HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: The impact of body image on physical and mental health, HC 114

Tuesday 17 May 2022

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Watch the meeting

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

Questions 99 - 160

Witnesses

I: Charlie King, reality TV star and influencer.

II: Tam Fry, Chairman, National Obesity Forum; Dr Angela Meadows, Lecturer, Department of Psychology, University of Essex; and Helen James, Founder, Nutriri.

III: Gillian Keegan MP, Minister for Care and Mental Health, Department of Health and Social Care; and Zoe Seager, Deputy Director for Mental Health Policy and Operations, Department of Health and Social Care.

Examination of witness

Witness: Charlie King.

Chair: Good morning. This is the final evidence session of the Health and Social Care Committee's inquiry into body image. Later, we will hear from experts on obesity and the stigma associated with body weight. We want to explore the conflict sometimes between those two agendas and to try to work out what the right way through both of them is, because they are both extremely important. As this is our final evidence session, we will finish this morning by hearing from the Minister of State for Care and Mental Health, Gillian Keegan MP.

First, we are delighted to have as our guest Charlie King, best known for appearing on "The Only Way is Essex", who has spoken very publicly and bravely about his diagnosis of body dysmorphic disorder and his experience with cosmetic procedures. I give the floor to Taiwo, who will start by asking Charlie some questions.

Q99 **Taiwo Owatemi:** Thank you, Charlie, for coming to the Committee today. I will start by asking you to take a couple of minutes to explain to us your experience with body image.

Charlie King: Body image is something I have always had an awareness of. I went to an all-boys school. If we take it right back, back in school, as I was at an all-boys school, there was always a lot of competition and a fight for popularity. Unfortunately, I was not one of the popular kids. I was terribly bullied, and it was not a great experience at school. Sitting here now, as a 36-year-old man, I look back on my past and definitely see a trauma from school, which must have given me an in-built insecurity.

It is quite well documented that over the years I struggled with my sexuality as well. I came out—I hate that term—quite late. I was 29 years old. I had spent many years through my teens and 20s living in internal turmoil. I struggled with my own identity. That was quite challenging.

One of the things that I could control was my image. Because I was not quite sure of my social circuit or where to put myself, the gym became my best friend. It was a way of being able to work on myself and to be around people, but without having to say too much.

Q100 **Taiwo Owatemi:** At what age did you become aware of your body image?

Charlie King: It was probably in my early 20s. Then I got thrust on to "The Only Way is Essex", which is a reality TV show that is primarily focused on the fabulous lives of us Essex folk and all the glitz and glamour that goes with it. From my upbringing and how I was as a person, to be put into that territory was so alien to me, but image was everything, popularity was everything so I was just going to go with it. I

became very aware of image there. Then came social media and people's public opinion of you. I became quite a visual character.

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.

Q101 **Taiwo Owatemi:** You have spoken about your experience of school and then becoming a social media sensation. How do you think we can better protect young people to ensure that they are able to be supported through that process?

Charlie King: It is so subjective. It is a very difficult one to try to grasp. I had a very unique experience because I was put into the public eye. I had no real experience of that before. I was just a regular guy, and then I was put out there. You cannot really fathom what goes on with that. It did not really work for me, if I am honest. It was not my cup of tea, but it was an amazing opportunity and an opportunity that has led me here today.

As I have moved on in my career and tried to understand a little more about my own journey, I can see that there needs to be more duty of care or education around the pressures of growing up, turmoil, trauma and things that could affect you a bit later on. I think that this awareness of the pressure that youngsters feel needs to start earlier. It is not just youngsters—we all have insecurities, to an extent—but if we were learning tools to handle that quite early on, we might not get into positions like those I have found myself in in recent years.

Q102 **Taiwo Owatemi:** When you were trying to access support, did you feel that it was available for you? When you became aware of your body image and the fact that you needed support to help you navigate through how you were feeling, were you able to access any support?

Charlie King: I think that I was naive to the fact that I was OCD. I had obsessive compulsive disorder. Obviously, I have understood body dysmorphia since having a diagnosis with the condition. OCD, depression and anxiety are all tributaries of that mental condition. I did not realise that one thing was going to lead into the next. If I had understood a little more that I was showing evidence of obsessive compulsive disorder, for example, it might not have led me down the obsessive route with my image that caused me the problems I have had recently.

Q103 **Taiwo Owatemi:** What resources did you use to help you? Were you aware of any, or did you just figure it out as you went?

Charlie King: With body image specifically, I have only learnt about the resources around the Body Dysmorphic Disorder Foundation. Kitty and Dr Rob Willson have been incredible. Prior to that, I did not really know that I had body dysmorphia. I just thought that I was a very self-critical person and I knew that I was quite compulsive. I felt pressures to look a certain way because I had seen through social media that people responded to me most when I had my top off and had a six-pack. If I was not getting that validation, there was a constant battle that I needed to keep like that.

During lockdown, when I was isolated and on my own, my obsession turned to my nose, which had been broken 15 or 20 years ago. It was something I became obsessed with: "It needs to change. I need to fix it. I need to see a plastic surgeon." So I did. The surgeon agreed: "We can improve that." With my nature as a person, I thought, "I've got the validation I need. Let's do it." That goes into a whole new conversation.

Q104 **Taiwo Owatemi:** When you had your nose job, how did you feel after you had received the procedure? Did you get the validation that you were expecting to receive post procedure?

Charlie King: 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.

Q105 **Taiwo Owatemi:** Do you think that professional safeguard advice should have been given before the consultant agreed to do the procedure?

Charlie King: I believe that there should be a period of time between consultation and a second consultation that would give you the time to seek therapy or that, within the plastic surgery realm or the aesthetic world, there should be access to resources or more education from the professionals to suggest that we might need to look at that angle before you go ahead and spend thousands of pounds on something that may or may not give you the results you are looking for.

This condition, body dysmorphia, is an appearance disorder. You need to make sure that the fact that you are touching your nose, for example, in my case, is not going to be the start of something else. Was I ever going to be happy with my nose, with my condition? Who knows? Actually, now I have an obvious deformity with it, which I will have to fix in due time, but that is another story.

Q106 **Taiwo Owatemi:** Earlier, you spoke about your childhood experiences with body dysmorphia leading on into adulthood. How has your life been

impacted from when you were younger until now, as an adult?

Charlie King: I have always been someone who has struggled with his mental health. I am very open about that and use my platform, wherever possible, to show that. I try to keep it as real as possible.

I look back to my school life and the trauma and turmoil. I was removed from schools because the bullying was so bad down in Essex. You can layer that with, unfortunately, my struggles with sexuality, not really understanding who I was and not feeling comfortable enough to explore that for many years. Obviously, that is my own journey, and it can be very different for everyone else, but when I look at my story now and how I am as a 36-year-old man, I can see that all those things were what led me to where I am today.

It has been tricky. I am still work in progress with it. I am not cured, if you like. I just try to use my experiences now for the greater good and keep navigating life as I am. That's it.

