HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: The impact of body image on physical and mental health, HC 891

Tuesday 26 April 2022

Ordered by the House of Commons to be published on 26 April 2022.

Watch the meeting

Members present: Jeremy Hunt (Chair); Dr Luke Evans; Taiwo Owatemi; Dean Russell; Laura Trott.

Questions 41 - 98

Witnesses

I: Kim Booker, speaking about experience of Body Dysmorphic Disorder.

II: Lucy Thorpe, Head of Policy, Mental Health Foundation; and Professor James McVeigh, Professor of Substance Use & Associated Behaviours Department of Sociology Manchester Metropolitan University.

III: Malcolm Phillips, Regulatory Policy Manager, Advertising Standards Authority; Professor David Sines, Chair, Joint Council for Cosmetic Practitioners; Professor Jean McHale, Director, Centre for Health Law Science and Policy, University of Birmingham; and Ashton Collins, Director, Save Face.

Examination of witness

Witness: Kim Booker.

Chair: Good morning. Welcome to the second session of the House of Commons Health and Social Care Select Committee inquiry into the impact of body image on mental and physical health. We have three panels this morning, including one with a range of clinical research and policy experts and one with regulators. First, we will hear from a lady called Kim Booker, who was diagnosed with body dysmorphic disorder when she was a teenager and has had non-surgical cosmetic procedures. Welcome, Kim. Thank you very much for joining us. I will hand over to Laura Trott, who will ask you a few questions.

Q41 **Laura Trott:** Hi, Kim. Thank you so much for joining us today. What drove you in the first instance to change things about your body? What was it that made you want to have those procedures in the first place?

Kim Booker: 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.

The procedures started at the age of 18. I remember that I was looking through *Vogue* magazine and there was an article about how to disguise your gummy smile with fillers. I felt that I had a gummy smile. Immediately, I looked for a local practitioner because I wanted to change that aspect of myself. It must have been the early 2000s. Even then, I did not know anyone who had had those procedures. It was just something that was accessible for me. I had the procedure done, and it just spiralled from there. It started with the lips. Then it went on to Botox. Then it went on to cheek fillers.

There was a real boom in the filler industry, or the aesthetics industry, around my mid-20s. I don't know whether you have heard of Kylie Jenner or Kim Kardashian. I remember that I used to have my lips done, and nobody really knew about it. Nobody could tell because it was not a mainstream thing, but as soon as Kylie Jenner came out about the fact that she had had her lips done, there was just this huge boom. You could find aestheticians left, right and centre.

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 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?"

Q42 **Laura Trott:** When you were going to get these treatments done, how did you find that process? Was there anyone who ever said to you, "I don't think that you need this," or, "Have you thought about the wider counselling that you might need?" Were you consulted properly when you went for those treatments?

Kim Booker: There were some who said, "You look fine." I would really have to push them to have the procedure. If they could not give me what I wanted, it was not difficult for me to find someone who could.

I remember that situation happening. I found an aesthetician who had a huge following on Instagram, with very glossy pictures of women with those princess looks, almost. It looked so glossy and it really drew me in. I thought, "That's what I want. They'll give me what I want." 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.

That is the thing. You get some really good aestheticians who do not want to alter you; they want to keep you intact with the way that you naturally look. Then you get the other ones. Back in the day—I don't know if you remember this—I used to look through hair magazines, and I would pick out a hairstyle that I liked, take it to my hairdresser and say, "I want my hair like this." Now you can go through Instagram and aesthetic or cosmetic pages or accounts, take that picture to people and say, "I want my face to look like this." That is the world we are in now. You become so warped and so desperate to look like the images that you see, which bombard you daily everywhere you look, that it just becomes the norm. You cannot escape it.

So many women I know, and men, seek validation through the way that we look. That is the monster of social media these days. We cannot avoid it, either. I have a yoga business on there. I can unfollow certain accounts, but you still get targeted by advertising. You still see stories that are heavily filtered. The editing apps are everywhere. I have deleted all of mine now, but, my goodness, I was sat there making my nose smaller and making my eyes bigger. It was like that five-year-old little girl in me.

You have that side of things, and you have easy access to go and actually do it, and I have—I have done it. I am looking more and more like those beauty girls than ever, but it is never ending. You have one thing, but then there is another thing, and another thing, and another thing, and another thing. I am rambling. Sorry.

Q43 **Laura Trott:** Not at all. It is all very helpful. Earlier, you mentioned cheap fillers. Have you ever had an adverse reaction to any of the procedures that you had?

Kim Booker: I have had a couple of situations. My cheek fillers were okay, but they were huge at one point. I looked very strange. I had my lips done, and I had a situation where they got infected. It was so bad. My lips came out here, basically. I had to go on antibiotics, and they actually burst. It was the most painful thing I have ever gone through—the lips are a really sensitive area—but it did not deter me from having them done again. That was one situation. The aesthetician was a lovely woman and had medical training, but it can happen to anyone, I suppose.

The other thing that I have had is under-eye fillers, which are the worst kind of fillers you can get because, obviously, it is such a delicate area. I had my eye fillers with the lady I was telling you about, who was in the grotty set-up. She pumped far too much filler under my eyes. I ended up having big bags under my eyes for a couple of years, until recently. I have started to have the filler dissolved because I am trying to get the normal contours of my face back, to some degree. I have scar tissue. Basically, the filler was put in so superficially that scar tissue ended up encasing it, and I am stuck with two lumps under my eyes, probably forever.

That is the thing. A lot of people go in for having fillers done because it is a semi-permanent thing. Yes, it is, but the fillers I had in my eyes did not dissolve naturally. They were still there six years later. People think, "Oh, it will dissolve in six months if I don't like it," or, "I can just have it dissolved," but it doesn't work like that. There needs to be more understanding of the longevity of certain fillers. That was not out there when I was getting them. I did not know that, and I do not think that a lot of people know that.

Q44 **Laura Trott:** I have one last question. In this Committee, we have been talking about regulating the non-surgical cosmetic intervention industry. Indeed, the Government are committed to doing something in this space, which is very good news, for all the reasons we have just talked about here today. What difference do you think that that would have made to you?

Kim Booker: More regulation in what way?

Laura Trott: More information about the risks of the procedures that you were undergoing, consultation about what was happening to you, regulation of the types of people who can undertake those procedures, and some follow-up and consequences where things have gone wrong.

Kim Booker: That would have made a huge difference. I wish that I had had better consultation. I wish that there was better understanding of mental health and body dysmorphia. I think that aestheticians and cosmetic surgeons need to be rigorously trained in that area so that they can spot the symptoms.

Yes, there should be a follow-up appointment. 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.

It would be good to have a consultation, not to have the procedure there and then, and to allow the client to go away and think about what they want to have done. They can then book the follow-up appointment to go on to the next step. That is it. We are in a world where we want instant gratification, where everything is expected immediately. Especially for things like this—such a delicate situation as our faces and bodies—we need time to think it through. If I wanted to, I could book an appointment with an aesthetician this afternoon and have a treatment done then. It should not be that way, especially when people have compulsive disorders, as I do. It is so dangerous.

Laura Trott: Thank you so much, Kim. What you have spoken about today will make a big difference. It has really helped our inquiry. I know how difficult it can be to talk about these types of issues. We really appreciate it.

