11% had felt suicidal.[32] As with girls, a pattern of issues developing at an early stage was noted, with a survey by Credos, an advertising think-tank, in 2016 finding that 10% of secondary school boys have skipped a meal to change how they look.[33]

24. We were told that male body image issues typically receive less attention than female body image issues in research and policy but that this may be due to the different ways that body image dissatisfaction can manifest in boys and men.[34] Changing Faces highlighted that three-quarters of men 'with a visible difference' say that men are under pressure to meet macho male stereotypes and that men do not talk about their appearance,[35] suggesting that existing stigma about body image issues may be masking the true prevalence of issues within boys and men.

25. One of our lived experience witnesses, Charlie King, told us how as a male, his struggles with his sexuality added to the development of body image issues at a young age:

> You start feeling pressures. I started feeling pressures within myself. Because I had not identified with my sexuality then, I was going above and beyond to try to be something that I was not. There was a lot going on. In that period of my life, there was a lot of focus on my image. I was being very critical, I noticed. I wanted to be like the cool guys. I wanted to fit in with them, and I was trying my best to do whatever I could to do that. That all stemmed from back at school, when I felt quite isolated, to be honest.[36]

31 Q41
32 Mental Health Foundation IBI0046
33 Credos, A Picture of Health, 2016
34 Mr Chris Bell, Dr Charlotte Kerner IBI0035
35 Changing Faces IBI0024
36 Q100

Body image issues across the life course

26. Body image issues do not only affect the young. We received written evidence highlighting that body dissatisfaction can persist into mid- and later-life and may even be exacerbated by age-related physiological changes.[37] With evidence highlighting that poor body image tends to remain stable from adolescence through midlife,[38] potential consequences from poor body image in childhood and adolescence may have longer-lasting impacts than previously thought. Alex Light, a lived experience witness, told us how the body image issues she developed in childhood expressed themselves as in adulthood:

> I started dieting around the age of 11. I quickly became a chronic dieter, flitting from diet to diet. Eventually that led to an eating disorder. After years of suffering in silence, I told my mum what was going on. We sought professional help. I was diagnosed with anorexia nervosa at age 25. It soon morphed into bulimia nervosa, and ultimately I was diagnosed with binge eating disorder. I spent years of my life locked in this mental prison. It did not just have an impact on my mental health but a serious impact on my physical health as well. I am now 33, and it is only in the last couple of years that I have really been able to create an existence free of eating disorders.[39]

27. Responses to our survey also highlighted the negative impacts that body image dissatisfaction can have into mid- and later-life:

> Being now 66 with a long standing body image problem I feel even more in invisible in society, focus continues to be on young and middle aged people.[40]

Body image issues, research and policy directions

28. We heard evidence describing the unexpected ways that body image issues can develop and take root. One of our lived experience witnesses, James Brittain-McVey, described the insidious process by which body image issues developed and was keen to draw a distinction between some people's perception that vanity drives body image issues and the reality experienced by those suffering from those issues:

> One of the biggest misconceptions in my opinion is people presuming that this was striving for vanity because I absolutely loved myself. That was not what it was. There was a degree of self-destruction in my mind about how I looked. There was also pressure to conform to stereotypes and gender constructs. Before I realised, my whole life was controlled by the chase to look a certain way… Without realising, I still had unanswered demons in my head about my body.[41]

37 CLOSER IBI0043
38 Centre for Appearance Research MISS0045
39 Q6
40 Survey, respondent 410
41 Q1, Q7

29. Alex Light, another lived experience witness, was clear in stating that "it is not a vanity issue… and [the attitude] that it is something purely for vanity …prevents people from getting the help they need."[42]

30. Throughout the inquiry, we heard about the need for more research to better understand the differing causal mechanisms of body image dissatisfaction in certain groups.[43] We believe that James' and Alex's testimonies provide insight into different ways of thinking about and understanding those struggling with their body image, and provide fruitful paths forward for further research.

31. ***We recommend that the Department of Health and Social Care, along with the National Institute for Health Research, commission and fund new research to understand the causal pathways that are leading to a rise in body image dissatisfaction across the population and the impact of social media on body image. This is of particular importance in relation to groups that are known to be particularly affected by body image dissatisfaction: for example, adolescents, people with disabilities and LGBT people. However, it is also vital for groups in relation to which the understanding of body image dissatisfaction is less clear, such as those from BAME communities and older people.***

42 Q6
43 Q21, Q22

2 Impact of body image on health and lifestyle

32. With rising rates of body dissatisfaction across the population, the determinant impacts of this on health are becoming clearer. We received a wide range of evidence detailing the different ways that poor body image can result in the development of mental health conditions and of physical health conditions, some of which are associated with those mental health conditions.

The Committee's body image survey

33. To better understand the scale of the issue, we launched a survey on Twitter on 25 April 2022. The survey gave respondents the opportunity to reflect on how body image had impacted on their own mental and physical health. 1,550 people completed the survey over two weeks. The results were stark:

- 80% of respondents either strongly agreed or agreed with the statement 'My perception of my body image has a negative impact on my mental health.'
- 61% of respondents either strongly agreed or agreed with the statement 'My perception of my body image has a negative impact on my physical health.'
- 71% of respondents said Yes to the question 'Do your thoughts and feelings about your body image have a negative impact on your quality of life?'

Body image and mental health

34. The evidence we received draws a clear link between poor body image and mental health issues across different age groups. The Mental Health Foundation pointed out that having body image concerns is not a mental health problem in and of itself; however, it can be a risk factor for the development of mental health problems.[44]

35. Dr Georgina Krebs of University College London summarised the clear relationship:

> It is well established that poor body image is associated with a wide range of mental health difficulties. Most obviously, body image problems can escalate over time and lead to body image disorders. These are conditions where body image problems have escalated to such a level that they are causing significant distress and impairment. There have been longitudinal studies showing that body image problems in early adolescence are the strongest predictor of the development of eating disorders, for example. To put that in numbers, individuals who have high levels of body dissatisfaction are four times more likely to develop an eating disorder. Beyond those body image disorders, we know that poor body image is linked with a variety of other mental health difficulties such as anxiety, depression and suicidality. Looking at the research, individuals with high levels of body dissatisfaction are twice as likely to attempt suicide.[45]

44 Mental Health Foundation IBI0046
45 Q22

36. Conversely, it was noted in the evidence that body satisfaction and appreciation are linked to better overall mental wellbeing and fewer unhealthy dieting behaviours.[46]

Body Dysmorphic Disorder

37. We received much evidence detailing one of the conditions that can directly develop because of poor body image: Body Dysmorphic Disorder (BDD). The Body Dysmorphic Disorder Foundation described this disorder as:

> a mental health condition characterised by excessive preoccupation with perceived flaws in physical appearance. These flaws appear as very minimal or completely unobservable to others, but are a source of great distress to the BDD sufferer. People with BDD can be preoccupied with any aspect of their appearance, but the most common focus is facial features, such as eyes, teeth, nose, skin and hair.[47]

38. BDD differs from body image issues seen in other conditions such as eating disorders, which focus primarily on weight and shape.

39. Dr Georgina Krebs, a specialist in BDD, highlighted that BDD was previously thought to be rare, but recent studies have shown that about 2% of the general population experience BDD at any one point in time. She said that it is not known if BDD is becoming increasingly common over time, but this is plausible in the context of rising sociocultural pressures relating to appearance.[48] It is known, however, that the prevalence of BDD is much higher in certain groups. For example, the Mental Health in Young People 2017 survey, commissioned by NHS Digital and conducted by the Office for National Statistics, found that more than one in 20 (5.6%) 17- to 19-year-old girls experience BDD.[49]

40. We heard that the impact of BDD can be profound and that the disorder often leads to other mental health conditions, such as depression and substance misuse. Concerningly, rates of suicidality are also very high. Approximately one in four people with BDD attempt suicide, making it one of the highest risk of all mental health disorders.[50]

41. We were told of the significant impact that BDD can have on how people function. Evidence shows that, among young people attending mental health services for BDD, one in three are out of school because of their appearance concerns.[51] It is also common for young people with BDD to completely withdraw from social activities because of their appearance concerns, and even become housebound. This echoes the experience of Kim Booker, one of our lived experience witnesses. She described how it felt to live with BDD:

> Rather than see myself as a whole, I see myself as fractured pieces. I home in and zoom in on certain parts of myself and heavily criticise parts that I see as flaws. When I have really bad flare-ups, it can take up about 80% of my mind capacity. It is all I can think about. For instance, when I want to change certain features of my face, I am constantly thinking about how

46 Dr Alison Owen IBI00001
47 Body Dysmorphic Disorder Foundation IBI0032
48 Dr Georgina Krebs IBI0029
49 NHS Digital, Mental Health of Child and Young People 2017: Emotional disorders, 2018
50 Dr Georgina Krebs IBI0029
51 Dr Georgina Krebs IBI0029

> I am going to change it. I feel ugly. I do not like people looking at certain sides of my face. Sometimes I do not want to leave the house. It is in the category of OCD; it is a compulsive disorder. We ruminate and cannot stop seeing the flaws, even though other people probably cannot see them.[52]

42. As with Kim, we were told that BDD typically emerges during adolescence and that it is essential that the disorder is recognised and treated early to avert the potentially devasting impact that it can have at this crucial developmental period.[53]

43. Most worryingly, the BDD Foundation estimated that 85% of individuals with BDD do not receive an accurate diagnosis, due both to sufferers being reluctant to seek help and to healthcare professionals lacking adequate knowledge about the condition. We are concerned at the lack of resource being directed toward the treatment of those suffering, many unknowingly, with BDD.