Q107 **Taiwo Owatemi:** It is good that you are trying to use your experience to impact people's lives. If you could really make a change, what would you like to see?

Charlie King: I am a great believer that there needs to be more awareness around someone's mental health before, when we look at aesthetics. Being in the public eye and having social media followers, I am contacted very often by people who would like to put a bit of botox and a bit of filler into me and asking if I have thought about ab sculpting or veneers. With my type of nature, and having body dysmorphia, I then start second-guessing, "Maybe I need that." Now my brain works in another way and I think, "Hang on a minute. No, I don't need that," but many people will go ahead and do these things. Are the companies, individuals, businesses and procedures regulated? Does someone know that if they go in and, potentially, put lip filler in their lips, they might have an adverse reaction? Will that then impact the NHS? There are so many things to this that make it a very complex subject.

I feel that, with the plastic surgeons, duty of care is No. 1. They need at least to offer accessibility to potential mental health resources for body dysmorphia analysis, working with charities and foundations to understand the condition. I do not want to say that I had a botched nose job; I had a nose job that did not go to plan. I could not do anything about it. There I was, with scar tissue and a collapsed columella, and the surgeon said, "We will have to wait."

Every day of my life in that waiting period, until I had surgery No. 2, I just had to get on with it. I went into the depths of despair. I have had to move back to live with my mum right now because I could not earn money and was depressed. I am still not myself. Getting ready to come here this morning, I started picking flaws in myself. I had to live with that. There were no resources, apart from being told, "We'll fix it in a

year's time, when you have healed." That year was, and still is, one of the most challenging times of my life. I took a decision because I thought that there was an improvement to be made.

I do not know how we govern this. I made the choice to have this surgery, but I was told that an improvement could be made. There was no warranty. There is no way of getting my money back just yet, if that is the route I want to go down. It will be a whole legal proceeding and will get nasty, which I do not want, because my mental health and my career have been floored by it. I wish that there had been someone in that room or at that whole time of my life who had said, "You don't really need this," or, "Do you know what you are embarking on?" That is where there needs to be more attention in the plastic surgery realm. They should not just say, "I'm going to take your money. I'm going to make you look beautiful." It is deeper than that.

Q108 **Taiwo Owatemi:** It is indeed. I have one last question. What advice would you give to somebody who is 18 right now and is experiencing this? What would you say to them?

Charlie King: You need help, because it is a condition. You need to understand that your thoughts and how you feel are valid. I have felt so embarrassed, as a man, as a gay guy, as a reality TV star—whatever you want to call me—that I went ahead and did this. There is a stigma around it. It feels vacuous. It feels like I am just worrying about my image when there is a whole world of problems going on out there. But that is not the case; it is how you feel. If a person is feeling that, they need to know that what they feel is valid. It is perfectly okay. It is a treatable condition.

There needs to be more therapy and help for people. There are amazing foundations such as the BDDF that are doing amazing things right now to try to help people to have access to what they need. First and foremost, you need the diagnosis. People need to understand that so that they can work on it, as opposed to thinking that they need to change themselves, which will never really give them the result they want. I want to promote that. That is why I am here today.

Taiwo Owatemi: You are right. Early diagnosis makes a massive difference to so many patients.

Charlie King: It does.

Taiwo Owatemi: Thank you so much for sharing your experiences with me.

Q109 **Dr Evans:** Thank you, Charlie, for speaking so eloquently. Can you explain the impact that social media has on you?

Charlie King: Social media is a funny world. It is a totally different world. I understand it a lot more now than I did. If you get put on television or go viral and end up with a surge of followers, you are instantly under the eyes of many people and many different people's

opinions. You end up becoming consumed by this world. It is like a dopamine hit. There is nothing quite like it. I do not know whether any of you have huge followings or get that surge. It feels great. You know what it is like.

With that come a lot of brands, companies and endorsements. They want you to promote this or that. I have been asked to promote teas that, basically, work as laxatives. They offer you big money. You end up thinking, "Do I do it, because I need to pay my wages?" You cannot help but start falling into webs. Again, there needs to be a bit more of a disclaimer around products when an influencer is influencing.

There is also the filter situation. Many times when you see someone, they have been altered, blown up, snatched or whatever. You do not really know what is real any more.

Q110 **Dr Evans:** Can I pick you up on that point? You are in an interesting position because you are someone who looks at the images and suffers, but also an influencer who has a lot of pressure. If there had been a disclaimer, do you think that it would have stopped you going down this path? As an influencer, do you think that it would have prevented you from changing your image? There are two different approaches.

Charlie King: There are. Some people absolutely love it and are all for it. When we look at what I call the Kardashian lifestyle, it is an aspirational world where you can make loads of money and look fantastic, and your life is like a movie star's. We need to get real; that is a very unique situation. They are what they are, and good luck to them. The average person or influencer will never get to that standard.

There needs to be a lot more transparency in it. The Hollywood lifestyle image that it can portray needs to come down a notch. We need to get real a bit more. People are becoming a bit savvier about endorsements, paid ads and things like that, but it is a tricky one. When I put out fitness content or content where I am showing my body, I know that protein companies want me because they think that I am a good representation of what their product could do for people.

Q111 **Dr Evans:** Are you under pressure, as a celebrity, to digitally alter your image when you put it out? Has that ever been the case through the production companies or the stuff that you are doing?

Charlie King: We know that if you go on these apps you can make yourself look that little bit better. It goes back to the fact that you become engrossed in it. It is not necessarily always the brands. They cannot really alter it. If I do not want something altered, we leave it as it is. This is where, through social media, people get caught up in thinking that they now need to become a version of themselves.

I fell into that. I knew that, if I was doing magazine covers and looked a certain way, that was where my market was. Then people started saying, "You should take some testosterone on that. You should take steroids. If

you've got to that level naturally, imagine what you will be blown." You cannot help but start thinking, "This could be something to do. Just a course." It falls into a very dangerous world.

This is what I said at the beginning. The whole thing is so complex and subjective. It is so much about the individual. It is a tricky one for you to try to get right, but awareness is key in all angles of it. All we can do is keep using different case studies and examples to try to find common ground somewhere.

Dr Evans: Thank you.

Q112 **Chair:** I have just a couple of quick ones to finish up with. First, I am quite bowled over by your courage.

Charlie King: Thank you.

Chair: You spent your life trying to look like the perfect man. Then you had a nose job that went wrong. Instead of covering it up, you have gone public and told everyone that you had an illness. Where did you find the courage to be so open about the fact that you had that mental illness when your whole life had been obsessed with image? Can you talk us through how you managed to do that, because it is a huge thing?

Charlie King: It is. It is in part a testimony to my character, which I own with pride. I am someone who really believes in being as transparent as they can. That has been very prevalent in my upbringing. I have always had quite a safe space, which has always helped.