Q45 **Chair:** Kim, can I ask a follow-up question? I do not know whether you have kids. I have three young kids. I am intrigued about what you would do if you had a daughter, for example. I remember taking my daughters to Disneyland. It was one of the big highlights to meet all those princesses. If you had a daughter who was considering cosmetic surgery, would your advice as a mum be, "Actually, you should just avoid this. You've got to learn to love yourself as you are," or would it be, "In moderation—a little bit here and a little bit there. If it is done sensibly and properly, under regulated conditions, it can be okay"?

Kim Booker: I am hoping that when I become a mother I will have done enough healing on myself to feel comfortable in my own skin. I think that it was about my nurture growing up. I was brought up in a very body-conscious, image-conscious family. I hope that I will give my child the foundation of feeling comfortable in her skin, as much as possible.

The thing is, if someone makes a decision and wants to do something, especially if they are a teenager or in their early 20s, it is very difficult for you to tell them not to do it, so I would need to support them in the best way that I could. What I would do, especially from a mental health aspect, is look into some counselling, just to dive in a bit deeper and see why they feel that they need to change this. My body dysmorphia can be a genetic thing, so I would have to be very careful and give her or him as much attention as possible to make sure that they were making the right decision.

Ideally, I would not want them to touch themselves. I wish that I had never felt the need to do the things that I have done. I wish that that had not happened in my life, but it is what it is.

Q46 **Chair:** Can I ask you one last question? For those of us who are not doctors, could you explain what body dysmorphia is?

Kim Booker: What is the best way to describe it? 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 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.

Q47 **Chair:** Do any colleagues want to come in? Are you happy to take a few other questions, Kim?

Kim Booker: Yes, of course.

Q48 **Dean Russell:** Thank you, Kim. Your testimony has been so powerful. For anyone watching this, you have given a great explanation of the challenges, but also of the compulsion that is there around body dysmorphia.

My question is about the role of social media in this. We have the Online Safety Bill going through at the moment. I was very fortunate to be on the Joint Committee looking at this last year. Repeatedly, we heard the point that social media is pushing people to look at more harmful content that wants them to harm themselves in some way, as well as to feel harm from others. What more do you think needs to be done around the social media piece? How does that affect how you see yourself and how you look at images related to your own self-identity on a daily basis?

Kim Booker: I get that, with social media, there is a certain aesthetic, with filters and so on, for artistic reasons, but they have now taken a really dark turn with the editing apps. I got to the point where I constantly had these filters. I was putting filters on my face on my stories and things like that, and it completely altered the way I looked. When the video flipped off to my natural face, I got a bit of a shock. I hated what I saw, because you get used to the filtered version of yourself.

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. Ideally, I would like them banned, because we would get more used to seeing each other in our natural state. There needs to be a lot more in place on social media to protect us against

images that are not real. They are just not real. That could do absolute wonders. I would love to see something like that enforced.

Q49 **Dean Russell:** My colleague Dr Evans is doing an incredible amount of campaigning on this point, so I do not want to cover his question, which I am sure he will come to. When you were describing the process of going to have procedures and the run-up to that, it sounded almost quite addictive. If in any other part of our society there were people with an addiction that was being fed very easily in a way that was doing them harm, we would have many more blocks on that. I want to get your take on that point, if you don't mind.

Kim Booker: All you do is ruminate and constantly think about it. You get excited about having a procedure because you think that once you have had it life will be better, that you will feel better—"If I just have this," or, "If I just have that." You end up having the procedure. Honestly, you get a kind of endorphin boost—a rush. That feeling lasts for anywhere up to a few hours or a few days. Then you literally come crashing down, because you have nothing else to think about. You have done that now, so you think, "What else could I have done?" What else is not right about me that I need to correct or cut apart? There is definitely an addictive element to it. I am a very addictive person. I have an addictive personality, and it is so dangerous. Yes, absolutely, there is that.

Q50 **Dr Evans:** Thank you, Kim, for speaking so passionately. I declare an interest, because I am trying to bring forward a Bill that would label images going forward.

Kim Booker: Thank you.

Q51 **Dr Evans:** If you have doctored your body image—your body proportion—it should carry a label.

To play devil's advocate, if you had seen images that were carrying a label—that had a logo on—would that have stopped you from getting to where you are?

Kim Booker: This is the thing. Because I come from a BDD standpoint, it is tricky. Although my logical mind can see that the image is altered, subconsciously my brain is seeing an image and trying to replicate it on my own face. If that label is on there—

Q52 **Dr Evans:** You said that you altered your images, though. If you, as someone who is an influencer on that basis, had to put a label on it and were breaking the law if you did not, would that have stopped you altering the images that you are putting out?

Kim Booker: Yes, definitely, because you could be embarrassed.

Q53 **Dr Evans:** It is a preventive thing.

Kim Booker: Especially when I did it, 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. That is it. You would definitely be much more perturbed about doing that. Yes, the labels would help massively in that sense.

There is definitely some kind of revolt going on at the moment, especially in the accounts I am following. There is a craving for real images, real content. Any time I post real content, about my real skin or anything like that, I get such a big following with that. Yes, please put that through.

Q54 **Dr Evans:** We will use your testament to tell the Government that. Is it your feeling that there would then be social pressure not to alter your images, because if it had to carry a label you would be busted, basically?

Kim Booker: Yes.

Q55 **Dr Evans:** That is the power in doing such a measure.

Kim Booker: Definitely.

Dr Evans: Excellent. Thank you.

Q56 **Taiwo Owatemi:** Thank you, Kim, for your powerful insight. You spoke about first recognising the fact that you wanted to change your body image at the age of five. When did you realise that you had body dysmorphia? What thought processes and support were you given to come to terms with that?

Kim Booker: I probably started to realise it in my early 20s, but body dysmorphia was not a well-known thing. It still isn't, really. Recently, I contacted my doctor because I had a bad spell of it. I was struggling to function normally because it was so powerful at that time. I contacted my doctor and said, "Look, I have this body dysmorphic disorder," but they did not really know what it was. It was not until I found the Body Dysmorphic Disorder Foundation, which is a charity, that I started to get the help that I need. I had to seek it out. I really had to try to find that help. I did not quite find it in the usual way, with the doctor. It is just not something that is on their radar.

It's right doctor, right time—it depends on who you speak to. Some will know more about it. Some do not. I would love there to be more access for people like me, because it is everywhere. I have done a lot of posts on body dysmorphia and had people reach out to me saying, "Look, I think I'm struggling with this. I didn't even know what it was." There definitely needs to be more awareness.

Q57 **Taiwo Owatemi:** Do you think that it would benefit many young people, especially teenagers, to have more information about it so that they can make an informed decision at a younger age?

Kim Booker: Definitely. I used to think that it was just me; it was my personality. Now, since I have been doing the work on it, I can see that it is an illness and a separate entity. As soon as you can create that division between you and the illness, you can start to work towards healing it, because it is not me, it is the condition.

It is such a wide spectrum. There are so many different versions of body dysmorphia. It can be on a lower scale, or up to where some people literally cannot leave the house or show their face to anyone. There is the other end of the spectrum, where people seek validation through their looks. Obviously, the cosmetic industry will feed that. There needs to be a lot more awareness around the topic, to help people who are suffering in silence.

Q58 **Taiwo Owatemi:** I have one more question, on the point about people seeking validation through their looks. You spoke about how you always thought that if you did one procedure things would be better, but then you wanted another. How did you feel in that realisation once the procedure had been done? How much did that impact different areas of your life?