44. ***We urge the Department to ensure more is done to make the diagnosis and treatment of Body Dysmorphic Disorder (BDD) a priority. From a diagnostic perspective, we recommend that Health Education England update the IAPT (Improving Access to Psychological Therapies) and EMHP (Educational Mental Health Practitioner) curricula to make training in BDD compulsory for all mental health practitioners. The Government should ensure BDD is included in the PSHE (personal, social, health and economic) education curricula within the section on body image, to promote early detection and early intervention within schools. As well as improved diagnosis rates, suitable care for those living with BDD must be available. We recommend that BDD specialist practitioners are eventually embedded into the multidisciplinary teams in every new community model for adults severely affected by mental illness.***

45. ***We call on the Government to better equip future generations and their families with the skills and resources required to tackle body image issues. These skills and resources include critical thinking, particularly when it comes to appraising images, and self-worth. We recommend that the Government explores the use of family hubs as a route to educate parents and young people about body image, self-worth, and body positivity.***

46. ***We commend the Government's work to date to introduce Education Mental Health Practitioners within school-based Mental Health Support Teams across the country, as well as the commitment to have a Mental Health Lead teacher in schools. We recommend that the Government review the training of these practitioners to ensure it includes spotting early signs of conditions related to body image issues. We ask the Government to provide us with a further update on their progress in introducing these roles and to set out the timeframe for establishing them in every school in England.***

52 Q46
53 Body Dysmorphic Disorder Foundation IBI0032

Body image and physical health

47. Poor body image can impact on physical health in many direct and indirect ways. Perception of body image can have a detrimental impact on physical health as it can deter an individual from engaging with certain healthcare treatments. For example, we were told that some women considering breast surgery for reducing the risk of cancer rank their future body image as a key factor in their decision whether to proceed or not.[54]

48. We were also told that those with visible difference can have health implications from their body image dissatisfaction. One fifth of people in the UK self-identify as having a visible difference such as a mark, scar or visible physical condition and Changing Faces told us that a third of those people report low levels of confidence, three in 10 admit to having struggled with body image (31%) and low self-esteem (29%), and a quarter (24%) say it has negatively affected their health.[55]

Eating disorders

49. The physical consequences of poor body image often stem from related mental health issues. Poor body image is a well-established factor for developing an eating disorder. An eating disorder is a serious mental health condition which can result in long-term physical health consequences including cardiovascular, gastrointestinal, endocrine and fertility complications. Eating disorders include conditions such as anorexia, bulimia and binge eating disorder. The most common age of onset is between 15 and 25 years-old, during a developmentally sensitive time.[56]

50. With the highest mortality rate of any type of psychiatric condition and an estimated 1.25 million people in the UK having an eating disorder,[57] eating disorders are a source of increasing morbidity and mortality. The Children and Young People's Mental Health Coalition told us of their growing concern about the increasing numbers of young people experiencing eating disorders, particularly following the Covid-19 pandemic. Recent data from NHS Digital shows that the proportion of children and young people in England with possible eating problems has increased significantly since 2017: from 6.7% to 13% in 11 to 16-year-olds, and from 44.6% to 58.2% in 17 to 19-year-olds.[58] Similarly in 2020/21, the NHS saw an 83% increase in demand for urgent eating disorder services and a 41% increase for routine services. Data also shows that between April and October 2021, there were 4,238 hospital admissions for eating disorders for children aged 17 and under, up 41% compared to the same period the year before.[59]

51. This spike in presentations of those suffering from eating disorders causes us concern, and we agree with our witness Professor Sandeep Ranote, who called for more robust data and research that can identify clearer causation for the rise in eating disorders.[60] In 2015, the then Government introduced an access and waiting time standard for children and young people's eating disorder services. However, these efforts have not been enough and,

54 British Psychological Society IBI0028
55 Changing Faces IBI00024
56 The Children and Young People's Mental Health Coalition IBI0015
57 The Children and Young People's Mental Health Coalition IBI0015
58 NHS Digital, Mental health of children and young people in England, 2021: Wave 2 follow up to the 2017 survey, 2021
59 NHS Digital, Hospital admissions with a primary or secondary diagnosis of eating disorders, 2022
60 Q20

as we identified in our 'Children and young people's mental health' report in November 2021, far too many children and young people are unable to access the care that they need.[61]

52. We recently made several recommendations in our 'Children and young people's mental health' report that sought to ensure better support was available for those suffering from eating disorders, in clinical areas and in schools.[62] We are worried, however, about the recent research from the Nuffield Trust showing that waiting lists are still increasing and more children and young people are waiting longer than ever before to receive urgent treatment.[63]

53. **While we commend the funding set aside for eating disorders to date and the actions taken by the Government so far, we are now of the opinion that a more co-ordinated approach is essential to properly understand and tackle this growing issue**.

54. ***We recommend that the Government develops a national eating disorder strategy that aims to understand the causal mechanisms that lead to the development of eating disorders and earmarks adequate funding to bolster existing services as well as to increase investment in research. We further recommend that alongside the quarterly publication of data on existing access and waiting time standards across every region, the Government pledges and provides additional resources to address any increase in the need for treatment identified, in order to eliminate regional inequalities in care.***

Muscle dysmorphia

55. Another condition that has serious physical health implications is muscle dysmorphia, a subtype of BDD characterised by the preoccupation with the idea that one's body is not sufficiently lean and muscular. Chris Bell and Dr Charlotte Kerner from Brunel University told us that what can appear to be simply a high drive for muscularity in men and women can result in several potentially deleterious health consequences such as dietary restraint and binge eating practices, depression, anxiety, low self-esteem, perfectionism and steroid/supplement use.[64]

56. According to the UK Anti-Doping Agency, there are more than one million, predominantly male (around 98%), steroid users in the UK. They describe the most common type of steroid abuser as a thirtysomething white-collar professional, not elite sportspeople as some may assume.[65] The Agency describe steroid abuse as "now a serious public health issue", citing that 56% of these users took steroids for improving body image or cosmetic reasons.[66]

61 Health and Social Care Committee, Eighth Report of Session 2021–22, Children and young people's mental health, para 5
62 Health and Social Care Committee, Eighth Report of Session 2021–22, Children and young people's mental health, para 5
63 Nuffield Trust, Children and young people with an eating disorder waiting times, 2022
64 Mr Chris Bell and Dr Charlotte Kerner IBI0035
65 UK Anti-Doping Agency, Image and Performance Enhancing Drugs, 2019
66 UK Anti-Doping Agency, Image and Performance Enhancing Drugs, 2019

57. Professor James McVeigh told us that "we may be seeing a large increase [of anabolic steroid use] on the horizon for young people … [due to] a combination of home life and external factors … [and] a lot to do with their own mental health and impulsivity around issues to do with their critical thinking."[67] Professor McVeigh described the physical health implications of long-term steroid use:

> Until your body is sufficiently matured, you do not control your hormones and the influx of male hormones in testosterone. We know that the longer the period people use, the more damage there is in later life, with cardiovascular disease and brain changes. One of the key things that we are facing is that many people taking anabolic steroids for a prolonged period of time will not return to normal testosterone production. A point will come when they may want to stop using anabolic steroids, but they will face a severe crash. That dip when you stop using puts you at the point of zero testosterone, with depression and a lot of mental health problems[68]

58. We were encouraged by Professor McVeigh's description of the UK being in an "ideal position around harm reduction … with high numbers of anabolic steroid users presenting to needle and syringe programmes, unlike anywhere else in the world."[69] However, with research by the healthcare firm Medichecks finding that 75% of gym-going males have considered steroid use and 90% of those currently taking anabolic steroids saying they wanted more advice on safe use,[70] there is a pressing need to better understand the scale of the issue.

59. ***We recommend that the Department commissions a national review of the growing use of anabolic steroids in England as it relates to body image. We further recommend that the Department introduces a national awareness campaign around safe anabolic steroid use. This ought to be coordinated through existing steroid user support groups and targeted at areas of highest risk, such as gyms with a high proportion of body builders.***

Body image, lifestyles and modern society

60. The negative impact of poor body image on daily life was apparent throughout the evidence. Young Minds, the children and young people's mental health charity, told us that poor body image can lead to a reluctance to engage in exercise, participate in school, or visit a GP and can result in a tendency to engage in behaviours such as problematic consumption of drugs and alcohol—all of which can, for some young people, result in a reduced quality of psychological wellbeing and curtailed academic aspirations.[71] Their evidence highlighted that young women are particularly affected: they are less likely to achieve their academic potential when they feel negative about their bodies and can also experience emotional setbacks in job interviews and sporting activities.

67 Q63
68 Q70
69 Q71
70 Medichecks, Bigorexia Survey, 2021
71 YoungMinds IBI0012

Advertising and social media

61. The presence of social media and the way in which we increasingly live and experience our lives online was a frequent point of discussion throughout the inquiry. In our first evidence session, the link between social media, online presence, body image issues and consequences on health and lifestyle was pointed out by several lived experience witnesses. James Brittain-McVey spoke openly about his struggles with body image in the past and what led him to wish to change his body:

> Now, looking back, I try to retrace the steps to how I got to that point, and I realise that there were a few factors. It was pressure at school, but for me it was not being open about how I felt. There was also the content around me, social media, billboards, advertisements and everything. They definitely encouraged me then, and I think they still do now.[72]

62. While not specifically within the terms of reference of the inquiry, the need for better protections against harmful online content for all, and particularly for children and young people, was identified. At the time of writing, the Online Safety Bill is making its ways through both Houses of Parliament. The Bill would create a new duty of care for online platforms towards their users. We welcome the steps the Government are taking through the Online Safety Bill to protect people from these potential harms.