What it stemmed from for me was that when I came out on "This Morning", the ITV show, at 29 the response was insane. I was an older guy coming out and talking about his own struggles with it. I still had to navigate life as a more mature gay man. Life was not necessarily rosy just because I had come out of the closet. I then had to learn, at an older age, to try to find out who I really was. After years and years of trying to hide myself, that was really tricky, but to this very day, people still say that that has helped them.

When I fell into the situation I have been in for the last few years, and once I had understood the body dysmorphia, I asked myself, "If I want to try to carry on with my career and rebuild myself after Covid and surgery that has gone wrong and that I can't do anything for, what am I to do? Just sit and hide for a year? The best thing I can do is use my profile and experience to try to make something positive out of it, to an extent." I am quite self-aware. I just had that drive in me. I thought that, if there is an opportunity for me to talk about this, I know it can help people, and it has. It has led me here, and I meet a lot of people who suffer with the condition. From a male perspective, it is really important, because a lot of people think that it is a female issue. It affects all people. Gender is not important.

Q113 **Chair:** Let me ask you to think about another group of people we have

not mentioned today. What advice would you give parents who have teenage kids who are looking at a lot of stuff on social media and seeing a lot of perfect bodies? What should they be talking to their kids about?

Charlie King: It is a very tricky question. I am not a parent, but my sister is. I see how imagery can impact youngsters. The worry that we have—again, I am not quite sure how we grasp this—is that in our downtime we all seem to be consuming information. A lot of us, and youngsters, use our downtime on our phones and computers. It is just a bombardment of imagery and stuff.

From a parent's perspective, it is important that you try to know what your children are looking at. Conversations in school about what they see on social media are important. I do not mean just graphic material and things like that, which you have to control. This stuff is harmful, at times, in itself. There need to be conversations about what you might see on Instagram, TikTok and those sorts of things, and that it is not necessarily real. That is where it starts. If we try to talk about these things from a young age, children can then go home and talk to their parents about them. The parents will know that that is coming up in the syllabus or that these are conversations that they are going to start bringing into education. It is part of our day-to-day world now. We all see it.

Q114 **Chair:** I have one final, slightly more light-hearted question. I noticed that you said that you became very political. You wanted to be the cool guy. Do you have any message to MPs about the right way to be political?

Charlie King: The right way to be political? I think what you guys are doing here today is really cool. It is a subject that has had a lot of stigma around it, but you are hearing from someone like me. I still get embarrassed when people refer to me as being from "The Only Way is Essex", because there was stigma around that show. Equally, it has been an amazing opportunity for me, so great.

Who is really cool? I don't know. Cool is subjective. I think that what you guys are doing is great. If we can do something positive here today, that is a cool win, in my view.

Q115 **Chair:** I don't think we have ever been called cool before, so history has definitely been made today. Charlie King, thank you so much for joining us. We really appreciate that. We appreciate your courage in doing so.

Charlie King: Thank you very much. It was my pleasure.

Chair: We will now move on to our second panel. I will pause for a moment while our three panellists take their seats.

Examination of witnesses

Witnesses: Tam Fry, Dr Meadows and Helen James.

Q116 **Chair:** I now introduce our second panel, which will focus specifically on something we have touched on briefly—the interaction between the obesity agenda and the body image and dysmorphia agenda. We want to surface whether there are tensions and trade-offs, or whether there is a way that both agendas can be addressed.

I am very pleased to welcome Tam Fry, who is chair of the National Obesity Forum, which raises awareness of obesity and ways it can be tackled; Dr Angela Meadows, who is a lecturer in the department of psychology at the University of Essex and specialises in prejudice and discrimination relating to weight and body size; and Helen James, who is the founder of Nutriri, a social enterprise that works to help people accept their bodies and quit disordered eating. A very warm welcome to you all.

Tam, the Government's policies on obesity have been in the news today. What is your view of the current state of play with respect to the obesity agenda and what the Government are doing about it?

Tam Fry: Basically, the current state of play is stagnant. I have been looking at obesity for the last 30 years, and I have not seen any movement of any significance to tackle obesity. That appals me.

There is a lot that can be done. I notice that you are going to reform the hospitals of the United Kingdom. I think you should also reform community healthcare, particularly for children. The relationship that I would make between why I am here and body image is personified in a chart that I have produced and that Conor O'Neill will give you. It shows how, if you started to monitor children's weight properly from the early years, you would pick up anorexia or obesity at a much earlier stage than we have ever contemplated. It involves measuring children from the age of two. That is now agreed by the Royal College of Paediatrics and Child Health. It should be done every year from that age onwards. Your predecessor Health Committee recommended it in 2004, and it has never been implemented.

I have to say with due angst, because I am nearest the door, that I am afraid that I was watching you very carefully when you were Health Secretary and you did very little, either. It is now high time that you took the bullet between the teeth and did something with the current Government.

You will have read this morning in *The Times* that William Hague said, "Obesity U-turn is weak, shallow and immoral." I perfectly agree with all those factors. If Boris Johnson wants to halve childhood obesity by the year 2030, as he proclaimed, and as you announced in 2018, he really has to do something as of tomorrow—and I mean tomorrow. He ain't going to get there, unfortunately, but at least he should try. It is not just me saying that; the National Audit Office, when looking at the strategy that he produced in 2020, said that the measures were by no means sufficient to enable that aspiration to be achieved.

Q117 **Chair:** Thank you. Let me follow up on the point that is central to this

inquiry and this morning's evidence. A lot of people who are concerned about body dysmorphia say that we should avoid telling people they have the wrong body shape or the wrong body size because that can lead to some of the things that we heard earlier from Charlie King and, indeed, have heard very powerfully from other people giving evidence. From the point of view of an obesity campaigner, are you completely happy with that approach?

Tam Fry: Yes. I think it is disgraceful that both overweight and underweight are stigmatised in the way they are. In my view, that could be avoided if we had a proper health system in place which looked at children. I am concentrating on children because, in fact, if you miss children developing in one way or the other, they will go on developing that into their adult life. It is children who are the object of my energy, if you will. I want to make sure that all children are properly monitored, and then any sign of emerging loss of weight or too much weight is dealt with at the time with physicians who are properly trained to do it. I am happy, in a sense, that £100 million was devoted by Johnson to new weight management clinics. It is not enough. It is peanuts, but at least it is a start. It should be implemented and expanded.

Q118 **Chair:** Dr Meadows, could you talk us through the concept behind the Health at Every Size approach, and what sort of Government interventions you would be looking for to make that happen?

Dr Meadows: Yes, of course. First of all, I want to thank you because I never thought this would happen, but I actually agree with Mr Fry on something. Over the last 30 years, there has been no progress whatsoever on changing the trajectory of obesity or weight-related conditions despite hundreds of millions of pounds being invested in research intervention services and the national childhood measurement programme. The point is that none of it is working, and there is a reason for that.