Kim Booker: What would happen is that I would have the procedure, get really excited about it and feel that rush, that elation. Then I would realise that I was still not happy and crash. I would think, "Gosh, it's just another thing. It's another thing that hasn't worked." You find that it is never ending. You get to a point where you think, "If that doesn't work, I don't know how I can live like this. I can't live like this." I have got to those points in my life. It is almost like a rock-bottom moment.

Taiwo Owatemi: Thank you so much for sharing. That is very helpful and very powerful. Thank you so much for taking the time.

Q59 **Chair:** Kim, we are really grateful. Of course, your talking openly like this will be of enormous support to many other people in the same situation. We have enormous respect for the courage you have shown this morning. You are very welcome to stay tuned in, if you want to hear the rest of our discussions, or to disappear, whichever you prefer. Thank you from all of us. It is enormously appreciated.

Kim Booker: Thank you so much for your time. I really appreciate it. Thank you, everyone.

Chair: Not at all.

Examination of witnesses

Witnesses: Lucy Thorpe and Professor McVeigh.

Q60 **Chair:** We move to our second panel. Unfortunately, Phillippa Diedrichs, who is professor at the Centre for Appearance Research at the University of the West of England, is unwell and unable to join us. I am very pleased to welcome Lucy Thorpe, head of policy at the Mental Health Foundation, and James McVeigh, who is professor in substance use epidemiology and deputy director of the Centre for Public Health at Manchester Metropolitan University. Thank you both very much for joining us. It is really appreciated.

Lucy, the Mental Health Foundation did research a couple of years ago

that found that the concerns we have been hearing about from Kim this morning are worryingly widespread. I think the numbers were that 31% of people in your survey felt ashamed of their body image; 37% of teenagers felt upset; just over a third of adults had felt anxious or depressed; and one in eight had experienced suicidal thoughts because of concerns about body image. Is this something we have uncovered that has always been there, or has it been trending upwards recently?

Lucy Thorpe: Thank you very much. We would say that the trends have increased. We are living in a very different environment, as we have just heard from Kim's very powerful testimony. In the past, we did not have an online environment. In fact, many of the harms now will be largely invisible to people who may not engage in social media, for example. We live in a culture that places a lot of emphasis on how people look. There is a lot of appearance-related bullying.

We need to think about the whole environment in which people are living; the family environment, the school environment and what happens on and offline. We must also think about people's vulnerabilities. We have always known that adolescence is a unique time, when children's bodies are changing very quickly. They are very vulnerable to what their peers think of them and comparisons of themselves with others and, of course, they want to fit in.

In thinking about young people, as I say, we need to think about the broader context in which they are living, and whether they are living in a family, or have friends or adults in their lives, who place a lot of emphasis on how they look. Indeed, adults themselves struggle with this. We know that. One in five adults has felt shame about their body image. This is not something unique to children and young people. All generations live together in our society. How we interact and how we talk about these things is just as important as how we deal with many of the harms that we have discussed today.

Q61 **Chair:** I want to ask you about something that is of particular interest to us as the Health and Social Care Select Committee. Obviously, when you hear testimony like Kim's, your instinct is to say that we should be putting people under much less pressure about their appearance. We also have an obesity crisis and there is another group of public health professionals who spend a lot of time worrying about the fact that we are the second most obese country in Europe, and obesity is in the process of overtaking smoking as the biggest cause of cancer.

The debate, if you were sitting in Sajid Javid's chair at the moment, is: to what extent do you focus on obesity and to what extent do you think about body image? How do you find a way through that rather difficult dilemma?

Lucy Thorpe: That is a very important thing to consider. The Mental Health Foundation takes a public mental health approach to all of these

issues. We are very concerned about looking at the root causes that may underlie many of these things.

There is a relationship between the images people see and how people talk about weight, so any obesity strategy also needs to take account of that, and to focus on healthy bodies and healthy eating and less on weight, in fact, and on messaging that could inadvertently—there is no intention to do this, I think—feed into anxiety that children, young people and adults have about their weight. In fact, that can be counterproductive because it may mean they will feel less able to engage in physical activity, for example, because they feel ashamed of their weight. The research supports an approach that is more about healthy activity, healthy eating and healthy bodies, and does not talk too much about being overweight and being obese.

Q62 **Chair:** Before I bring in my colleagues, let me bring in Professor McVeigh. James, can you talk to us a little bit about muscle dysmorphia, the scale of steroid use among men and how that relates to body image?

Professor McVeigh: Thank you for the opportunity to talk to you. Muscle dysmorphia is relatively new. It came to light in the 1990s in the United States as part of a spectrum of body dysmorphic disorders. What we have seen in recent years is, partially, an increased number of people using steroids, but also a recognition that there are different populations of users. Until relatively recently, when we thought of anabolic steroid users and when we engaged in research, it was with bodybuilders. It was very visual and very easy to access.

What we have seen in recent years is a greater appreciation of those different populations. Obviously, it is not just men but women as well. While the focus, quite rightly, has been on young people, what we are seeing now, in a lot of our research for instance, is that there are as many people over the age of 40 using anabolic steroids as under the age of 25. Some of those people have continued using for many years, but other people commenced in their middle years, and that has been due primarily to issues to do with body image.

Quite often, we see people with changes in their lives or social settings that can often trigger re-engaging in the gym. When we talk about enhancement drugs, it is not just about being better than you could ever be. It is returning to the best you have ever been. We are increasingly seeing that in older men.

When we have spoken in detail with anabolic steroid users over the years, they talked about a complex range of factors. There are some of the things that you have already mentioned, but also the replacement of masculinity and muscularity, and confusion between the two. We often hear of people recounting things that happened in their early childhood, things to do with their father and things that have been said to them, that have played on their mind for years. They may not have gone to the gym during their youth. I suppose they have gone down quite a

damaging route. Rather than focusing on training and nutrition, they are looking for a very impulsive, fast gain that can be gained from anabolic steroids. It is quite a complex picture.

Chair: Thank you.

Q63 **Dr Evans:** Professor, I am keen to explore this because body image is often put into the female aspect. We know that there are a million people using steroids and image-enhancing drugs. On the male side, how much do you think that social media plays a part in terms of the images that people put forward? Could you comment a little about that?

Professor McVeigh: Yes. It is interesting because most of our research is with men who have been using for a considerable period. They will at least claim that the forums and the internet play little part in it. What we have not seen, and have difficulty engaging with as researchers, are young people. While it is clear that we have hundreds of thousands of anabolic steroid users, we may be seeing a large increase on the horizon for young people.

It certainly seems to be a combination of home life and external factors, but it is a lot to do with their own mental health and impulsivity around issues to do with their critical thinking. Those are the things that they put forward that they would have liked more support with.

Q64 **Dr Evans:** How much do you think it is to do with the culture that we have, particularly in the western world? We have the Marvel movies, for example, with Captain America and the Hulk. People see those images, and it is now much more accessible to be able to go to the gym. There is a culture of what you should look like and be able to aspire to. "Love Island" is a good example of having a physique that will get you into a certain position. Can you comment a little bit about the societal effect?

Professor McVeigh: Yes. It is probably a factor that contributes, but it would be quite simplistic to put too much emphasis on that and how much of it is reflecting life and vice versa. It is probably a combination of several things, but that will contribute.

In the proportions not of action heroes but just of male actors on television, you do not see male actors who are not sculpted. That drip-drip effect probably has more impact than the obvious Hulk/Captain America-type appearance.