63. However, we believe that more needs to be done in regard to the regulation of digitally altered images for advertising and social media use. We heard evidence about the potential harm from online content that promotes an idealised, often doctored and unrealistic, body image and the link to developing low self-esteem and related mental health conditions.[73] Kim Booker spoke of her own experience, agreeing that having to declare that an image had been doctored could have dissuaded her from altering it:

> I feel that it should be made very transparent that people are using filters, or that they have edited or photoshopped their images. That needs to be very clear … I did not want people to know that I was editing my image—oh my God, no. I wanted people to think that I looked like that. You would definitely be much more perturbed about doing that. Yes, the labels would help massively in that sense.[74]

64. We learnt that the pressures to alter body image come not only through social media and altered images, but also through advertising. Alex Light, a lived experience witness who is a body positivity influencer, told us of her experience:

> I saw a celebrity recently who has a huge following. He had a gastric band. It was paid for with a clinic. It was an ad; he promoted the clinic. There is a lack of regulation around that. It is not enforced properly, especially with Botox and fillers. I could go to a clinic now and they would give me the treatment for free. I could say, "I just had my Botox topped up at Dah, dah, dah" and promote the clinic. It is quite scary.[75]

72 Q1
73 Girlguiding IBI0013
74 Q48
75 Q15

65. We acknowledge the complexities surrounding the debate on digitally altered images and welcome the progress that is being made with the Online Safety Bill, in particular with the proposed responsibility on tech companies to regulate 'legal but harmful' content (such as content that promotes eating disorders) to better protect the most vulnerable. However, we believe further action is needed now in terms of both culture and legislation.

66. ***We call on the Government to work with advertisers to feature a wider variety of body aesthetics, and work with industry and the ASA to encourage advertisers and influencers not to doctor their images. We believe the Government should introduce legislation that ensures commercial images are labelled with a logo where any part of the body, including its proportions and skin tone, are digitally altered.***

67. Furthermore, we have major concern for one group that was noted throughout the inquiry as being particularly vulnerable to body image issues: children and young people. The pressures on today's young people are unprecedented, having grown up with social media and lived through a global pandemic in their formative years.

68. Each of our lived experience witnesses told us that their body image issues started in childhood and adolescence[76] and that social media and online advertising often exacerbated their concerns, in some cases, leading to the development of mental and physical health conditions and to their seeking out physical interventions to alter their bodies. The window of opportunity to best effect positive change exists in childhood and early adolescence. We do not believe that sufficient or decisive action is being taken to protect those most vulnerable from developing mental health conditions or seeking physical health interventions such steroid use or cosmetic interventions, many of which may lead to long-term health impacts.

69. ***We echo the call of our witness Professor Sandeep Ranote for the creation of a national public health strategy akin to the 1970s 'Green Cross Code'. A 'Screen Cross Code' would be a nationwide public health campaign, which would use short effective messages to educate the public on best practice with screen use for children and young people, as well as the potential negative health impacts resulting from excessive screen use or exposure to content that may lead to body dissatisfaction. This should include limits on daily screen use, promotion of social media sabbaticals, having digital sunrises/sunsets, as well as prompts to encourage discussion between parents and their children if there is content that could cause concern relating to body image and self-esteem. We recommend that the Department of Health and Social Care plays a leading role, in collaboration with the Department for Education and the Department for Digital, Culture, Media and Sport, in this work, given its implications for young people's health.***

76 Q1, Q3, Q6, Q41, Q99

3 Body image and experience of healthcare services

70. 31% of those who completed our body image survey[77] said that they had accessed, or tried to access, health services for issues relating to body image in the past. Of these respondents:

- 64% felt their experience of accessing services was either negative or strongly negative, with only 14% saying their experience was positive or strongly positive
- 72% either disagreed or strongly disagreed with the statement 'The services I received were appropriate and fully met my needs.'
- Most worryingly, 55% either agreed or strongly agreed with the statement "I felt stigmatised when I accessed, or tried to access, these services.'

Experience of accessing services

71. Respondents to our survey had the opportunity to leave written answers in open text boxes. Many spoke of their trepidation about seeking help from health professionals for their issues relating to poor body image. One survey respondent told us:

> I've not spoken to a doctor about my dysmorphia since the 1990s (before social media). I'm too scared to because I don't think doctors will understand or be able to help me. Never approached it with any mental health service I've ever used, either.[78]

72. Many causes of this fear of seeking professional help were noted, and many were often overlapping. We heard of the struggles of those from minority communities:

> As a trans woman the only place I have found support is through private. NHS needs to do much better![79]

73. We also heard from people who have developed body image issues at a later age, or due to medical conditions:

> My negative body image stems from breast cancer, chemo and weight gain from steroids. Ten years on my body has physically changed due to ageing and as a result of surgery and long term side effects of treatment and resulting hair loss, changes to skin conditions have ensued. As a result my body image is zero and I don't recognise or like my body or how I look.[80]

74. Some spoke of their concern about the existing pressures within the NHS and queried the existence of timely and/or appropriate services for issues relating to poor body image in the NHS:

77 See annex
78 Survey respondent 305
79 Survey respondent 232
80 Survey respondent 1532

> I would think that contacting my GP about my mental perception of my body image should be the right thing to do but mental health services are so limited, and it takes so long to access them, I don't think there is any point in trying.[81]

> As someone who has struggled with body image issues for many years now, I have found that it is difficult to access timely and appropriate help. Since my BMI is within the normal range, there appears to exist an assumption that my problems are not urgent and can wait.[82]

75. Most worryingly, many spoke of feeling stigmatised when they tried to get help from healthcare professionals. One person said that having gone "to the doctor for help. I was dismissed, I was diminished."[83] This correlates with the testimony given by a lived experience witness, Nyome Nicholas-Williams. She told us:

> When I had my eating disorder I went to the doctor. I have quite a weak ankle and I have always had physio for it. The first thing they said was, "You need to lose weight," when I was in the midst of an eating disorder and I was trying, not to get help, because I was like, "There's nothing wrong with me, I'm fine and I don't need help. I'm good." But to have the doctor say that to me without having asked or tried to understand, and say, "Well, it's about your weight," when I was already struggling with my weight in the midst of all of that, was quite hard. I guess I did not really get a diagnosis but I knew that there was something wrong because of the amount I was not eating. I definitely went through it by myself. I would not say that I got diagnosed, but I knew within myself that there was something wrong because I was not eating at all.[84]

76. These findings are worrying and highlight the need for further awareness of and training about body image issues among all healthcare staff.

77. ***We urge Health Education England, the General Medical Council and Nursing and Midwifery Council to collaborate with third sector organisations that are currently educating people about, and promoting awareness of, body image issues, and after a period of assessment, integrate the most effective existing training and resources into all training programmes within the medical, nursing and midwifery fields within the next two years. We echo the Mental Health Foundation's recommendation for any further training for professionals interacting with parents - that is, GPs, health visitors, dietitians and other frontline practitioners - to include information about how parents and carers can, from a very early age, positively influence their children's feelings about their bodies through the behaviours and attitudes they express.***

81 Survey respondent 786
82 Survey respondent 687
83 Survey respondent 399
84 Q17

4 The balance of tackling obesity and reducing weight stigma

Obesity rates

78. Rates of obesity have risen across England in the past few decades, with the largest increase between 1993 and 2001, then small increases since.[85] Almost two-thirds of adults in England are currently overweight or obese, and one in three children leave primary school overweight or obese. Obesity is a significant health risk and is associated with increased risk of diseases including diabetes, heart disease and some cancers.

79. There has been a significant increase in obesity in the most deprived communities in England in recent years, leading to a widening gap in rates of obesity between the most and least deprived areas. The obesity prevalence gap between women from the most and least deprived areas is currently 17 percentage points and for men it is 8 percentage points.[86] Childhood obesity has followed a similar pattern. For children in year six, there was a 13-percentage point gap in obesity rates between the most and least deprived children in 2019, up by 5 percentage points since 2006.[87]

80. The causes of obesity are many and varied. The most important risk factor is an unhealthy diet, while physical inactivity also plays a role. We are aware that people in deprived areas often face significant barriers to accessing affordable, healthy food and to taking regular exercise.

81. In 2019/20 there were more than 1 million hospital admissions linked to obesity in England, an increase of 17% on the previous year.[88] Rising rates of obesity translate to increasing costs for the NHS. In 2014/15, the NHS spent £6.1 billion on treating obesity-related ill health. This is forecast to rise to £9.7 billion per year by 2050.[89]

Latest Government action on obesity / weight management

82. In July 2020, the Government announced its obesity strategy.[90] There were previous strategies in 2016[91] and 2018,[92] as well as a Prevention Green Paper in 2019.[93] The latest strategy proposed:

- a ban on TV and online adverts for food high in fat, sugar and salt before 9pm;
- calories to be displayed on menus to help people make healthier choices when eating out–while alcoholic drinks could soon have to list hidden 'liquid calories'; and

85 Obesity Statistics, Standard Note, SN03336, House of Commons Library, 2021
86 NHS Digital, Health Survey for England, 2019: Data tables, 2019
87 NHS Digital, National Child Measurement Programme, England 2019/20 School Year, 2020
88 NHS Digital, Statistics on Obesity, Physical Activity and Diet, England, 2021
89 Public Health England, Health matters: obesity and the food environment, 2017
90 Department of Health and Social Care, New obesity strategy unveiled as country urged to lose weight to beat coronavirus (COVID-19) and protect the NHS, 2020
91 Department of Health and Social Care, Childhood obesity: a plan for action, 2016
92 Department of Health and Social Care, Childhood obesity: a plan for action, chapter 2, 2018
93 Department of Health and Social Care, Advancing our health: prevention in the 2020s – consultation document, 2019

- a new campaign to help people lose weight, get active and eat better after the COVID-19 'wake-up call'.[94]

83. We are aware of the Government's further measures since, including a Digital Weight Management Programme in July 2021, backed by £12 million of funding,[95] and £30 million for councils to provide services to include dietary advice, physical activity guidance and support to help adults start and maintain healthier habits. We further note the Government's decision to allocate £4.3 million to increase child weight management services in 2021 to 2022 and think it proves a degree of ambition to tackle obesity at the earliest stages so to prevent future ill-health.