Weight is not as much under individual control as we like to think it is. Things that we do to control weight, such as food restriction and dieting, tend to have rebound effects, where you end up heavier than you were when you started. Stigma itself is a chronic stressor. This is not just true for weight stigma. It is true for racism, sexism and heterosexism. People who belong to marginalised groups go through a society that is hostile to them. On a daily basis, that is a chronic problem of stress. The body responds to stress in certain, very well-known ways, by increasing stress hormones, cortisol and so on, and inflammation in the body, all of which are associated with increased risk of diabetes, heart disease, hypertension and some cancers. That is not just in high-weight populations; it is in people from racial and ethnic groups who are a minority in a given country or a community.

Telling children that they are overweight has been tried. It tends to have the opposite effect from that intended. It is associated with higher weight further down the line, independent of the original starting weight. It

tends to promote body image issues, mental health problems, anxiety, depression, isolation, internalised weight stigma, and maladaptive coping behaviours. Food restriction tends to lead them to binge eating.

Q119 **Chair:** What you are saying is that, if a child is told they are overweight, the stress that creates in fact tends to lead to them eating more. Is that potentially—

Dr Meadows: Partly, but also the behaviours associated with that tend to lead to higher weight. It actually has a rebound effect. It is not achieving what we think it is achieving.

You keep coming back to the balance between a weight-neutral size positive agenda and the obesity agenda. The simple answer is that there isn't one. However, the good news is that I think obesity is actually a big red herring. The goal is not to create a thin population; it is to create a healthy population. The two are not the same thing. We all know thin people who are ill. We all know normal weight people who are ill, and heavier people who are not necessarily ill. There are ways to achieve the end goals that we are looking at and that we want to achieve, which is reduced illness, as I am sure Mr Fry would also agree with, but what we are looking for is not a number on a scale, but ultimately reduced conditions.

Q120 **Chair:** Let me bring Mr Fry in. Do you agree with what Dr Meadows has just said?

Tam Fry: I would not dare disagree with her.

Chair: Good. We are breaking out into harmony. That is excellent.

Dr Meadows: Coming back to your original question on the Health at Every Size approach, first of all one of the common misconceptions is that health at every size means that bodies of all sizes can be healthy or are healthy, and that is not at all what it means. It means that whatever your size, if you want to do something about your health and if you want to change or improve your health, focus on evidence-based health-giving behaviours and measure the outcome with health metrics, not with a number on a scale. If you want to do something about high blood pressure, maybe reduce salt in your diet, get a little bit more exercise, improve your sleep and reduce your stress. You measure the progress with a sphygmomanometer—a blood pressure monitor—and not by how much weight you have lost, because that is not sustainable.

The long-term effects of weight loss tend to be weight gain. While we know that the programme that Mr Fry mentioned in Amsterdam appears to have had quite good effects on reducing BMI in the adolescent population, from the National Obesity Forum's own evidence and report on that data there is no control group, there is no long-term data, there is no peer review and we have no knowledge of whether it actually improved health in the children. We have no knowledge of the long-term effects and harms that might have arisen from it.

Q121 **Chair:** Thank you. Helen James, first of all, how widespread do you think weight discrimination is in healthcare? Are there particular groups that are affected more than others?

Helen James: Very widespread. It is in the essence of healthcare itself. I like to think of health at every size as healthcare at every size, so it is about access. Sorry, can you repeat the second half of your question?

Q122 **Chair:** I was asking about weight discrimination. Is it harder for people who are overweight to get access to the healthcare they need?

Helen James: Yes. I speak on a daily basis to people who do not even take themselves to the doctor because they fear that they will be told to lose weight, and not have their medical condition addressed. We have designed a weight-neutral patient activation card that somebody can take to their GP and say, "Is my weight causing me to be ill or is it a side effect? Is weighing me today medically necessary for what I present with today?"

We feel that we need to arm people even to access their own healthcare, but we find that every individual who comes through our doors wants to be active in their own healthcare. The stigmatised view that heavier people are lazy and not interested in looking after themselves is what is causing harm. That is what is creating the barriers.

Q123 **Chair:** What would you say to doctors who say that the name of the game in modern healthcare is prevention rather than cure, and that even if you do not have an apparent health condition, if you have a high BMI, you are more likely to develop something like diabetes, so the purpose of weighing patients is to try to understand who is at risk even if they do not actually have a long-term condition?

Helen James: You have to focus on causality and correlation of weight. I know that Angela will nod her head to this because I have learnt it all from her. It is a side effect; the weight is a symptom of something else. Whether it is a mental health condition, anxiety, depression, or a heart condition, or you are inactive for other reasons, for example for something musculoskeletal, focusing on weight is very lazy diagnosing.

Chair: Dr Luke Evans.

Q124 **Dr Evans:** I knew you'd do that—*[Laughter.]* I declare an interest as a GP. I have gone through many weight managements. I agree with part of what is being said on the stigma aspect that can present, but fundamentally if someone is obese they are going to put extra strain on their organs and their blood pressure, and so on. How do we tailor national policy to make sure that we hit those individuals in a way that will help them? Fundamentally, you are in a vicious circle. If you are putting on weight, you are going to have problems with your knee joints. Therefore, you are going to have pain. You need to reduce the weight, but you need to exercise to help to do that.

I entirely agree with your point as well about diets not working; it is a lifestyle. How do we get lifestyle advice to people at both ends of the spectrum: those with eating disorders in extreme sports and those who are morbidly obese, and everything in between? You are nodding along, so I will go to Angela first and then Helen.

Dr Meadows: You are absolutely right. It is about behaviour change. Weight loss is not a behaviour. It should not be given as the outcome. Nothing about what I have said, or the science behind it, is to suggest that people of higher weight are not at greater risk of various health problems. That is absolutely true. The question is, why are they at greater risk and what shall we do about it?

Even if you believe that the fat cells that they are carrying per se are what are causing the ill health, everything that we are trying to do to reduce their weight is not evidence-based. We cannot ethically promote intentional weight loss as a health-giving behaviour because it is not. Although this might sound quite radical, the best thing to do would be to stop trying to interfere with people's weight. By all means, get them to try to increase access to diet and safe spaces, make communities safer and reduce crime and poverty. It is all those big things. Health will be the result of that.

When you make it about weight, we can focus on behaviours, but in people's minds, and often in doctors' minds, it is, "And then you will lose weight." People are doing those things because they are told there is weight loss at the end of it, and it is the weight loss that is the benefit. That is not at all true. Diet interventions in studies and randomised controlled trials have horrifically bad results. They are not associated with improvements in metabolic function except where there is an exercise intervention. Exercise is good for just about every system in your body. It is not good for weight loss at the amount that is safe and sustainable.

Getting people moving will improve health. It will not necessarily reduce their weight, but because people are being told, and the public health messaging they are getting, is that it is all about weight, they exercise and work out like they see on "The Biggest Loser" until they are sweating and vomiting over the side of the treadmill. They are doing something that they hate and that they have always hated because they were bullied at school. They do not lose the weight and they stop. What we really need to be doing is promoting health behaviours for the goal of health behaviours without the focus on weight. It would be wonderful if the Committee could look at the wealth of evidence on this and remove that focus on weight. I keep coming back to this. It is a red herring. We have to focus on health behaviours and health outcomes.