Chair: Thank you.

Q65 **Taiwo Owatemi:** Lucy, are you able to explain to the panel how body image could eventually result in the development of mental health issues?

Lucy Thorpe: Certainly. Body image is something that we all have, and it is created by a number of different factors. A healthy body image means that you are comfortable in your body, and you feel satisfied with what it can do and how it looks—with yourself. Body dissatisfaction can

be created by a number of things. Essentially, it can be about the internalisation of an ideal that you may see elsewhere and feel that you fall short.

It can be something that builds up over time. It is a process. It does not happen overnight. If you see one or two images, for example on your social media, that is unlikely to a create body image problem. The thing is—Kim used this word as well—that there is now bombardment of these images, particularly on social media but also in all sorts of other places; we have heard about some reality TV programmes. That can build up over time.

We know that people can be particularly vulnerable at certain ages. One figure that has not been mentioned, and which our research found, is that 41% of women after pregnancy felt more negative about their bodies; 18% of that 41% felt very negative about their bodies after giving birth. This is something that permeates lives in a way that is often quite subtle. If you are a young person or anyone else who uses social media, it probably does not feel very subtle. It just feels as though it is all around you, and it is very difficult to escape.

The Online Safety Bill has already been mentioned. We would like the Online Safety Bill to introduce some safeguards in this regard. We heard about body and face editing apps. We feel that there should be an age limit of at least 16 for accessing those, to try to find a balance between protecting children at the most vulnerable stage and as they become older.

We would also like to see the Bill introducing controls so that algorithmic content is something that users themselves can control. We know about the marketing techniques. I was looking at something yesterday from a marketing company, and I will give you this quote: "One of the main reasons social media marketing is so effective is that brands can hyper-target ideal clients based on exact demographics. Showing ads to the right individuals is a critical part of the marketing process and must be taken seriously to avoid wasted ad spend."

The Government Equalities Office found that people would like more control over the content that they are fed. We would absolutely like that kind of control to come in. It cannot be right that because you like something, or have inadvertently found it, you are then bombarded with lots of similar issues and have no control over that.

Q66 **Taiwo Owatemi:** Absolutely. I know that is something that we are looking at later on in our meeting today.

You spoke about age being a factor. A study by Girlguiding found that, at ages seven to 10, 51% of girls are very happy with their body or how they look, but by the time they get to 11 to 16 that decreases to 16%, which is a huge decrease. What do you think is happening within such a short period of time to cause such a massive change in perception of

body image?

Lucy Thorpe: At the ages of 10, 11 and 12, you are transitioning to secondary school. It will be different for everybody, of course, but you may have your first smartphone, and your peers become ever more important in your life. We know that some apps can be fun, changing your shape and maybe giving yourself some cat whiskers or eyes or something like that, but some much more harmful things are readily available. There are apps like Body Tune which are available to quite young children. That is something that needs to be looked at.

Q67 **Taiwo Owatemi:** Do you think that young people would benefit from early intervention from a young age, talking to them about the impact of the changes that their bodies are going through?

Lucy Thorpe: Yes, absolutely. Thinking about puberty and education about that, and how bodies change, there can be very difficult periods that people go through. Maybe they are developing acne and their bodies are developing in ways that they do not like. They should be supported to understand that this is a normal process. People should talk to them about it.

Media literacy is a concept that people are very familiar with, but we also need to think about social media literacy. One thing that we understand about young people is that they do not tend to like feeling that they have been manipulated into doing something. That may be one of the more powerful messages that it is possible to use in relation to any advertising that might be deliberately targeted at them. It is getting underneath the motivations for that advertising and the commercial pressures and commercial interests that might be contributing to that. It is being able to understand some of that and unpack it. Obviously, it will depend on the age of the child. You need to begin with many more simple messages when children are younger. We have heard already today that this can start very young. We definitely need to be thinking about that as well, yes.

Q68 **Taiwo Owatemi:** People from ethnic minority groups are affected differently by body image and mental health. Research shows that the challenges faced by different ethnic groups tend to be different from those faced by their white counterparts, in terms of having to lighten their skin tone or change their hair texture. In some cases there are people who have the desired hour-glass shape or the lips, but still feel the need to enhance those images. What factors do you think are causing that?

Lucy Thorpe: We have to look at wider societal factors and the kinds of images that we see everywhere, and ideas that are inherent in those images about what is the ideal of beauty. It will be different for different people, but it is very important to have images of real people and many diverse images.

One of the young leaders we work with talked about a healthy body image not being a destination but a journey towards acceptance. We would say that acceptance is a really important concept, both self-acceptance and acceptance from other people. It is valuing people not only for their appearance.

Taiwo Owatemi: Thank you.

Q69 **Laura Trott:** I want to follow up on a couple of things you said, Lucy. There are protections that we talked about that we need to put in place, but the concept of building resilience into these images is also really important.

You talked just then about social and media literacy, but have you developed ideas about what that would look like? How should we do that? Is it more information for parents? Is it more going through schools? What do you think we need to do to get that in place and to help support our young people to manage some of the images that they are seeing and their reactions to them?

Lucy Thorpe: The Mental Health Foundation would say it is about all of those things. It is about parents, wider family and friends and the kinds of messages that they are giving. It is about schools. We have the relationships, sex and health education curriculum now, and I think that contains a component on body image. It is very important to understand how that is working and how that type of education examines these things.

We would always say that it is important to work with young people themselves and ask them what kinds of things it is most helpful for them to know, and perhaps what they wish they had been told when they were younger. It is about involving a number of different actors.

Q70 **Laura Trott:** Professor McVeigh, do you have any thoughts on building resilience to some of the images that are pervasive in our society at the moment?

Professor McVeigh: Yes, and this is work we have done directly with anabolic steroid users. They have talked a lot about what they would have wanted when they were growing up. It falls into two camps. One is around skills for combating impulsivity and looking at how they can negotiate social situations with peers. The other aspect they focus on a lot is about training and nutrition to increase muscularity. We cannot get away from the fact that there is a drive for muscularity that many young men feel. In many cases, they can gain good physicality, and they can gain good health status from that. Again, it is the point that you made earlier. It is being able to ensure that it stays within the healthier area.

A common theme with all the anabolic steroid users is that we hear that the key for them is delaying the onset of first use. Even people who have very few regrets about their use say that the key thing is people not starting use, if it is something they choose to do, until they are in their

20s, for a number of short-term health consequences and the longer-term health consequences.

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. Those are the things that come up frequently in interviews with steroid users.

Q71 **Laura Trott:** Is there anything that you think the Government could do to help facilitate information about the culture you have just talked about?

Professor McVeigh: There are a number of things that I feel need to be done. We are in an ideal position in the UK around harm reduction because we have taken quite an unusual but what seems to be a beneficial step. While the supply of anabolic steroids is controlled, their personal use is not an offence. We have high numbers of anabolic steroid users presenting to needle and syringe programmes, unlike anywhere else in the world. What we have not done is the research to see how we are changing and supporting people effectively. It is not enough just to give them clean injecting equipment. We have to support them in either healthier continuance or discontinuation of use.

The other thing is that for general practice there will be large numbers of anabolic steroid users, or former anabolic steroid users, presenting with very low anabolic steroid-induced hypogonadism—non-production of testosterone. That is something we have to be prepared for.

Laura Trott: Thank you.