84. However, the efficacy of past and current obesity measures was roundly criticised by many of our witnesses, including Mr Tam Fry of the National Obesity Forum, and Dr Angela Meadows of the University of Essex.[96] With research from the University of Cambridge showing that Government obesity campaigns over the last 30 years have largely been unsuccessful due to an over-reliance on trying to persuade individuals to change their behaviour rather than addressing the unhealthy environments and emotional and mental health factors that lead to obesity, we call into question the Government's commitment to truly tackling obesity rates.[97]

85. **We were extremely disappointed that during the inquiry, the Government delayed the introduction of restrictions on multibuy deals on food and drinks high in fat, salt, or sugar, including buy-one-get-one-free deals. It is essential that the Government prioritises interventions that provide a healthy environment, rather than focusing solely on individual action. We are frustrated that the Government has not made more progress in tackling the obesity crisis in our population.**

86. ***We propose that, in line with the introduction of Integrated Care Systems which seek to tackle health inequalities and focus on prevention, the Department ought to bolster the Healthy Child Programme, the programme for prevention and public health of children and young people aged 0–19-year-old and their families. We propose that the Government introduce annual holistic health and wellbeing assessments for every child and young person, using the existing workforce of school nurses, health visitors, as well as those in associated roles such as community paediatrics and primary care. These assessments should monitor a range of physical and mental health markers including, but not limited to, weight and mental wellbeing. They should provide an opportunity to explore the context in which the young person and their family live, how these circumstances can relate to their health. They should aim to engage the wider family (if appropriate, depending on age) to ensure early detection of potential health risks, with signposting to appropriate services if required.***

87. ***We urge the Government to implement population-level policies that ensure healthier choices and lifestyles are made a priority in tackling obesity rates, rather than schemes that focus solely on weight loss and can engender weight stigma and result in***

94 Department of Health and Social Care, New obesity strategy unveiled as country urged to lose weight to beat coronavirus (COVID-19) and protect the NHS, 2020

95 Department of Health and Social Care, New services launched to help people achieve a healthier weight and improve wellbeing, 2021

96 Q117, Q118

97 University of Cambridge, Successive governments' approach to obesity policies has destined them to fail, say researchers, 2021

adverse health outcomes. We were disappointed by the Government's delay in restricting multibuy deals for foods and drinks high in fat, salt, or sugar–including buy one get one free. We urge the Government to reconsider this decision and to implement this measure immediately.

Weight stigma

88. It was not just the efficacy of past and present Government obesity policy that was called into question during the inquiry; the prevalence of stigmatising language within public health campaigns and its resultant damaging impact on health was raised throughout.

89. The Obesity Health Alliance told us that interventions that focus on individual behaviour change reflect and reinforce the assumption that obesity is entirely within people's control and that this has the potential to perpetuate weight stigma.[98] Weight stigma is a negative attitude towards someone based on their weight status and it can be experienced by people across the weight spectrum.[99] People with a low weight status, as well as those with a high weight status, can experience weight stigma. However, due to society's perceptions, and, indeed, the rhetoric used in the media and in some public health campaigns, weight stigma is most commonly directed towards people falling within the overweight or obese weight ranges.[100]

90. Dr Flint described weight stigma in the UK as 'pervasive'.[101] He stated:

> There is a lot of combative language that is used which we would not see if we were talking about other health outcomes. That is because the stigma has become so ingrained in our society. It has become accepted that we think about people differently and, in some instances, treat them differently purely based on their body shape and size. To give you an example, I have done quite a lot of different types of comparisons where I have looked at the framing of obesity in policies and the media as well as the framing of health conditions such as cancer. That is not to say that the two are the same—of course not—but what I am saying is that dignity and respect should be offered to everybody, whether it is somebody coming to healthcare or other things. It should be the same.[102]

91. Dr Flint highlighted the issues weight stigma can present in accessing services:

> In healthcare, people report stigma from professionals including but not limited to GPs, nurses, dietitians, psychologists, physiotherapists and trainee students. Research has demonstrated that clinicians openly stigmatise and discriminate against people with excess weight or obesity, overlook people for referral to weight management services, and report that supporting people with a higher weight is a greater waste of their time compared to healthy weight counterparts. Some clinicians display a lack of respect

98 Obesity Health Alliance IBI0041
99 R Pearl, "Weight Bias and Stigma: Public Health Implications and Structural Solutions", Social Issues and Policy Review, 2018
100 Dr Stuart W. Flint IBI0036
101 Q23
102 Q23

> towards people with a higher weight, and that they are ambivalent about how to support people with a higher weight. Experiences of weight stigma and discrimination in healthcare settings can result in worse outcomes, due to avoidance or delay in healthcare seeking behaviours and reduced trust in healthcare professionals.[103]

92. It is no surprise that people who are overweight and obese respond positively to discussions about weight and health-related behaviours that are supportive and empathetic. The Obesity Health Alliance suggested that educating healthcare professionals about the causes of obesity, including a focus on the genetic and social determinants, could help to reduce weight stigma.[104]

93. We heard from those who challenge the prevalent assumption that a weight-focused approach to obesity management is either appropriate or effective. Dr Meadows and Helen James, of the group Nutriri, both advocated for a 'Health at Every Size' (HAES) or a 'weight-neutral' approach, which typically has three aims:

- encourage body acceptance;
- support intuitive eating (the idea of making food choices that feel good, without judgement or the influence of diet culture); and
- support physical activity for movement and health rather than for performance or to shape the body.[105]

94. FoodActive and Nutriri are two Voluntary, Community and Social Enterprise organisations (VCSEs) which submitted evidence promoting weight-neutral approaches. FoodActive pointed to local council efforts that focused on health gains rather than weight loss and felt these were particularly innovative and effective.[106]

95. **Throughout the inquiry, we have been aware of the importance and complexities involved in tackling obesity rates to improve population health and reducing weight stigma to not perpetuate mental and physical health issues.**

96. ***We recommend that the Government undertakes an urgent review of its current campaigns related to obesity and alters any language or media used that fail to mention being underweight is as big a risk as being overweight. We also recommend that training on weight stigma is integrated into undergraduate and trainee curricula in all medical, nursing and other allied professional programmes to address stigma early on. This requires professional bodies and Health Education England to update their curricula and training standards, coupled with training offered to all current clinical staff, on how best to discuss weight and health.***

97. ***There needs to be further research to establish how best to tackle obesity while eliminating weight stigma and discrimination, and to establish the efficacy of weight-neutral interventions, and we recommend that the National Institute for Health Research put aside funding for this purpose.***

103 Dr Stuart W. Flint IBI0036
104 Obesity Health Alliance IBI0041
105 Penney, T. L., & Kirk, S, "The Health at Every Size paradigm and obesity: missing empirical evidence may help push the reframing obesity debate forward", American Journal of Public Health, 105(5), e38–e42, 2015.
106 Food Active IBI0016

5 Non-surgical cosmetic procedures

98. Save Face, an organisation which keeps a national register of accredited practitioners who provide non-surgical cosmetic treatments, defines non-surgical cosmetic procedures as those which "do not require a surgical incision to be made and are usually considered minimally invasive." These includes Botox injections, chemical peels, microdermabrasion, and non-surgical laser interventions.[107]

99. The number of cosmetic treatments being carried out across the UK has risen considerably over the years and continues to do so.[108] With a recent survey finding that 8% of adults (4% of men and 13% of women) had considered cosmetic procedures, fillers, or Botox because of their body image,[109] the rise in body image dissatisfaction has driven a new market that to date has remained largely unregulated.

What drives people to undergo non-surgical cosmetic procedures?

100. The British Psychological Society told us of the overwhelming pressure on women, and more recently men, to conform to a particular beauty ideal that is portrayed by the media and magazines.[110] They noted that an individual with low self-esteem is more susceptible to the media's normalisation of non-surgical procedures.[111]

101. As in other areas we explored in this inquiry, we heard that the pressure for people with poor body image to change their bodies via cosmetic procedures begins early. One survey of UK adolescents found that 36% of young people agreed they would do 'whatever it took' to look good, with 10% saying they had considered cosmetic procedures.[112]

102. In its evidence, the Joint Council for Cosmetic Practitioners (JCCP) highlighted the difficulty in getting the right balance between access and safeguarding for non-surgical cosmetic procedures. They noted that, when performed appropriately, procedures can improve confidence, lessen the burden of mental health challenges, and improve individual wellbeing. Conversely, poorly performed procedures can add to these challenges on both an individual and a societal level. This is particularly so where outcomes are not as expected, or when an overly commercial attitude is taken towards the vulnerable consumer, for example, someone suffering from BDD.[113]

103. Worryingly, the Nuffield Council of Bioethics pointed to international studies that suggest that between 5% and 15% of patients who present for cosmetic procedures meet the diagnostic criteria for BDD.[114] This correlates with the experience that Kim Booker shared with us:

> With my body dysmorphia and having those very strong compulsions to erase or fix certain parts of myself, I got overwhelmed by it. I went to see so

107 Save Face, Non-Surgical Cosmetic Procedures
108 Health Education England, Review of qualifications required for delivery of non-surgical cosmetic interventions, 2014
109 Mental Health Foundation, Body image: How we think and feel about our bodies, 2019
110 British Psychological Society IBI0028
111 British Psychological Society Society IBI0028
112 Be Real, Somebody Like Me: A report investigating the impact of body image anxiety on young people in the UK, 2017
113 Joint Council for Cosmetic Practitioners IBI0003
114 Nuffield Council Bioethics Bioethics IBI0019

> many different aestheticians that it was unbelievable. I looked very odd for a period of time. I couldn't see it, because the more you have done, the more you get used to that look. Your lips become a lot bigger, but you think that looks normal. It is not until you look back at photos that you think, "Oh my gosh. What was I doing?"[115]

Actions to date

104. In 2013, Sir Bruce Keogh was asked to lead a review into regulation in the surgical and non-surgical cosmetic interventions sector following the PIP implant scandal which exposed lapses in product quality, after-care and record-keeping.[116] The review drew attention to use of misleading advertising and inappropriate marketing and concluded that:

> non-surgical interventions, which can have major and irreversible adverse impacts on health and wellbeing, are almost entirely unregulated. In fact, a person having a non-surgical cosmetic intervention has no more protection and redress than someone buying a ballpoint pen or a toothbrush.[117]

105. The landscape has changed little in the years since. The Joint Council for Cosmetic Practitioners told us that of those seeking non-surgical procedures:[118]

- 22% did not have any pre-treatment consultation;
- 70% had a consultation that lasted less than 20 minutes;
- almost one in four were not asked anything about their previous medical history during their consultation; and
- almost four out of five patients were not asked anything about body image or psychological/emotional challenges.