Because of the disparities in body weight across different racial groups, socioeconomic status and what have you, this focus is actually increasing health disparities. By removing the focus on weight and introducing what I would recommend, which is to do away with all the weight management services, the interventions and the public health stuff, and go for a health

promotion approach that can be targeted as culturally appropriate health promotion approaches in different communities, not only does that work on the individual level but it starts to even out some of the disparities that we are seeing.

Dr Evans: Helen, do you want to come in as well?

Helen James: I have managed to access some up-to-date figures on what we are spending and what is working out. I will share those. For April to December last year there was a £100 million pot that was allocated to cover tier 2 weight management services—only tier 2. Of that £100 million, about £30 million was drawn down and accepted by local authorities. For that £30 million, this is what we got.

First of all, £7 million of the £30 million resulted in no referrals, so no action was taken. A further £7.5 million of it had some referrals but nobody completed the programmes that they were referred to. Going back to the headline figures, 15,753 people had referrals, and 9,327 people enrolled on the suggested weight-focused intervention. Of those, 1,601 people completed. That is £30 million and 1,601 people, of whom 14% possibly lost 5% of their body weight: 220 people possibly losing 5% of their body weight and we spent £30 million on that between April and December last year. I want to bring out just how ineffective we are being.

I do not see that as an individual failure. It is nowhere close to being the individual's fault. It is a commissioning problem. It is a policy problem. I sit in weight management service provider engagement meetings. We are ready for a change in policy. We are being asked for it. What we do at Nutriri is being asked for. We sat in a one-to-one commissioning meeting for this very tender, for this pot of money. We were told that unless we were willing to weigh our participants we would not be paid for our work, so we did not bid. Then we see these results. It is pretty dramatic when you bring it back down to the pounds that we are spending and thinking that that comes down to somebody not adhering to something. All we need to do is to stop making it about weight. We can get further engagement. We get prolonged engagement and completers of our programmes, and people come to us specifically because we are not weight focused. We are weight-neutral.

Q125 **Dr Evans:** We have two differing opinions on the panel. Is there an argument that it is human nature to make different choices? Some will choose to go to your situation; others will be motivated by having their weight managed. On the one hand we have both of you saying, "Do away with weight," and on the other hand we have Tam saying that we should be measuring people more. Why are we in this situation? Tam, do you want to come in on this? There is clearly an obvious divide.

Tam Fry: The really important thing in this conversation is that I have not heard the word "prevention" too much. We are waiting for the problem to develop before we do anything about it. What we should be

doing is getting in early in order to look at the charts and to see the way that the trajectories are going for each individual child. If there is a reason for being referred for weight management, that is the time to do it. That is what the charts are about.

Last week, we had the Maastricht convention on obesity in Europe. A paper there said that 3% of doctors referred to weight management courses. One of the reasons they do that is that they are so inadequately trained. In this country, for the first time, we now have, pinched from the United States, an obesity competency management. It is absolutely fundamental that we train our doctors much better in identifying weight, the causes and the way that weight will start to engender other problems like diabetes, cancer and heart problems.

Children should be not told but advised about the consequences of being underweight and overweight, and I do not think that that happens. It should happen pre-school. It should happen in the early years of school, so that by the age of puberty children know what to expect, we know what to expect and there will not be this real problem which I have of the media and the fashion industry picking up small, thin girls as models and persuading girls that, if they want to get on in life, they should be thin and successful. That is just ruinous, in my view.

Q126 **Dr Evans:** Thank you for that. We could debate obesity for a very long time. I am keen to pull it slightly back towards body image. I would like to come to you on this basis, Dr Meadows. Do you think society has opened to the fact that you are not talking about weight but about healthy bodies? Do you think advertisers and social media are seeing that? If so, what should we do to help expedite it, so that people look at a better variety of images in the world where we live?

Dr Meadows: Absolutely. It is very interesting and very commendable that this Committee has had lived experience statements from a very wide range of people with different body image issues.

If I may tell you a very quick story, a few years ago I was invited to speak at a body positivity café that was a Social Science in the City event run by the University of the West of England Centre for Appearance Research. They did something similar. They had a disability activist, a trans activist, a researcher on colourism, one on LGBTQ+ body images and me. It was the first time I had ever spoken to a group of people about my research without PowerPoint slides. I jotted down a dozen points that I wanted to make. I was the last speaker, and as everybody else was talking I was going, "No. No. Been said. Been said. Been said." What was really fascinating about it was that all of those different groups were having the same issues.

Somebody asked, "What can we do to help people with their body image issues?" The answer should be far more obvious than it is. This is not about people's body image issues. This is a society that tells people that their bodies are wrong, that they are deviant and that, if they do not

meet the ideal slim or muscular white, young, able-bodied, straight or whatever it happens to be, there is something wrong with them. This underpins just about everything else that you are hearing.

Yet again, I agree with Mr Fry; we need to start young. But not with that. I'm sorry. In schools we need to be making people more aware and accepting of diversity of all kinds. We need to make people more aware of critical media analysis. I do not think you can control the media. I do not think you can control social media, but any intervention that you come up with that is designed to improve body image or psycho-education if people had more information is not going to work as long as society is telling them that people who fit this mould are successful and good, and people who do not are flawed in some way.

Q127 **Chair:** To be very specific, so that I understand, you do not agree with the idea that children should be weighed every year at school.

Dr Meadows: Absolutely not.

Chair: Explain why.

Dr Meadows: There is no evidence that it leads to improved health. There is no evidence that I am aware of that it actually leads to weight loss.

Tam Fry: I think—

Chair: I will bring you in in a moment, Tam. I want to hear Dr Meadows out.

Dr Meadows: It creates unnecessary stress. There is some really interesting research that has come out of the US—the aerobics center longitudinal study, which is a very well-run cohort of tens of thousands of people followed over a long period of time, 30-odd years. What they found is that being unhappy with your body is associated with about two and a half to three times the risk of developing diabetes, independent of your body weight. That is mind-blowing. We are talking at population level.

Q128 **Chair:** To be very clear, do you think there would be more cases of body dysmorphia if we were to weigh children every year?

Dr Meadows: Absolutely.

Q129 **Chair:** Do you have that view, Helen James? I will then bring in Mr Fry.

Helen James: Yes, absolutely. I was a straight-sized infant, child and teenager. My dieting career started in early adulthood. I would have passed through Tam's suggested child measuring approach with flying colours. My stuff started much later in life.

I have two daughters and I am very grateful that I am aware of all the evidence that points to us needing to stop focusing and centring weight in our healthcare systems. I think it is the biggest operant conditioning

distraction on public health, and a significant drain on NHS resources. I am really grateful that on this inquiry you have brought weight into it; I know you did not start out on that tack.