Q72 **Dean Russell:** Lucy, as I mentioned earlier I was involved with the Online Safety Bill last year. When we talk about this topic, the thing that often occurs to me is the quote by Andy Warhol that in the future everyone will have 15 minutes of fame. I often think now, sadly, that it is 15 minutes of shame. It seems to be that people are shamed online for how they look, what they say and sometimes what they do not say. It is especially very much on their appearance.

I wonder whether it is not just the intolerance within society, but whether you think that is being given credibility—that okayness, as it were, to shame people—by the fact that there are medical practitioners, as we heard from our first witness, Kim, who are very quick to do procedures on people, especially those with body dysmorphia, and making it okay that you should change yourself to fit in.

Lucy Thorpe: There is certainly an environment now where that is made very easy. Adverts are targeted at people to promote this.

Q73 **Dean Russell:** My key question is, do you think that credibility is being given to people actually changing how they look to fit in online because of the fact that medical professionals are doing the procedures so easily?

Lucy Thorpe: It is certainly very much an environment where that is very possible, and many people are doing it. That is going to lead to it being considered something that is normalised. We would be very concerned about that.

The people doing these procedures are not necessarily medically trained, but there can be an expectation on the part of people who are going to have these procedures, or maybe an assumption, that that would be the case. I know that you are going to talk about regulation and the very important change that the Government have made to introduce a licensing scheme, which we really welcome. It is very important that the training and education that follows from that, and the consultation on it, should think not only about physical harms but about the mental health dimension and the psychological motivations, as well as the consequences. We look forward to seeing how strong that can be.

We also feel that app developers and social media platforms need to take this very seriously. The harm is absolutely there to be seen. There is no way that research of the type that we might look to be in place before action is taken on certain issues can possibly keep up with the developments in the technology. We would, at the Mental Health Foundation, encourage the adoption of the precautionary principle and say that, on the balance of the evidence we have about the harms that already exist in relation to this issue, action needs to be taken in a precautionary way. We do not want to see more and more harm accumulating from the issue, when we have opportunities to help to prevent some of that.

Q74 **Dean Russell:** I want to ask a very brief question in terms of practicalities. If somebody is sat at home watching this Select Committee and they are feeling that they do not like how they look and perhaps want to have some surgery or other non-invasive activity to change their look, what would you say they should do? Who should they speak to? What is the process practically that they should take?

Lucy Thorpe: First of all, we would suggest that they talk to a friend or somebody they trust about how they are feeling. Other things that people can do are to mute certain apps or to come off certain social media, if they reflect on how it is making them feel and they feel it is negatively affecting them. They can take action there.

If talking to somebody you trust and know does not help, then of course we would encourage people to go to their GP. It is possible, depending on how severe the feeling is, that sometimes things like cognitive

behavioural therapy can be helpful. Obviously, we would not say that everybody would go straight to that because it is a process.

It is having permission from society, and Government, to be honest, to acknowledge that this is a problem. It is something that many people feel. With many mental health issues, often people feel that they are on their own with them and that it is only them experiencing this. Actually, if they are able to take some time and find other people to talk to, they find that they are not on their own and that there are ways in which they can begin to address this.

We know that, generally, and when we talk to children and young people for example, when we compliment people it is always worth thinking about things other than appearance. It could be people's characteristics or things they have done that are impressive or brave. Building people up in all sorts of other ways is really important, but that also has to come from society. It is very difficult if what you see is the beauty ideal being held up as something that everyone needs to aspire to. That is a big challenge for people.

Chair: Thank you very much. It has been a very helpful panel. Thank you, Lucy and James, for joining us. It is much appreciated and very important testimony.

Examination of witnesses

Witnesses: Malcolm Phillips, Professor Sines, Professor McHale and Ashton Collins.

Q75 **Chair:** I welcome our final panel this morning: Malcolm Phillips, the regulatory policy manager at the Advertising Standards Authority; David Sines, chair of the Joint Council for Cosmetic Practitioners; virtually—we hope—Jean McHale, professor of healthcare law and director of the Centre for Health Law Science and Policy at the University of Birmingham; and Ashton Collins, a director at Save Face, which is a national register of accredited practitioners who provide non-surgical cosmetic treatment.

Let me start with a question to everyone. A number of you have been listening to the testimony we heard before. We started off with very powerful evidence from a lady called Kim Booker about her experience of having a mental health condition that led her to want to undergo a series of cosmetic surgeries, some of which sounded essentially pretty cowboy-like in the way they were done. She felt that she ended up in a vicious spiral where she wanted endlessly more surgery and it was never enough. As a Committee we want to consider recommendations to the Government as to how to change the regulatory framework, so that people like Kim are better supported to avoid getting into that vicious cycle. *[Interruption.]*

We now have Jean McHale. Can you hear me, Jean?

Professor McHale: I can. Thank you.

Q76 **Chair:** I do not know if you have been following our session this morning to date, Jean, but what we are trying to get to the heart of in our recommendations from this inquiry is what the changes should be to regulations and the law to make cosmetic surgery safer when it comes to people who have body dysmorphia and have mental health issues that can lead them on an inappropriate and sometimes dangerous journey. If I may, I will open with you, Jean, and ask what you think an ideal regulatory and legislative approach to non-surgical cosmetic procedures should look like.

Professor McHale: First of all, what an ideal approach is depends essentially on what questions we are asking. The first question is: why are we regulating? Are we addressing questions of safety as such? Those are really important questions. Obviously, it is a very good thing that the Government are now willing to take this forward in the legislation.

Is it also the case that we are addressing questions of ethics, and how do we have an ideal regulatory framework that flows from that? It is not simply about safety. It relates to some of the issues that you have just picked up. It is also about looking at the question of what you do in a situation in which perhaps you have somebody coming back for a whole series of repeat treatments, and the person performing those treatments is very worried about the approach that person is taking and that there may indeed be other underlying health issues. It is how you address that.

That comes to the second question in terms of a regulatory framework, which is: what are we regulating and what do we precisely mean by "cosmetic procedures"? That is something which obviously will be a matter for the consultation exercise for the Government. There is potentially a very huge spectrum of procedures.

It then comes down to the extent of proportionality as well and what comes within this. Botox and fillers are very likely to come within it. Are questions such as hair restoration going to come within it? Is teeth whitening going to come within it? At the far extreme, one might say that someone having shellac nails put on is a cosmetic procedure. There has been no suggestion that that sort of thing would necessarily come within this regulatory framework.

Q77 **Chair:** I am so sorry, and I hope you don't mind, but could you try to answer the questions rather than ask us questions? You are the expert, and we really want to know what should change. What do you think needs to change? We all agree that there is a safety element and an ethics element. If you were doing Sajid Javid's job for a day, what changes would you actually make, given your huge experience of the area?

Professor McHale: First of all, an ideal potential way of doing it would be to establish a body effectively to regulate the area. In doing that, the

body itself could have the ability both to regulate practitioners and to have oversight of the licensing of premises and when certain products were used. That would have to be in conjunction with existing law in the area.

That would be an ideal type of model. A regulatory body could produce a code of practice for practitioners themselves, which could be linked to professional education and training. This, of course, could build on the work that is out there by existing bodies. We have bodies who are involved in this area—the Joint Council for Cosmetic Practitioners and Save Face, and they are with you today.

Q78 **Chair:** I will come back to you, but that is really helpful. I am going to ask some opening questions, and then we will drill down. Let me ask the other members of the panel the exact same question. What is the ideal regulatory environment? The heart of what we are going to recommend is some changes. I will start with Malcolm Phillips from the ASA.