106. The Joint Council for Cosmetic Practitioners[119] and the Mental Health Foundation[120] emphasised the importance of ensuring that anyone considering cosmetic procedures is fully informed about what they can expect to achieve from a procedure, and that the emotional and psychological needs of everyone seeking or considering cosmetic treatments should be considered at the time of the initial consultation. In her oral evidence, Kim Booker made it clear this is currently not happening:

> There are some people who just do not do that. Literally, you walk into these places and it is like a conveyor belt. You have 10 to 15 minutes for a procedure that, from start to finish, should take at least an hour, to really survey the person's face and understand their reasons for wanting the procedures to be done. I have been to countless places where I have been completely neglected in that way.[121]

115 Q41
116 Department of Health and Social Care, Review of the Regulation of Cosmetic Interventions Final Report, 2013
117 Department of Health and Social Care, Review of the Regulation of Cosmetic Interventions Final Report, 2013
118 Joint Council for Cosmetic Practitioners IBI0003
119 Joint Council for Cosmetic Practitioners IBI0003
120 Mental Health Foundation IBI0046
121 Q44

107. On 1 March 2022, an amendment was tabled to the Health and Care Bill that gave the Secretary of State for Health and Social Care the power to introduce a licensing regime for non-surgical cosmetic procedures such as Botox and fillers. This amendment was agreed and included in the resulting Act. The move follows a ban on the administration of Botox and other substances for cosmetic purposes to under 18s in England and Wales, as a result of Laura Trott MP's Private Member's Bill, in 2021.[122] Professor David Sines told us that the proposals for a regulatory regime are "a great way forward that will take us towards some solutions".[123] We agree and the focus must now be on exactly what should be included in that regime.

108. The Minister of State for Care and Mental Health, Gillian Keegan MP, informed us that the Department are currently working with stakeholders to design a consultation and that it "will cover registration, licensing and banning".[124] We were however disappointed to hear that, at that point in May 2022, there was no timeframe in place for the consultation.

109. ***The risk of exploitation of vulnerable groups seeking non-surgical cosmetic procedures is too great and we recommend that to prevent further exploitation, the Department immediately draws up a clear timeframe for the consultation process. We urge the Government to make this a priority and to introduce the licensing regime for non-surgical cosmetic procedures by July 2023.***

A future regulatory regime for non-surgical cosmetic procedures

Patient safety

110. We were told time after time that patient safety must be at the heart of a future licensing regime. Charlie King shared with us his worrying experience of undergoing a procedure (in this case, a surgical cosmetic procedure) when vulnerable:

> I was always told that I was quite a nice-looking guy, but it was not enough. When I sat in the surgeon's office, there was never any analysis of my previous history and how my mental health had been in the past. Looking back now, I think the surgeon should have given me a different approach and said to me, "You don't need this, unless it is medical or something. We need to make sure you are mentally prepared for this," because it is a big ordeal to alter your face and it can have psychological impacts—for some better, for some worse. Unfortunately, mine did not go to plan.[125]

111. Professor David Sines of the JCCP and Ashton Collins of Save Face both said that no treatment should be provided without a pre-consultation. Professor Sines stated: "There should be no assessment without psychological and emotional assessment, and that safety nets must be built into the context of the pre-treatment, the treatment and the post-treatment plan for aftercare."[126]

122 Botulism and Cosmetic Fillers Act (Children) Act 2021
123 Q80
124 Q144
125 Q104
126 Q83

112. The Nuffield Council of Bioethics urged major providers of non-surgical cosmetic procedures to work together to develop a code of best practice for each provider to adhere to. They recommended that this code ought to include a commitment to a two-part consent process for anyone considering having a procedure.[127]

113. **The dangers posed by non-surgical cosmetic procedures in vulnerable groups have been evident throughout the inquiry. The new licensing regime provides an opportunity to ensure that anyone planning to undertake a non-surgical cosmetic procedure has the time and space to consider their decision, and weigh up the risks and benefits. It is clear this is not currently the case for everyone in that position.**

114. ***We recommend that the new licensing regime for non-surgical cosmetic procedures includes a commitment to a two-part consent process for anyone considering having a non-surgical cosmetic procedure, including, at a minimum, a full medical and mental health history, as well as a mandatory 48-hour cooling off period between the consent process and undergoing the procedure. We further believe that information provided to patients or clients who are considering any treatments should always be provided with information in an accessible format to ensure they are able to make an informed choice about their proposed treatment.***

Premises

115. Kim Booker told us of her negative experience of safety in certain premises where she had undergone previous procedures:

> I remember finding this place. I was expecting to go into this really nice clinic, and it would be really over the top, but it was a really grotty room that was filthy. You had to walk through a filthy hairdresser's to go in. I had about 10 to 15 minutes with her. She just said, "What do you want?" I said, "I want my cheeks, this, this, this," and she just did it, without any questioning at all.[128]

116. This testimony also echoes the call from the JCCP[129] and the National Hair and Beauty Foundation[130] which called for safer premises.

117. ***There should be specific premises standards for all beauty salons and non-CQC registered premises providing non-surgical cosmetic procedures. Local Authority Enforcement Officers should be given extended powers to enforce compliance with a nationally agreed set of premises standards.***

Education and training for practitioners

118. There is currently a total absence of mandatory education and training standards for those administering non-surgical cosmetic procedures, which can lead to a wide variety in the quality of interventions, resulting in potential patient safety issues. Anyone can administer a non-surgical cosmetic procedure. We heard from those who argue that accredited training should be a prerequisite for belonging to any register introduced

127 Nuffield Council for Bioethics IBI0019
128 Q42
129 Joint Council for Cosmetic Practitioners IBI0003
130 National Hair and Beauty Foundation IBI0045

under the proposed new licensing regime and that this should include mental health and safeguarding training for practitioners.[131] We also heard from organisations calling for a qualifications and training framework.[132]

119. Professor Sines shared the belief that any future education and training framework must include mandatory mental health screening. He stated:

> With education and training being set as a new standard, which of course is the spirit of the licence, within that, the curriculum would require that any person who demonstrates the proficiency to achieve that education and training standard should and will be trained in psychological and emotional screening, pre-consultation.[133]

120. ***We are convinced that there is a need for a minimum standard to be met in regards to the education and training of practitioners who perform non-surgical cosmetic procedures. It is essential to ensure patient safety, and thus should be a central pillar of a future licensing regime. The Professional Standards Authority should be given the power to oversee a register of approved training providers. All training providers should have to meet an Ofqual-regulated standard.***

Remote prescribing

121. Ashton Collins from Save Face described the issue of remote prescribing: the process by which a practitioner relies on a prescriber, who may not even have met the patient, to prescribe the medicines the practitioner needs to perform the procedure. We were surprised that Professor Sines told us that "not all of our professional regulators have ruled that it is unprofessional to remotely prescribe to a third party for medicines without meeting or reviewing the patient".[134] Ashton Collins described remote prescribing as a "huge problem at the moment, especially among the non-healthcare professionals who struggle to forge relationships with legitimate prescribers."[135]

Dermal fillers

122. Botulinum toxin, more popularly known as Botox, is at least a prescription-only medicine, meaning it has to be prescribed before it can be used on a patient. Professor Sines explained that dermal fillers, on the other hand, are not prescription-only medicines and are treated as medical devices.[136] He explained that if they were to be treated as prescription-only devices, then "there would be a requirement for oversight from prescribers, which would certainly provide greater protection for the public."[137]

123. ***We recommend that the Department review the licencing of dermal fillers to be prescription-only substances, in line with Botox, in order to provide more protection for people undertaking procedures involving dermal fillers.***

131 Mental Health Foundation IBI0046
132 National Hair and Beauty Foundation IBI0045, Joint Council for Cosmetic Practitioners IBI0003, Mental Health Foundation IBI0046
133 Q83
134 Q84
135 Q82
136 Q84
137 Q81

124. ***We recommend that the Department establish a 'Non-Surgical Cosmetic Procedures' safety taskforce that comprises each of the regulatory bodies that have input into the sector, including the MHRA, the nine statutory bodies, the ASA and stakeholders like the JCCP, Save Face and other industry bodies. This taskforce's remit should be centred on patient safety and should include, but not be limited to, examining the issues of remote prescribing, appropriateness of premises, education and training standards as well as accountability and governance. The existence of a taskforce should provide the opportunity for a more co-ordinated approach. The taskforce should also review the impact and operation of the future licensing regime when it is in place. We also heard evidence about the difficulties in enforcing existing regulations of non-surgical cosmetic procedures, as complaints relating to an aesthetic practice often span a number of different regulators. The new safety taskforce must ensure a coordinated approach to the enforcement of new and existing regulations in the industry, and the Government must ensure sufficient resources are available to the relevant bodies.***