Q130 **Chair:** Let me ask you one question finally before I bring in Mr Fry. Even if you accept that someone having a high BMI is a symptom and not the cause of health issues, is it not important to have the data, so that you actually identify which children at which ages might have abnormally high BMI or abnormally low BMI? You could then devise a treatment programme that would be based, as you say, on improving health outcomes. Is it not helpful to have that data in the first place?

Helen James: We need to make weight measurement akin to measuring the size of people's feet. It is literally not relevant. It is in the way. It is causing more harm than good. I cannot put it clearer.

Chair: Thank you. Mr Fry, it is your turn. You have been patient.

Tam Fry: Thank you very much. By several decades I am the oldest person in this room. You will not remember, as I do, being weighed and measured every year at school, way before there was any big theory about whether it was a good idea or not. It was part of life, rather like brushing your teeth. The nit nurse would come up and stick you against the wall, put you on the scales and write some figures down, and off you went. We did not care a damn because we were not, if you will, overtly drawn to the problem.

We are agreeing on a lot of things, but I disagree with you totally because what you have just said is sending out of the window the combined advice from four or five royal colleges, who say that we now have to really look at the data. Without the data, you cannot make any sensible decision. If you want to get the data, you have to go and measure people, and then you will see what is happening to them—whether they are going up, whether they are keeping on the right centile or whether they are going down. Then you give them advice. If you do not have that data, you are swimming around in thin air. Fundamentally, we have had a lot of fun together and we have agreed, but I disagree with you totally.

Q131 **Chair:** We will have the final comment from Helen James and Dr Meadows, and then we will suspend the session until the Minister arrives. First of all, Helen.

Helen James: I have a suggestion—a random idea about that £70 million that was not even drawn down by local authorities. Why don't we use just a fraction of that to commission some weight-neutral services and some testbeds and see how we do? A lot of people are under the impression that there is a dichotomy—that if we are not monitoring weight, everybody is going to get fat. That is just not the case. Individuals want to be very active in their own care. Monitoring weight is the barrier.

Chair: I will bring in Dr Meadows, and then Taiwo has a question.

Dr Meadows: The reason why people were measured back then was to make sure that they were developing normally. It was not really about problem weights.

To go back to your question, Jeremy, of whether we want to know if people are underweight or overweight so that we can intervene, we are focusing all our efforts on people at the extremes, not all of whom necessarily need those efforts. We are missing a lot of people in the middle who might have some quite serious problems.

The idea is not just to spend money on children who are fat, or what have you, but to promote health and wellbeing for people of all body sizes. To the extent that we have data on this—it is underfunded and difficult to get research money, and programmes tend not to have long outcomes—I agree with Helen on the call to action. In data from two to five years, what we are seeing is that weight-neutral interventions deliver improved mental health and improved physical health markers. They are much more sustainable. The attrition rate is lower. Engagement in adaptive health behaviours is sustained, as opposed to people who temporarily lose weight and then gain it back again and stop doing all the healthy things because they have regained the weight. We can achieve what we are trying to achieve, without doing the harm, much more cheaply and much more effectively.

Q132 **Taiwo Owatemi:** We heard earlier about Charlie's experience and that he believes there should be a duty of care from clinicians. Do you share the same views as him, Dr Meadows?

Dr Meadows: Absolutely. The stories I heard from Charlie today—I watched some of the earlier evidence about influencers being offered all of these opportunities—are horrifying. One practical thing that could be done or recommended by this Committee might be to prevent or disallow organisations or surgeons that promote these kinds of bodily interventions from chasing business. I will stop at that.

Q133 **Taiwo Owatemi:** Helen, as a mother and also in your work, do you agree with the comments made by Dr Meadows with regard to having a duty of care for clinicians?

Helen James: Yes, and I do not think it is that difficult to achieve. It is about stopping something rather than trying to start something completely different. It is just one element. Everything else is employed already. We have service providers that do not like delivering a weight-centric programme. I have spoken to social prescribers who dread making calls to parents whose children have been picked up through the national measurement programme. They do not feel that they have supportive language. They feel the telephone call in the first place is very inflammatory. There are boots on the ground currently doing the work, paid for as I detailed earlier, and ready to work weight-neutrally.

Q134 **Taiwo Owatemi:** Tam, you wanted to come in.

Tam Fry: I am glad that you have brought up the national child measurement programme. That is nothing whatsoever to do with obesity, anorexia or anything. The national measurement programme was a device set up in 2005 to provide two snapshots of the state of weight of four-year-olds, five-year-olds and 10 to 11-year-olds. It is simply a snapshot of life as it is.

In my career, I have sat in on about five Governments and five Health Committees. They have all talked and talked and talked, and what has come out of it is absolutely nothing. I have to tell you frankly that if your Committee does not actually stand up to Government and take some action, in 10 years' time we will still be talking about this problem and it will be worse; 75% of the nation is overweight. That is a disaster, and you should be doing something about it, please.

Chair: Thank you. We have heard loud and clear what you said. We are very grateful. We have certainly surfaced the tension in this debate. I am afraid it is bad news for you, Mr Fry. This is not an inquiry about obesity. This is an inquiry about body image, but we thought it was very important to hear about obesity issues because we need to understand the interaction between the two. It would be disingenuous to pretend that there were not tensions between those two agendas. That is why we thought it best to address them head on.

I found myself in the curious position of agreeing with two sets of witnesses who profoundly disagree with each other. That is why we will think very hard in our report with what we come out with. I am very grateful to you all for coming this morning. I am now going to finish this panel and suspend the sitting for five minutes. We will then continue and talk to the Minister.

Examination of witnesses

Witnesses: Gillian Keegan MP and Zoe Seager.

Q135 **Chair:** We now move to our final panel this morning. I welcome the Minister of State for Care and Mental Health, Gillian Keegan, and Zoe Seager, who is the deputy director for mental health policy and operations at the Department of Health and Social Care.

We have been talking about the tensions between the desire to address body image issues and how they can lead to mental illness, on which we heard very powerful testimony, and the obesity agenda. That has obviously been in the news this week, with the Government's decision to postpone measures to deal with BOGOFs and other measures.

I want to ask you to start, Minister, by commenting on William Hague's comments this morning in *The Times*, where he said that the decision to delay certain measures to tackle childhood obesity were "profoundly

mistaken" and "morally reprehensible". What do you say to that?

Gillian Keegan: It is not my area of policy, but I know that the regulations came into force on 6 April. The decision has been made to pause by a year. The reason is that the evidence that they put together, which showed the behavioural impacts, could change as a result of the cost of living crisis. At the time, I think it showed that people were eating more and actually not saving much money because there was more waste. That was some of the evidence. I suppose the unknown thing is whether people will be less wasteful when we are paying more for food. So that the Government could do some analysis on that, they have decided to pause it because of the cost of living. Food inflation and food costs are obviously the other things that peak in the news, and none of that was anticipated when the original evidence gathering was done.