Malcolm Phillips: Thank you, Chair. Listening to what has just been said and what has happened here today, and thinking about what the ideal regulatory framework is, at the Advertising Standards Authority we know that we have a role to play in improving the situation with the impact of the media on people's body image in the UK. We have done a lot of work in this area, and we are nowhere near the end of it. It is also important for us to say that the regulation of advertising cannot be a proxy for the regulation of business practices in an industry. I think there is sometimes a tendency in policy making to wish that it were so.

In terms of the ideal regulatory framework for cosmetic intervention advertising, we feel that we are doing a lot of work to try to develop that. We have recently published a call for evidence. We are evaluating the responses to that right now.

Q79 **Chair:** Give us a flavour. What would you like to see in terms of new regulations to make sure there is responsible advertising for cosmetic procedures?

Malcolm Phillips: I don't want to duck the question, but we are evaluating responses to a call for evidence that we put out specifically to ask people this question. What are the areas in which there needs to be more change? We obviously want to play our role in setting rules and writing guidance to address that. We want to do so on the basis of the best evidence we can.

Q80 **Chair:** If you are not ready to tell us, I am not going to waste time. I will come back to you later. Let me come to Professor David Sines. What do you think the regulatory changes need to be?

Professor Sines: Thank you very much for the opportunity. It is a multifarious and complex area. There is not one simple solution, but there are some things that could be really helpful.

First of all, I give credit and pay tribute to Laura Trott for the work she has done with the under-18s. It is a superb piece of work, which has led the way for the work we have now achieved with regard to licensing. I know that we are still waiting for the final decision on the Health and Care Bill, but the amendment, as far as I am concerned, is now a clause and we have been very involved in drafting that. We are delighted that it is before you. It is a great way forward. It will take us towards some solutions, but not far enough.

The conversations that I have been having with a number of regulators over the last weeks tell me where some of the gaps are. I think this is about trying to draw a conclusion on some of the gaps and remove some of the fracturing. The first example is that there needs to be a real level of understanding between the role of the CQC and the non-healthcare professional colleagues who are working in the beauty industry. I use the word "professional" in the sense of providing that title, but not as registered professionals.

For example, non-healthcare professionals can undertake a range of restricted CQC treatments without any sanction provided by the CQC, because they do not have the authority to actually inspect or regulate non-healthcare professionals. There is no point having a licence with a scope of treatments without understanding how the regulatory opportunity to inspect will come on board. That is the first question, and I have had that conversation with the CQC to start the conversation.

Q81 **Chair:** Do you think they should have the authority to regulate and inspect?

Professor Sines: Yes, I do. It is a critical gap in public safety and protection because no matter how we restrict the treatments to the licence, they are still going to be operable. That is No. 1.

The second is the MHRA. Again, I have a memorandum of understanding with the MHRA. It is a superb organisation. They are now considering another major change, which is looking at the dermal fillers that we believe firmly should become prescription-only devices. That, again, is a critical issue. If they were, Chair, there would be a requirement for oversight from prescribers, which would certainly provide greater protection for the public.

The third, and I am sorry, but these are all relevant, I am afraid—

Chair: No; it is what I asked for, so this is perfect.

Professor Sines: Education and training has been raised by colleagues. I chaired the HEE work on this particular matter at the time. What we are now saying is, who will oversee the education and training providers and the qualifications once the new licence has been agreed and the standard set? There is another opportunity. I think powers should be extended to the Professional Standards Authority to oversee registers of approved

training providers. At the moment, they can only oversee registers of actual practitioners. Somebody has to do that.

Linked to that, and finally on education and training, is Ofqual. Ofqual is our regulator. At the present time, they have no power to impose an industry standard for the aesthetics industry. They will certainly impose one should that be mandated, but in the absence of that anyone can produce a qualification and provide it, against or outwith a regulatory standard. Ofqual will need to take that on board.

Finally, I make this point. We have heard from our colleagues at the ASA. I know that Luke does excellent work in this area around the online safety issues. For us, there needs to be a kitemark and a warning logo on any advertisement for treatments that fall within the scope of the licence. I agree with Jean about what the scope might look like. We pretty well know what the scope will be. It is defined in the amendment at the present time. It is any treatment that enters the epidermis or beyond. There needs to be a real tightening up, within Parliament if you don't mind, between the actual private Member's Bill going forward and the licence. As far as I am concerned, they cannot work without parallel agreement.

Q82 **Chair:** I am going to bring in my colleague, Dean. First I want briefly to ask Ashton something. You represent practitioners. Is there anything you disagree with in what you have heard, or anything you would add?

Ashton Collins: There is nothing I disagree with. For me, a starting point would be to bridge the gap between the legislation that exists. People often complain that the industry is a wild west, but there are actual pieces of legislation and regulation that apply to the procedures, and they are not properly enforced. It would be a good starting point to establish a taskforce across each of the regulatory bodies that have input into the sector, which would be the MHRA, the nine statutory bodies, the ASA and stakeholders like the JCCP, Save Face and other industry bodies, to tackle the issue of remote prescribing and the illegal importation of medicines into the UK. That is a huge problem at the moment, especially among the non-healthcare professionals who struggle to forge relationships with legitimate prescribers. We also need something to tackle the advertising breaches that are ubiquitous within the industry.

Chair: Thank you; that is very helpful.

Q83 **Dean Russell:** I just have one question for Professor Sines. It is regarding safeguarding. We heard this morning incredibly powerful testimony from Kim. It sounds to me like there is an absolute close connection between the cosmetic procedures and mental health. I wonder whether more needs to be done. When somebody has a cosmetic procedure, should they have to get pre, during and post mental health support to make sure that they go through that safeguarding?

Professor Sines: Thank you very much for that comment. I am sure that Ashton and I will be totally agreed on this. We had a conversation before we came in. Absolutely.

We have heard about a code of practice that relates to ethical, moral and of course professional principles. We are absolutely clear that no treatment should be provided without a pre-consultation. 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. We are pretty clear what that needs to look like. I work very closely with the Mental Health Foundation, with Lucy and colleagues, and we would agree totally that those toolkits are there. That is the first thing.

Then, how can we be sure that it will be put in place? Commercially, there has been a lot of evidence to show that assessment of mental health—let's just talk about emotional, psychological health and wellbeing—is not being undertaken. We found that up to 78% of people had not had such an assessment. There needs to be a link back to previous history, and anticipation of outcome and motivation for treatment. There is every reason to believe that in some cases—a lot of cases—there will be sublimation and treatment of a "perceived imperfection". I use that term very carefully. It can, of course, lead to immediate satisfaction, but that can then lead to a realisation that things are not quite as good as people thought initially. That can lead to a transfer to yet another issue. It becomes quite challenging. The importance of not just a pre-assessment but the follow-up, and providing the safety net—your earlier question to Lucy—is really important.

We believe that 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.

Dean Russell: Thank you.

Q84 **Laura Trott:** Thank you, Professor Sines, for the detailed overview. I want to dig down on a couple of pieces that you said. You said that dermal fillers should become prescription-only medication. Do you think it should be just dermal fillers, or do you think there is a wider raft of things that we should make prescription-only as part of these reforms?

Professor Sines: I think there are two things. Specifically, at the moment, dermal fillers—to remind the Committee—are not medicines; they are devices. People are often quite challenged by that, but it is an important point. A prescription-only device, should the MHRA make that determination, would require the same operation through a prescriber having to provide.