Social media and advertising issues

125. We learnt that the lack of regulation and potential for harm extends to the social media and advertising realm. Ashton Collins told us that 80% of people find their practitioners online[138] and yet a lack of regulation has led to a worrying lack of accountability in the current system:

> Those people operate pretty much like ghosts. They operate on social media. They have burner mobile phone numbers. They only contact you on social media. They come to your house to do the treatment. When something goes wrong, they disappear. They block you from all channels and there is no way of tracing them. They literally shut that page down and operate somewhere else. It is very difficult to develop or even think of a strategy for how you would curtail those sorts of practitioners[139]

126. She also noted the need to do "something to tackle the advertising breaches that are [currently] ubiquitous within the industry".[140] In their evidence, the Advertising Standards Authority (ASA) outlined the overarching principle of the UK Advertising Codes, which is that advertisements should be prepared with a sense of responsibility to consumers and to society. The 'social responsibility' rule sits alongside other general theme-based and product specific rules and enables the ASA to take action if the content or placement of the advertisement has insufficient regard to the audience for the advertisement, to the extent that it is irresponsible or potentially harmful to particular members of that audience. Malcolm Phillips, Regulatory Policy Manager at the ASA noted the work of the ASA and their sister organisation the Committee of Advertising Practice to date in monitoring potentially harmful advertising, discussing the introduction of a new rule which prohibits cosmetic interventions advertising from being directed at under-18s and other newer targeting restrictions, and its ongoing review.[141]

138 Q88
139 Q89
140 Q82
141 Q92

127. **We welcome the decision to prohibit advertising for cosmetic procedures being directed at under-18s and we look forward to the results of the 12-month review of this new measure.**

128. However, we agree with the JCCP that there is a clear need for greater regulation and oversight to reduce the significant number of false and exaggerated advertising and social media claims that give misleading information to both members of the public and to practitioners about the safety and effectiveness of non-surgical cosmetic procedures. Professor Sines suggested a solution involving the introduction of "a kitemark and a warning logo" on any advertisement for treatments that fall within the scope of a future licencing regime.[142] Malcolm Phillips of the ASA outlined the need for such a measure to have some form of independent certification and assessment by a professional body. He suggested that the ASA were "open to further dialogue about how [they can] play a part in that."[143]

129. ***We recommend that the new licensing regime should include the requirement to display a kitemark and a warning logo on any advertisement for treatments that fall within the regime's scope.***

142 Q81
143 Q93

Conclusions and recommendations

Executive summary

1. *We urge the Government to immediately initiate a comprehensive cross-government strategy that brings together, at the very least, the Department of Health and Social Care, the Department for Digital, Culture, Media and Sport, and the Department for Education to tackle the current growing problem of body dissatisfaction and its related health, educational and social consequences. This strategy should include, but not be limited, to education about self-worth, body positivity, critical thinking and appraising images, as well as wider health advice such spotting signs and symptoms of eating disorders, anxiety and depression and body dysmorphia, within educational, health and online/media settings.* (Paragraph 14)

What drives poor body image and who does it impact?

2. *We recommend that the Department of Health and Social Care, along with the National Institute for Health Research, commission and fund new research to understand the causal pathways that are leading to a rise in body image dissatisfaction across the population and the impact of social media on body image. This is of particular importance in relation to groups that are known to be particularly affected by body image dissatisfaction: for example, adolescents, people with disabilities and LGBT people. However, it is also vital for groups in relation to which the understanding of body image dissatisfaction is less clear, such as those from BAME communities and older people.* (Paragraph 31)

Impact of body image on health and lifestyle

3. We urge the Department to ensure more is done to make the diagnosis and treatment of Body Dysmorphic Disorder (BDD) a priority. From a diagnostic perspective, we recommend that Health Education England update the IAPT (Improving Access to Psychological Therapies) and EMHP (Educational Mental Health Practitioner) curricula to make training in BDD compulsory for all mental health practitioners. The Government should ensure BDD is included in the PSHE (personal, social, health and economic) education curricula within the section on body image, to promote early detection and early intervention within schools. As well as improved diagnosis rates, suitable care for those living with BDD must be available. We recommend that BDD specialist practitioners are eventually embedded into the multidisciplinary teams in every new community model for adults severely affected by mental illness. (Paragraph 44)

4. *We call on the Government to better equip future generations and their families with the skills and resources required to tackle body image issues. These skills and resources include critical thinking, particularly when it comes to appraising images, and self-worth. We recommend that the Government explores the use of family hubs as a route to educate parents and young people about body image, self-worth, and body positivity.* (Paragraph 45)

5. *We commend the Government's work to date to introduce Education Mental Health Practitioners within school-based Mental Health Support Teams across the country, as well as the commitment to have a Mental Health Lead teacher in schools. We recommend that the Government review the training of these practitioners to ensure it includes spotting early signs of conditions related to body image issues. We ask the Government to provide us with a further update on their progress in introducing these roles and to set out the timeframe for establishing them in every school in England.* (Paragraph 46)

6. While we commend the funding set aside for eating disorders to date and the actions taken by the Government so far, we are now of the opinion that a more co-ordinated approach is essential to properly understand and tackle this growing issue (Paragraph 53)

7. *We recommend that the Government develops a national eating disorder strategy that aims to understand the causal mechanisms that lead to the development of eating disorders and earmarks adequate funding to bolster existing services as well as to increase investment in research. We further recommend that alongside the quarterly publication of data on existing access and waiting time standards across every region, the Government pledges and provides additional resources to address any increase in the need for treatment identified, in order to eliminate regional inequalities in care.* (Paragraph 54)

8. *We recommend that the Department commissions a national review of the growing use of anabolic steroids in England as it relates to body image. We further recommend that the Department introduces a national awareness campaign around safe anabolic steroid use. This ought to be coordinated through existing steroid user support groups and targeted at areas of highest risk, such as gyms with a high proportion of body builders.* (Paragraph 59)

9. *We call on the Government to work with advertisers to feature a wider variety of body aesthetics, and work with industry and the ASA to encourage advertisers and influencers not to doctor their images. We believe the Government should introduce legislation that ensures commercial images are labelled with a logo where any part of the body, including its proportions and skin tone, are digitally altered.* (Paragraph 66)

10. *We echo the call of our witness Professor Sandeep Ranote for the creation of a national public health strategy akin to the 1970s 'Green Cross Code'. A 'Screen Cross Code' would be a nationwide public health campaign, which would use short effective messages to educate the public on best practice with screen use for children and young people, as well as the potential negative health impacts resulting from excessive screen use or exposure to content that may lead to body dissatisfaction. This should include limits on daily screen use, promotion of social media sabbaticals, having digital sunrises/sunsets, as well as prompts to encourage discussion between parents and their children if there is content that could cause concern relating to body image and self-esteem. We recommend that the Department of Health and Social Care plays a leading role, in collaboration with the Department for Education and the Department for Digital, Culture, Media and Sport, in this work, given its implications for young people's health.* (Paragraph 69)

Body image and experience of healthcare services

11. *We urge Health Education England, the General Medical Council and Nursing and Midwifery Council to collaborate with third sector organisations that are currently educating people about, and promoting awareness of, body image issues, and after a period of assessment, integrate the most effective existing training and resources into all training programmes within the medical, nursing and midwifery fields within the next two years. We echo the Mental Health Foundation's recommendation for any further training for professionals interacting with parents - that is, GPs, health visitors, dietitians and other frontline practitioners - to include information about how parents and carers can, from a very early age, positively influence their children's feelings about their bodies through the behaviours and attitudes they express.* (Paragraph 77)

The balance of tackling obesity and reducing weight stigma

12. We were extremely disappointed that during the inquiry, the Government delayed the introduction of restrictions on multibuy deals on food and drinks high in fat, salt, or sugar, including buy-one-get-one-free deals. It is essential that the Government prioritises interventions that provide a healthy environment, rather than focusing solely on individual action. We are frustrated that the Government has not made more progress in tackling the obesity crisis in our population. (Paragraph 85)

13. *We propose that, in line with the introduction of Integrated Care Systems which seek to tackle health inequalities and focus on prevention, the Department ought to bolster the Healthy Child Programme, the programme for prevention and public health of children and young people aged 0–19-year-old and their families. We propose that the Government introduce annual holistic health and wellbeing assessments for every child and young person, using the existing workforce of school nurses, health visitors, as well as those in associated roles such as community paediatrics and primary care. These assessments should monitor a range of physical and mental health markers including, but not limited to, weight and mental wellbeing. They should provide an opportunity to explore the context in which the young person and their family live, how these circumstances can relate to their health. They should aim to engage the wider family (if appropriate, depending on age) to ensure early detection of potential health risks, with signposting to appropriate services if required.* (Paragraph 86)

14. *We urge the Government to implement population-level policies that ensure healthier choices and lifestyles are made a priority in tackling obesity rates, rather than schemes that focus solely on weight loss and can engender weight stigma and result in adverse health outcomes. We were disappointed by the Government's delay in restricting multibuy deals for foods and drinks high in fat, salt, or sugar–including buy one get one free. We urge the Government to reconsider this decision and to implement this measure immediately.* (Paragraph 87)

15. Throughout the inquiry, we have been aware of the importance and complexities involved in tackling obesity rates to improve population health and reducing weight stigma to not perpetuate mental and physical health issues. (Paragraph 95)

16. *We recommend that the Government undertakes an urgent review of its current campaigns related to obesity and alters any language or media used that fail to*

mention being underweight is as big a risk as being overweight. We also recommend that training on weight stigma is integrated into undergraduate and trainee curricula in all medical, nursing and other allied professional programmes to address stigma early on. This requires professional bodies and Health Education England to update their curricula and training standards, coupled with training offered to all current clinical staff, on how best to discuss weight and health. (Paragraph 96)