Q136 **Chair:** Let's move on to what we have been talking about this morning, which is the potential tension between the obesity agenda, where we are now the fattest nation in Europe, and the risk of body dysmorphia and people becoming obsessed with their image, having mental illness as a result.

We had very powerful evidence this morning from Charlie King. What is your view as to the right way through this so that we have a healthier population at both ends of the scale?

Gillian Keegan: Obesity is a global issue. Since 1975, many more of us are obese. There have been a lot of changes in eating patterns and behaviours. Clearly, it is an issue that we need to address. However, as you say, at the same time we have other phenomena as well. Social media, which did not exist when I was young, is also having an impact on other groups of the population who compare themselves unhealthily to other people and are constantly trying to reach unrealistic expectations. It can and does have an impact on people's mental health, with both obesity and eating disorders, as well as body dysmorphia, and so on.

It is very complex. We saw that with the calorie labelling that has recently been introduced to larger restaurants for out-of-home eating. A number of people were very concerned by that and how it would impact people with an eating disorder, who were already quite obsessed with calories and calorie counting. However, we have to get a balance of risk, basically to say that it is the harm to the large group of people who do not understand how much they are eating in calories outside the home, and it is probably going to change behaviours, reformulate production and maybe have a better impact. You are always trying to navigate between different groups of people because they have different concerns. In some ways, the two of them are competing to some degree.

Q137 **Chair:** I want to ask you about something that came up this morning, which feels less of a tightrope to walk on and something that feels more obviously wrong. Charlie King is a good-looking guy who is making a lot of money because of his image, but he had underlying mental health

issues which he was very courageously open about this morning. He decided he wanted to improve his nose. He went to a surgeon and the surgeon just said, "Yes, fine, I'll do it." There was absolutely no discussion about whether there were any underlying mental health issues that would make him want to change his nose. That has to be wrong, doesn't it?

Gillian Keegan: Yes, I think it is. I was watching Charlie this morning in my office. For surgical cosmetic interventions, the Royal College of Surgeons has guidance on good, surgical practice. It says that surgeons must "ensure that consent is obtained in a two-stage process…with a cooling-off period of…two weeks between the stages." That is what good practice looks like, and that is what they promote.

Q138 **Chair:** Does that include a discussion about mental health? That was the point he was making.

Gillian Keegan: It says, "When you discuss interventions and options with a patient, you must consider their vulnerabilities and psychological needs. You must satisfy yourself that a patient's request for the cosmetic intervention is voluntary."

Q139 **Chair:** So that was a rogue surgeon.

Gillian Keegan: It is certainly not following best practice. When I heard Charlie, I was not aware of it myself, so I looked at what the Royal College of Surgeons suggests. The guidance is there and that is best practice. I know there has been a lot of work done by some members of this Committee on tightening up elements of surgery, and I am sure there are some that do not fit those criteria, but that is best practice. It is a two-stage process, with at least a two-week cooling-off period between the stages. That is what is recommended by the Royal College of Surgeons.

Chair: Thank you. We did a survey on body image as part of this inquiry, and I am going to hand over to Dr Luke Evans to talk us through the findings because we now have the results, hot off the press. He will talk about those and follow up with a few questions to you, if we may, about that survey.

Q140 **Dr Evans:** Thank you, Minister. This was a two-week survey put out on social media by the Committee, which had 1,500 responses. I will go through a couple of the figures in that if that is all right: 80% of responders either agreed or strongly agreed that "My perception of my body image has a negative impact on mental health"; and 71% of respondents said yes to the question, "Do you feel your body image has a negative impact on your life?" We asked people how many of them had used services because of the problem: 31% of responders said that they had; 64% of that 31% said that accessing services was a negative or strongly negative issue, with only 14% saying that it was positive.

The question I have for you, which we put to them as well, is, "Do you think the topic of body image and its related health impacts is receiving

sufficient attention from national policymakers?" In answering that question, 72% of responders said no, with only 8% saying yes. Do you think that the Government get body image as an issue?

Gillian Keegan: Yes. It is recognised as a risk factor for mental health conditions, particularly eating disorders. I think it is clear—those high numbers confirm it and I think most of us would instinctively feel the same—that poor body image can, and will, affect most of us at some point in our life, whether that is when you are very young and feeling more insecure or when you are older and your body is changing a lot. It definitely impacts people.

It is a risk factor for mental health problems and for unhealthy eating as a result, or in some cases even drug taking with anabolic steroids. It can lead to other things that are an unhealthy obsession, which can get to be quite serious for some people—eating disorders in particular. We have seen a massive increase in demand for eating disorder services, particularly with young people. They have nearly quadrupled since the pandemic. I guess one of the things that we have been focused on doing is trying to grow and expand those services as quickly as we can to meet the need. We know that we are not meeting all of the demand at the moment.

I have been doing this job, on mental health, for eight months. As a society, we have changed quite a lot in how we talk about mental health, how social media impacts our mental health and what we need to do about that. There is obviously a whole load of work going on with my colleagues in DCMS on advertising and the online harms Bill, and so on. We are also being much more open about our mental health, leading to an explosion in demand. We are really running to try to keep up with that capacity. We will be spending more money on that.

Q141 **Dr Evans:** In terms of actual, tangible policy, you have a women's health strategy coming forward and you have opened a mental health consultation. Will body image be a section in both of those and be dealt with?

Gillian Keegan: We recognise body image, but what we have been working on that is tangible in terms of policy is that we have consulted on various new targets for waiting times for the NHS, which will be getting seen more quickly in various services. That is the focus of the policy. The NHS is now looking at those and seeing what it would take to implement them because we do not have that many waiting times in mental health. We are a bit further behind with mental health. As I say, we are really building up the resources and the workforce planning. It takes a long time to become a mental health specialist, so we have lots more places. It really is about building up to meet the demand, which has exploded.

Q142 **Dr Evans:** Perhaps we can try to break that down, because not every person suffers with their mental wellbeing and not every person has a mental health problem. Government and people in this House tend to

merge the two, which sometimes is not helpful. If you separate the two, you can actually do a lot to prevent things from getting there in the first place. Is it Government strategy to realise that and to separate the two? If so, what are you trying to do to prevent things from getting there? As we mentioned, everyone suffered with their wellbeing in lockdown. Their freedom was taken away and their interactions were changed and altered.

There is an obvious way of dealing with it that has a big impact for a lot of people. I guess that circles round to body image. Everyone feels that they are concerned about body image. How can we potentiate that as a policy?

Gillian Keegan: We have issued a call for evidence to inform a 10-year cross-Government mental health and wellbeing strategy, recognising that it is not just a health position. Mental health is everybody's business. It is your employer's business; it is your school's business; it is your friends as well and your family. All of those relationships are very important to your mental health.