First of all, any filler that is inserted would be critical. Alongside the consultation that DHSC will undertake on the scope of treatments, I think at that point we need to determine whether any of the other devices or medicines being used should be prescription-only—for example, vitamin infusions. How complex is it to start asking when something is a medicine or not? We need to look at that, if you do not mind my suggesting it, at that time.

The critical point that Ashton made, and it is really important, was on remote prescribing. I am sorry I missed this, but not all of our professional regulators have ruled that it is unprofessional to remotely prescribe to a third party for medicines. I do not want to name the regulator, but there is a specific one. Another recommendation is that all of our professional regulators should have prescribers within their authority or span of control. They should issue explicit guidance that remote prescribing should not take place under any circumstances.

Q85 **Laura Trott:** Most people are surprised that, first, you can inject fillers and that because fillers are not a licensed substance they could literally be anything, and, secondly, that with Botox the doctor would not necessarily need to see the person being injected or undertake a consultation with them. They have nothing to do with the actual injection of the Botox either.

Are you suggesting that the doctor or medical professional who prescribes it should have to inject the Botox or the fillers, or are you saying that that just needs to be in person and there should be a proper consultation beforehand?

Professor Sines: It is a bit complex. I will be brief. First of all, ideally the prescriber should be the person who actually injects. To remind you, prescribers are trained to a very significant standard beyond their initial registration in nursing, pharmacy and allied health. Doctors and dentists, of course, are trained as prescribers pre-qualifying, so they know what to look for with regard to complication. However, many of our nurses, for example, are not prescribers. That is a statement of fact. They rely on a prescriber to prescribe on their behalf, but at least they have the qualification to administer the medicine, in this case Botox or any other form of injectable. That is my second point.

The critical point is for non-healthcare professionals who obtain access to prescribed medicines from a prescriber who has never actually seen the client, the member of the public, and have never actually had their competence assessed by the prescriber. It is absolutely essential, and all of our regulators would agree, that it would be a matter of misconduct if a prescriber did not assure themselves that the person to whom they were delegating the prescription was fit and proficient to administer. Trying to measure that, Laura, is very difficult without tighter control.

Q86 **Laura Trott:** I agree with that. Ashton, you talked about enforcement. I think that is a really important area. We have been having conversations

recently about enforcement of my private Member's Bill. Can you talk a little bit more about the problems with enforcement currently, and what you would like to see in terms of enforcement under a new regulatory regime?

Ashton Collins: Enforcement is currently a challenge, I guess, because often complaints relating to aesthetic practice span a number of different regulators, whether it is trading standards, MHRA or any of the nine statutory regulators, where there is remote prescribing or illegal medicines are being used. Because all of those bodies work in silos and are restricted to the four corners of their own remit, not enough interaction goes on between them, which is why I think a taskforce would be essential to ensure that, from the start of the complaint right through to the end, it receives all the touch points it needs to actually prosecute in some cases or enforce the necessary action. I guess that is where it falls down.

The other frustration that we sometimes find is that there is not enough awareness in the regulators' teams about what the rules are and how they should be applied. When you make a complaint to a statutory body, for example, and it goes in at the enforcement team level, there isn't familiarity with the aesthetic treatments and how that ties in with the scope of practice. Therefore, those complaints can fall by the wayside, particularly those relating to remote prescribing.

Q87 **Laura Trott:** Interesting. Who would be on the taskforce, in your mind?

Ashton Collins: It would be representation from trading standards, from the MHRA, from each of the nine statutory regulators and from stakeholders like the JCCP and Save Face. They would gather evidence and complaints, and deal with members of the public and practitioners who experience issues on the ground, so to speak, and can then feed in data and information to the taskforce and have constructive meetings on who is the responsible body to take the complaint forward and what the appropriate action will be.

Q88 **Laura Trott:** I want to move on very briefly to social media. Obviously, it is a massive topic and one we will not have time to cover in full today, although I know that you will all be feeding into the consultation. Your research shows that 80% of people find their practitioners online. I think that is right, isn't it?

Ashton Collins: That is correct; yes.

Q89 **Laura Trott:** We know that in a lot of cases those are unscrupulous providers. They do things in a way that is not in line with the standards of your organisation and the others that are here today. What do you feel the Government need to do, on social media in particular, to make sure that providers advertising there do it in a way that is consistent with the high standards we would like to see?

Ashton Collins: It is a very tricky one. I think we have had these discussions before. On social media, there are guidelines around actual paid-for advertising on how you can promote Botox, fillers and other injectables, but if you are on an organic page promoting a business that is not a paid-for ad, you can basically post what you want. It is not policed. It is through those sorts of channels that the public find their way to unscrupulous practitioners. They promote cheap deals and time-limited offers.

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.

Q90 **Laura Trott:** Malcolm, does the ASA have a view on what Ashton has just raised? Obviously, this is a very serious issue. It is affecting the health of many people, particularly young people. What has been the response of your organisation to that?

Malcolm Phillips: First of all, organic posts by businesses are in the remit of the ASA system, but the ASA system is there primarily to regulate legitimate advertising by legitimate businesses. If you are dealing with criminal practices by people flying by night and setting up burner phones, I think you are entering the realms of the criminal, at which point regulatory co-operation between different bodies under different frameworks is going to be necessary.

With regard to organic posts, we do more and more work in general in our social media enforcement to use machine learning to avoid relying in any way on consumer complaint, but to get ahead and identify where key words are used, for example, to promote certain practices. We can then work with platforms to take down advertising, certainly in cases where we believe it to be illegal. That is my response in terms of our role, but I agree that there is a role for multiple bodies.

Q91 **Laura Trott:** Do you need additional powers to do more?

Malcolm Phillips: I would not say so. We need to develop the powers that we have. In machine learning, we are at the beginning of a journey. We are investing a great deal in that in the organisation. I am sure that over time our use of artificial intelligence will develop. That is true for all regulators, I think, in this space.

Q92 **Laura Trott:** Subsequent to my private Member's Bill passing, the British Committee of Advertising Practice brought in regulations that social media posts advertising cosmetic surgery should not be shown to audiences who are predominantly under 18. Do you have any data on how that has been enforced, or whether it has been effective so far?

Malcolm Phillips: Those rules come into place on 25 May. We have had a grace period, in recognition of the fact that lots of media booking and media arrangements happen over a longer period of time, to avoid disproportionate penalties to people who placed ads at a time when those rules were not in place. We have to have the grace period. That rule is coming in and we will be monitoring it. It will be subject to a 12-month review.

Chair: Thank you. Last but not least, Dr Luke Evans.

Q93 **Dr Evans:** Thank you, Chair. Malcolm, you rightly pointed out the difference between bad practice and criminal practice. I am keen to focus on what the ASA does and its relationship with Government going forward.

The professor talked about a kitemark, or a logo in this case, around advertising. What stops the ASA putting that in place? Does it need to have primary legislation first to bring something like that forward?

Malcolm Phillips: If I have understood the proposal correctly, a kitemark would need some form of independent certification and assessment by a professional body. It needs to be established. It needs to be trusted and so forth. If it were legally mandated, I guess it would be a simple matter to identify advertising that did not include it. We do not tend to be involved in kitemarks because they tend to be imposed by professional regulation, a trading standards regime or something of that nature, depending on the law. We would obviously be open to further dialogue about how we could play a part in that.