17. *There needs to be further research to establish how best to tackle obesity while eliminating weight stigma and discrimination, and to establish the efficacy of weight-neutral interventions, and we recommend that the National Institute for Health Research put aside funding for this purpose.* (Paragraph 97)

Non-surgical cosmetic procedures

18. The risk of exploitation of vulnerable groups seeking non-surgical cosmetic procedures is too great and we recommend that to prevent further exploitation, the Department immediately draws up a clear timeframe for the consultation process. We urge the Government to make this a priority and to introduce the licensing regime for non-surgical cosmetic procedures by July 2023 (Paragraph 109)

19. The dangers posed by non-surgical cosmetic procedures in vulnerable groups have been evident throughout the inquiry. The new licensing regime provides an opportunity to ensure that anyone planning to undertake a non-surgical cosmetic procedure has the time and space to consider their decision, and weigh up the risks and benefits. It is clear this is not currently the case for everyone in that position. (Paragraph 113)

20. *We recommend that the new licensing regime for non-surgical cosmetic procedures includes a commitment to a two-part consent process for anyone considering having a non-surgical cosmetic procedure, including, at a minimum, a full medical and mental health history, as well as a mandatory 48-hour cooling off period between the consent process and undergoing the procedure. We further believe that information provided to patients or clients who are considering any treatments should always be provided with information in an accessible format to ensure they are able to make an informed choice about their proposed treatment.* (Paragraph 114)

21. *There should be specific premises standards for all beauty salons and non-CQC registered premises providing non-surgical cosmetic procedures. Local Authority Enforcement Officers should be given extended powers to enforce compliance with a nationally agreed set of premises standards.* (Paragraph 117)

22. *We are convinced that there is a need for a minimum standard to be met in regards to the education and training of practitioners who perform non-surgical cosmetic procedures. It is essential to ensure patient safety, and thus should be a central pillar of a future licensing regime. The Professional Standards Authority should be given the power to oversee a register of approved training providers. All training providers should have to meet an Ofqual-regulated standard.* (Paragraph 120)

23. *We recommend that the Department review the licencing of dermal fillers to be prescription-only substances, in line with Botox, in order to provide more protection for people undertaking procedures involving dermal fillers.* (Paragraph 123)

24. *We recommend that the Department establish a 'Non-Surgical Cosmetic Procedures' safety taskforce that comprises each of the regulatory bodies that have input into the sector, including the MHRA, the nine statutory bodies, the ASA and stakeholders like the JCCP, Save Face and other industry bodies. This taskforce's remit should be centred on patient safety and should include, but not be limited to, examining the issues of remote prescribing, appropriateness of premises, education and training standards as well as accountability and governance. The existence of a taskforce should provide the opportunity for a more co-ordinated approach. The taskforce should also review the impact and operation of the future licensing regime when it is in place. We also heard evidence about the difficulties in enforcing existing regulations of non-surgical cosmetic procedures, as complaints relating to an aesthetic practice often span a number of different regulators. The new safety taskforce must ensure a coordinated approach to the enforcement of new and existing regulations in the industry, and the Government must ensure sufficient resources are available to the relevant bodies.* (Paragraph 124)

25. We welcome the decision to prohibit advertising for cosmetic procedures being directed at under-18s and we look forward to the results of the 12-month review of this new measure (Paragraph 127)

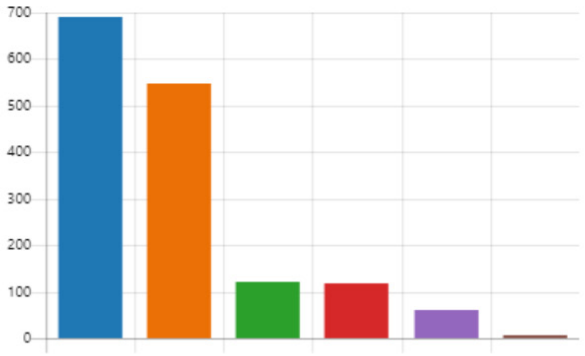
26. *We recommend that the new licensing regime should include the requirement to display a kitemark and a warning logo on any advertisement for treatments that fall within the regime's scope.* (Paragraph 129)

Annex: body image survey results

The Committee launched a public survey on Twitter on 25 April that remained opened for 15 days. The survey reached 1550 responses. The questions and results are as follows:

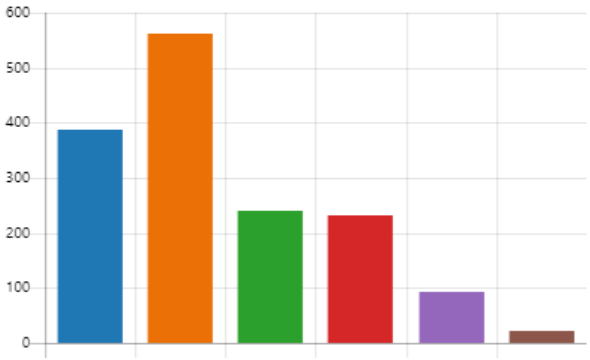
1. How much do you agree or disagree with this sentence: 'My perception of my body image has a negative impact on my **mental** health.'

Strongly agree	689
Agree	546
Neither agree nor disagree	121
Disagree	117
Strongly disagree	62
I don't know	5



2. How much do you agree or disagree with this sentence: 'My perception of my body image has a negative impact on my **physical** health.'

Strongly agree	387
Agree	562
Neither agree nor disagree	240
Disagree	231
Strongly disagree	94
I don't know	23

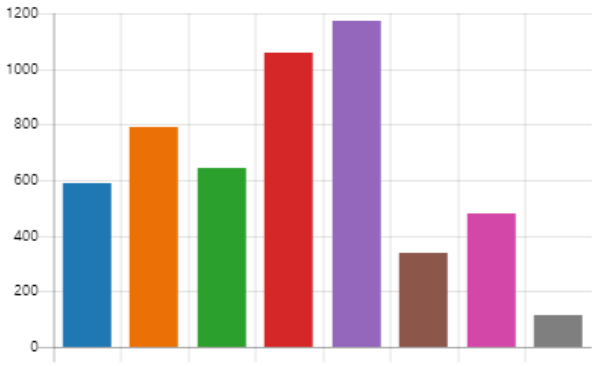


3. Do your thoughts and feelings about your body image have a negative impact on your quality of life?

Yes	1097
No	295
I am not sure	145

4. Which of the following aspects has your relationship with your body image impacted on?

Work	591
Friendships	789
Family relationships	642
Romantic relationships	1060
Fitness/ Exercise	1173
Education	340
Accessing health services	480
Other	115

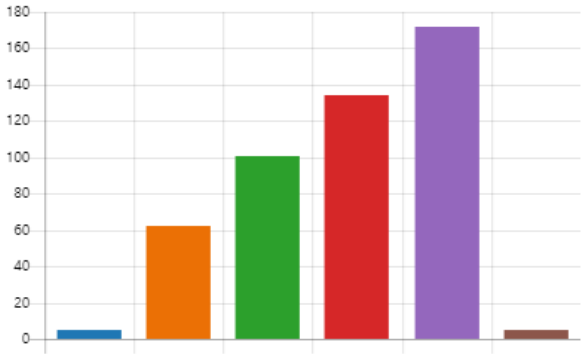


5. Have you accessed, or tried to access, health services for issues relating to body image in the past?

Yes	480
No	1015
I am not sure	45

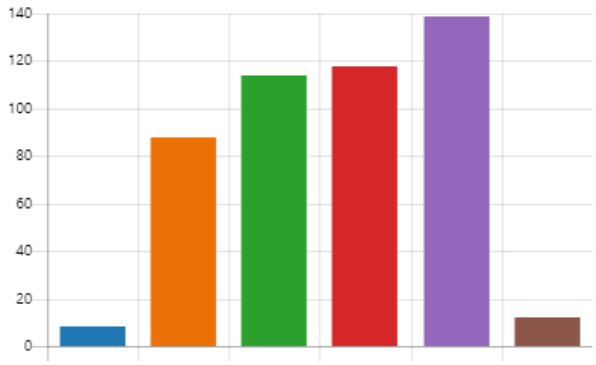
6. How would you rate your experience of **accessing** these services?

Strongly positive	5
Positive	62
Neutral	101
Negative	134
Strongly negative	172
I am not sure	5



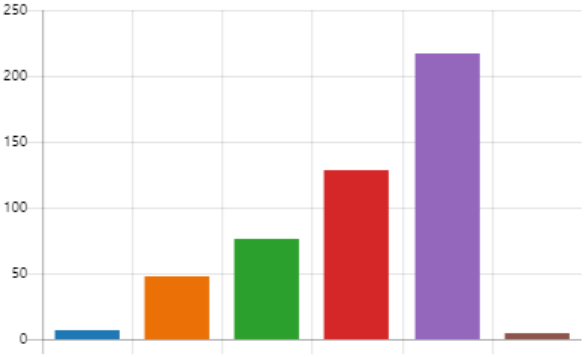
7. How would you rate the **experience** of the services received?

Strongly positive	8
Positive	88
Neutral	114
Negative	118
Strongly negative	139
I am not sure	12



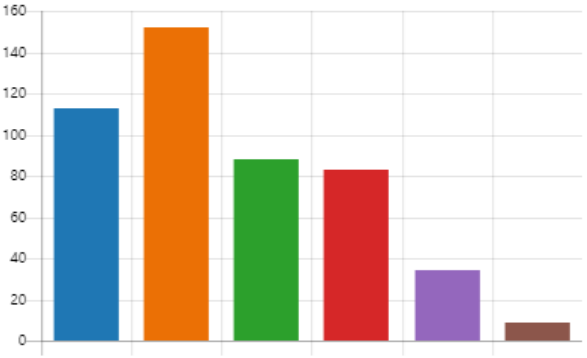
8. How much do you agree or disagree with this statement: 'The services I received were appropriate and fully met my needs.'

Strongly agree	7
Agree	48
Neither agree or disagree	76
Disagree	128
Strongly disagree	217
I don't know	4



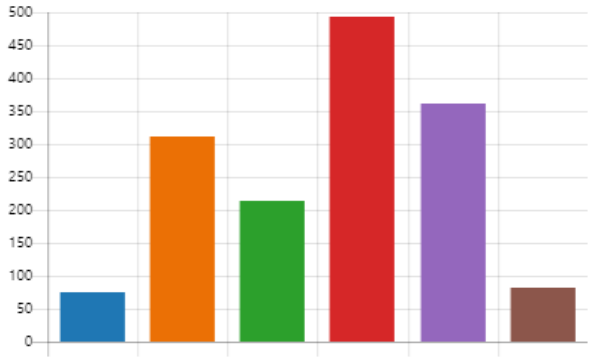
9. How much do you agree or disagree with this statement: 'I felt stigmatised when I accessed, or tried to access, these services.'

Strongly agree	113
Agree	152
Neither agree or disagree	88
Disagree	83
Strongly disagree	34
I don't know	9



10. How much do you agree or disagree with this sentence: 'I would know where to go to seek help for health issues relating to body image.'

Strongly agree	74
Agree	312
Neither agree or disagree	214
Disagree	494
Strongly disagree	362
I don't know	81



11. Do you think the current public health messaging on obesity and its health impacts is appropriate?

Yes	351
No	764
I am not sure	419

12. You said you don't think the current public health messaging on obesity is appropriate. Please can you explain why? [max 250 words].
Please be careful not to include any personal data (such as your name or address) that could identify you.

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Responses

13. Do you think the topic of body image and its related health impacts is receiving sufficient attention from national policymakers (the Department of Health and Social Care / NHS England)?

Yes	121
No	1120
I am not sure	289

14. Is there anything else about your experience and impact of body image on your health that you would like to tell us? [max 250 words].
Please be careful not to include any personal data (such as your name or address) that could identify you.

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Responses

Formal minutes

Tuesday 19 July 2022

Members present:

Jeremy Hunt, in the Chair

Lucy Allan

Luke Evans

Paulette Hamilton

Taiwo Owatemi

Laura Trott

Draft Report (*The impact of body image on mental and physical health*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 129 agreed to.

Annex agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjourment

Adjourned till Tuesday 19 July at 1.30pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 8 March 2022

James Brittain-McVey, Lead Guitarist in the Vamps and Campaigner; **Alex Light,** Journalist and Influencer; **Nyome Nicholas-Williams**, Model and Activist — Q1–19

Professor Heather Widdows, Pro-Vice-Chancellor (Research and Knowledge Transfer) and Professor of Global Ethics, University of Birmingham; **Dr Georgina Krebs**, Associate Professor in Young Person's Mental Health and Cognitive Behavioural Therapy, University College London; **Dr Stuart Flint**, Associate Professor of Psychology, University of Leeds, Honorary Academic, Office of Health Improvement and Disparities; **Professor Sandeep Ranote**, Children's Mental Health Lead, Greater Manchester Health and Social Care Partnership — Q20–40

Tuesday 26 April 2022

Kim Booker, lived experience witness — Q41–59

Lucy Thorpe, Head of Policy, Mental Health Foundation; **Professor James McVeigh**, Professor in Substance Use Epidemiology, Manchester Metropolitan University, Deputy Director, Centre for Public Health — Q60–74

Malcolm Phillips, Regulatory Policy Manager, Advertising Standards Authority; **Professor David Sines**, Chair, Joint Council for Cosmetic Practitioners - The JCCP; **Ashton Collins**, Director, Save Face; **Professor Jean McHale**, Professor of Healthcare Law and Director of the Centre for Health Law Science and Policy, University of Birmingham — Q75–98

Tuesday 17 May 2022

Charles King, lived experience witness — Q99–115

Tam Fry, Chairman, National Obesity Forum; **Dr Angela Meadows**, Lecturer, Department of Psychology, University of Essex; **Helen James**, Founder, Nutriri — Q116–134

Gillian Keegan MP, Minister for Care and Mental Health, Department of Health and Social Care; **Zoe Seager**, Deputy Director of Mental Health Policy and Operations, Department of Health and Social Care — Q135–160

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

IBI numbers are generated by the evidence processing system and so may not be complete.

1 Advertising Standards Authority (IBI0017)

2 Be Bold Be You boudoir photography at Studio1825 (IBI0014)

3 Bell, Mr Christopher (Doctoral Researcher, Brunel University); and Kerner, Dr Charlotte (Senior Lecturer, Brunel University) (IBI0035)

4 Bite Back 2030 (IBI0009)

5 Body Dysmorphic Disorder Foundation (IBI0032)

6 Breast Cancer Now (IBI0026)

7 British Heart Foundation (IBI0025)

8 British Psychological Society (IBI0028)

9 British Skin Foundation (IBI0006)

10 CLOSER, the home of longitudinal research (UCL Social Research Institute) (IBI0043)

11 Changing Faces (IBI0024)

12 Davies, Miss Bryony (PhD Candidate; Research Intern , University of Portsmouth; What Works Centre for Wellbeing) (IBI0020)

13 Day, Dr John (Lecturer, University of Essex) (IBI0005)

14 Department of Health and Social Care (IBI0047)

15 Diabetes UK (IBI0037)

16 Flint, Dr Stuart William (Associate Professor, University of Leeds) (IBI0036)

17 Food Active (IBI0016)

18 Fry, Tam (Chairman, National Obesity Forum) (IBI0053)

19 Gillmeister, Dr Helge (Reader, University of Essex) (IBI0039)

20 Girlguiding (IBI0013)

21 Heffernan, Mr Mark (Policy and Influencing Manager, Impact on Urban Health) (IBI0040)

22 Hill, Professor Andrew (Professor , York St John University); Madigan, Dr Daniel (Associate Professor, York St John University); Mallinson-Howard, Dr Sarah (Associate Head, York St John University); and Vaughan, Dr Robert (Senior Lecturer, York St John University) (IBI0018)

23 Howe, Ms Emi (Speaker / Author / Content Creator, Real Talk Solutions) (IBI0011)

24 Hunt, Dr Emily (Lecturer , Brunel University London); Kerner, Dr Charlotte (Senior Lecturer, Brunel University London); Balla, Dr Gianluca (Senior Lecturer, Brunel University London); Martin, Dr Wendy (Senior Lecturer, Brunel University London); Yu, Professor Keming (Professor, Brunel University London); and Bell, Mr Chris (Research Assistant, Brunel University London) (IBI0031)

25 Internet Matters (IBI0023)

26 Joint Council for Cosmetic Practitioners (IBI0003)

27 Joint Council for Cosmetic Practitioners (IBI0050)

28 Jones, The Rt Hon Kevan (Member of Parliament) (IBI0027)

29 Knight, Mrs Dawn (Lecturer, Newcastle College) (IBI0033)

30 Krebs, Dr Georgina (Associate Professor of Young People's Mental Health and Cognitive Behaviour Therapy, University College London) (IBI0029)

31 Latham, Dr Melanie, formerly Reader in Law, Manchester Metropolitan University (recently retired); McHale, Professor Jean, Professor of Healthcare Law and Director of the Centre for Health Law Science and Policy, University of Birmingham (IBI0034)

32 LGB Alliance (IBI0038)

33 Meadows, Dr Angela (Lecturer (Teaching and Research), University of Essex) (IBI0042)

34 Mental Health Foundation (IBI0046)

35 Mermaids (IBI0010)

36 National Hair & Beauty Federation (IBI0045)

37 Nottingham Trent University; and Macquarie University (IBI0007)

38 Nuffield Council on Bioethics (IBI0019)

39 Obesity Health Alliance (IBI0041)

40 Owen, Dr Alison (Lecturer in Health Psychology, Staffordshire University) (IBI0001)

41 The Cadogan Clinic (IBI0004)

42 The Children and Young People's Mental Health Coalition (IBI0015)

43 The Food Foundation (IBI0021)

44 Transform Hospital Group (IBI0022)

45 University of Essex (IBI0051)

46 University of Wolverhampton (IBI0048)

47 VCSFE Nutriri (IBI0044)

48 Wallis, Mr Harry (Undergraduate, History and Politics, University of Sheffield) (IBI0008)

49 YoungMinds (IBI0012)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

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Number	Title	Reference
1st	Pre-appointment hearing for the Government's preferred candidate for the role of Patient Safety Commissioner	HC 565
3rd	Workforce: recruitment, training and retention in health and social care	HC 115
1st Special	Cancer Services: Government Response to the Committee's Twelfth Report of 2021–22	HC 345
2nd Special	Government Response to the Expert Panel's Report on Government commitments in the area of cancer services in England	HC 346
3rd Special	Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce in England	HC 112

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Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232
4th	The safety of maternity services in England	HC 19
5th	The treatment of autistic people and people with learning disabilities	HC 21
6th	Coronavirus: lessons learned to date	HC 92
7th	Supporting people with dementia and their carers	HC 96
8th	Children and young people's mental health	HC 17
9th	Clearing the backlog caused by the pandemic	HC 599
10th	Pre-appointment hearing for the position of Chair of NHS England	HC 1035
11th	Pre-appointment hearing for the position of Chair of the Care Quality Commission	HC 1091
12th	Cancer services	HC 551
13th	NHS litigation reform	HC 740

Number	Title	Reference
1st Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England	HC 18
2nd Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England	HC 612
3rd Special	Supporting people with dementia and their carers: Government Response to the Committee's Seventh Report	HC 1125
4th Special	Expert Panel: evaluation of the Government's commitments in the area of cancer services in England	HC 1025

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Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311