Q94 **Dr Evans:** You have just done your big consultation on body image. It is, hopefully, going to give information later this year. How does the interaction work? How swiftly can the ASA act on some of the social media stuff? What I am getting at is, what needs Government legislation and what can you deal with already? To take the example—I declare an interest—of labelling images, why can't we go ahead? Why can't the ASA do that? Does it need primary legislation to change to facilitate that, or can you just carry on, make the mandate yourself and set the code?

Malcolm Phillips: Ideally, when it comes to setting advertising standards and advertising rules, we would want to follow our process and see what the best solutions were to match the problems that people brought to us. I was fascinated by a response that your life experience witness, Kim Booker, gave this morning. It struck me that there were two very different reactions to your questions. When you asked what the impact of labelling would have been on her as a user of social media, Kim seemed to hesitate and say that she was not sure that the psychological impact of the image would have been reduced by the label, but when you asked her what the impact would have been on her as a poster of images, her reaction was extremely different.

I was interested in that because we are involved in imposing standards on advertisers. We do so typically through an evidence-based process,

because potentially we need to justify these restrictions in a court of law. We can be judicially reviewed on all of the rules we impose, so we try to make sure that they are tailored solutions that will achieve the right impact. They are also being imposed on advertisers, not really on organic users of social media.

For me, there are questions about what the impact of labelling would be. We know that labelling can work very well in certain circumstances. We use and enforce rules on labelling for influence and marketing, so commercial relationships between influencers and brands have to be disclosed. The impact of a label is very simple there; it is to tell a consumer that they are being sold to. It involves a very slight and fairly rational alteration in the way you receive a communication. To know that you are being sold to makes you inquire a little more about the person's motivations and whether they are presenting something very positively to you.

What I was interested in from Kim's reaction on that question was, can we expect labelling to achieve the same result? If we cannot, is there another solution that we would be better justified in devoting our resources to imposing? I am not saying that that is our final answer in any way. As I say, we are still evaluating the call for evidence. It is very likely that in a number of our strands of work we will be looking to engage more people and looking to have more discussions, especially on the question of ad labelling.

Q95 **Dr Evans:** This is not the place to get into that, but I am interested in the concept of what you said, taking the broad principle. It sounds like the worry the ASA have is being challenged on the legislation. Therefore, you need primary legislation on whatever part we are going to put in place, be it labelling adverts, kitemarks or whatever. You are worried that that is your vulnerability, so that is the limitation on where the ASA will draw their line. They need that back-up rather than being much more gung-ho—maverick is not the right word—in going out there.

It is back to Laura's question. You have answered it by saying, "We believe we have the powers. We just need to get on with it and learn more." I am saying, when we see that, is there a far-reaching way that you would step up? Who makes the decision about driving it and how hard, and what do you need back-up from Government to say? Should they be saying, "Go on and get on with it, take that chance and the taxpayers will fund it?", or should you be saying, "No, we need that back-up and we need to do it all properly with a piece of legislation to take it forward"?

Malcolm Phillips: I might have made myself misunderstood on the question of judicial review. We are not really afraid of judicial review. We have been judicially reviewed as an organisation any number of times over the years, and in all but one case we came out of that being vindicated. It is an important test, and it will continue to be an important test of ASA rules and decision making. I do not think that is a barrier or a

disincentive to us to intervene in certain areas. It simply sharpens our minds with regard to whether the particular intervention is justified, but I think it is a question for legislators as much as it is a question for regulators.

Q96 **Dr Evans:** That is the question for the Committee and the Chair. We want to put forward some recommendations. If we come up with a report that has these recommendations, is it the fact that we can simply go, "These are the recommendations. Here you are, ASA. Put them in place and off you go"? Are we going to have to turn it more towards the Department of Health? These are the same questions I will be asking the Minister, to say, "Hang on, we have got these good ideas that you guys have all sat here and told us. Why can't we make them happen, and what do we need to do to make them happen?" Every day that goes past there are literally millions of young people being exposed to images and cosmetic procedures that may well not have gone ahead or who have no redress because of the situation that we are in. Can you comment on that aspect? You are the regulator. I want to know where you sit and how far forward you can drive that.

Malcolm Phillips: How far forward we can drive?

Dr Evans: Taking forward the mandate you have. Do you believe you are a proactive, forward-looking, go-get-'em kind of organisation, or are you always on the defensive because you need back-up from legislation and ministerial guidance to be able to say, "This is the broad primary legislation that we are setting, and this is the guidance to sort it out"? That is what I am looking for.

Malcolm Phillips: No, I don't think we do. I think we are quite comfortable setting advertising policies within our remit. We obviously understand that Parliament can and does legislate on advertising. We work in partnership with statutory regulators and with Government to ensure that legislative proposals have the best chance of success, as well as the policy setting that we do on our own. I do not think that we are afraid of setting policy, no, not by any means.

Q97 **Chair:** Before we wrap up, I want to bring in Jean McHale, who has been very patiently sitting there. I cut you short at the start, but having heard the rest of the discussion, is there anything you would like to add, either extra ideas to improve legislation or regulation, or cautions about the way it is implemented? Are there any areas where you feel that our discussion has not been going in a direction that you would agree with?

Professor McHale: Very important points have been raised. I do not disagree at all with the fundamental tenor of those issues. You asked me at the start for an ideal model. In terms of regulation, I think in a sense we have to pursue where things may be likely to go. The two things are not necessarily the same.

If, for example, a licensing approach is undertaken, the question is who should do that licensing. I think that is something important for policy,

going forward. If it is a separate, new body that has statutory powers, that is one thing. Alternatives would be for licensing and oversight powers to be given to the CQC or to local authorities. There are pros and cons in relation to both of those as well going forward. The CQC would align it generally with its work, and has vast experience of that. The question of course with the CQC is how far it would be stretched in doing that.

With local authorities, as was discussed by the APPG report, you have the question that, yes, they have local knowledge and there has been some licensing undertaken in the past. On the other hand, there is a question about resourcing and ultimately diversity in approach in different parts of the country if it is left to local level. There are those sorts of things going forward.

Points have been made about prescribing. They were very well made by David Sines. It is certainly the case, for example, that the GMC—I won't name all the bodies—requires in its good practice on prescribing that there is a physical examination of patients before prescribing non-surgical cosmetic medicines such as Botox. That is a really important question as well.

You came to it from my ideal perspective—recognition of the fact that where I might ideally like to go may not be where the Government are going. That does not mean that other approaches will not be important to go ahead with as well. Laura Trott, working with Save Face, has done important work in Parliament in putting the Bill forward and looking at the questions about Botox, fillers and children.

There are broader questions too about capacity, children and procedures going forward, but not just that. There is the question of adults lacking mental capacity or people developing things like early-stage dementia, and so on, and inclusion around that. There are those sorts of things going forward.

The other thing—

Q98 **Chair:** Make this the last point, if you will, please.

Professor McHale: Absolutely. The MHRA's consultation at the moment on medicines is very important for situating dermal fillers and whether that is in line with EU devices regulation, and the importance of recognising the special status of that. Thank you.

Chair: Thank you. We have had a fascinating discussion. It has crystallised things in my mind, certainly as regards safety issues, ethical issues and the interaction with mental health issues. I am grateful to you, Jean, Ashton, David and Malcolm. Thank you for joining us this morning. It has been very important evidence. That concludes this morning's session. Thank you all very much indeed.