If I could use the vehicle of this Committee, I would call for input from anybody who has lived experience or anything they want to say, and particularly some of the inputs you have made as well on body image. The call for evidence is open until 7 July. We are trying to get as many people as possible to really inform that. This is a real opportunity, as you say, for all the learnings we have about mental wellbeing, prevention, social prescribing and all the things that we can do, such as prevention in schools and some of the education and training, right through to dealing with quite serious mental health conditions and severe illness as well. There is a lot of work going on in mental health. On the very severe side, obviously, we have the reform of the Mental Health Act coming through as well, which is for people who tend to be in-patients or at risk of being in-patients.

Q143 **Dr Evans:** I declare an interest for my final set of questions. I would like to see images labelled with a logo if they have been digitally altered.

In your opening remarks to the Chair, you spoke about obesity and the fact that we have calorie labelling. Your justification was that we have calorie labelling because it is a widespread problem and people need to be aware of and informed about the difference, and it is very hard for those who have eating disorders because you have a conflict of interest between them.

I would argue that the same applies when we are dealing with doctored images. It is very widespread and has a big impact. As the mental health Minister, you could argue that you are informing people. We heard from Charlie that the biggest thing he asks us for is transparency, both from the Government and from the users and individuals who put it out there. Is this something you would consider?

Gillian Keegan: We are working with our colleagues in DCMS who ultimately have responsibility for both the online harms Bill and advertising standards, which is probably where this would come into place. They are consulting at the moment on those advertising standards. Again, I would urge people to input to that consultation.

The discussions that we are having at the moment are largely around what will be in scope in the online harms Bill and whether it will include the things that we concern ourselves about, like suicide prevention and suicide sites that tell people how to take their own life, or sites that tell people how to harm themselves. There is a big focus on that and a lot of discussions.

On the consultation, I think that what they need to do is figure out what would be effective. One of the things I have learnt from many years in business and then just a few years of being a Minister is that it is really important to spend time considering policy. It is difficult to set up policy that is scaleable, enforceable and that people can trust. How you do that is something that they have to consider very carefully. The consultation period will be the start of getting all the different views on that. It would then be up to my colleagues to start to formulate that. We would input into that, but it is their lead in terms of policy.

Q144 **Laura Trott:** Minister, in the Health and Care Bill the Department pledged to introduce a regulatory regime for non-surgical cosmetic interventions. Can you let the Committee know where the Department is in formulating the plans for that?

Gillian Keegan: Yes. The Bill has just passed, and it is our intention that the Secretary of State will have powers to do that, to be able to introduce licensing. At the moment, they are working with stakeholders to design the consultation, as it were, but the plan is that there will be quite a wide consultation on that. Again, it is to make sure that we get it right. Obviously, we have registration, licensing and banning, so there are different elements. It is definitely something that we will be consulting on, and we will let you know, with your particular interest and the fantastic work that you did on banning some of those treatments for under-18s. At the moment, they are working with the stakeholders to put together the consultation.

Q145 **Laura Trott:** Do we have a timeframe at all on that?

Gillian Keegan: I do not have a timeframe, but when we have a timeframe I will make sure that we let the Committee know. I will also let you know personally because I know that you are very interested in that. You have a lot of expertise and we would be very happy for you to input your expertise into that.

Q146 **Laura Trott:** Thank you. In terms of the types of stakeholders that are going to be involved, this is obviously primarily but not exclusively a women's health issue. Is it going to be included as part of the women's

health strategy that is coming out later this year? Do you know?

Gillian Keegan: I do not know. Women's health is not part of my portfolio and I have not seen the responses to the women's health consultation. I do not know whether it came up during that.

Your point about joined-up policy is an important one. We will make sure that it makes sense. With quite a lot of the things that we work on, such as women's health policy, mental health strategy and some of the things around body image and surgical interventions, there is obviously quite a lot of intersectionality, so we need to make sure that we refer to all of them and have a coherent strategy from the Department's viewpoint.

Q147 **Laura Trott:** We have discussed today the issues around mental health when we talk about consent for these types of procedures. We have discussed surgical procedures today. Obviously, it is an issue within the non-surgical cosmetic procedure environment as well. From your mental health responsibilities, do you think that is important as one of the steps in any regulatory regime?

Gillian Keegan: I think it is important that we consider people's mental health when they are making decisions that, as we heard from Charlie, can have a big impact. That is why it is important that somebody's mental health is taken into account.

It is obviously difficult. At the moment we know that we have an environment in social media that is encouraging a lot of unhealthy behaviour. It is concerning. You only need to go into schools. We all go into schools and talk to young people, particularly young girls. Social media is taking a terrible toll on their mental health. That is one of the things that has grown in the pandemic. It can be body image comparisons, unreasonable expectations or bullying. It is coming at them from all angles, and a key part of our mental health strategy is to make sure that we can pick up all of the things, and take sensible steps to protect and help children.

We are investing in the curriculum as well. RHSE has mental wellbeing now, where they are actually taught about unhealthy comparisons and unrealistic expectations. We are introducing mental health support teams in schools, which I think will be hugely important in both prevention and the lower stages of earlier interventions for anxiety, depression and those kinds of things. There is a lot of activity going on. It is the same with everything. Everyone wants to prevent as early as we can, and obviously not have people in these critical states, sometimes with their life at risk with eating disorders or other severe mental health issues. It is very important that we do as much as possible up front. Consulting people and their mental health before they make big decisions is good practice.

Q148 **Laura Trott:** Dr Evans has done a huge amount of work on body image and the labelling of images. There is the issue that we discussed about consent for non-surgical cosmetic procedures. You have rightly

mentioned the huge amount of pressure that young people, particularly, are under as a result of social media.

Where does responsibility lie for handling all of this? It is a vexed question in Government, I know, but specifically are you, as the Minister responsible for mental health, pulling all this together? Will it reside within the mental health strategy when that comes out? Is it more an issue for DCMS in the Online Safety Bill? Where does responsibility for this key issue really sit?

Gillian Keegan: In two places, actually. One is the mental health strategy and what we need to do to build mental health services from a health perspective. In terms of the legislation around what we do with the internet, that clearly is DCMS. There are very few things you do in Government over which you have complete control. You normally have to work at least with a number of other Departments. For example, when I am talking about learning disabilities, I work a lot with DWP. When we are talking about children's mental health, I work a lot with the Children and Families Minister. There is a lot of overlap.

In this particular case, it is the online harms Bill that will attempt to navigate the regulation of the internet and the advertising standards being consulted on, and will attempt to see what more should be done in terms of images and how images are portrayed. My role really is to build the mental health services for people to be able to both prevent and deal with mental health issues as they arise, and to deal with them better because we know the waiting lists are way too long.

Q149 **Laura Trott:** Is there any work ongoing in the Department to look specifically at the pressures on mental health that are put in place because of social media, or is that something you think resides more in DCMS?

Gillian Keegan: I imagine it will come forward very strongly in the call for evidence. Based on everything I have heard anecdotally, I would be very surprised if that does not come forward, particularly for a certain group of the population and younger people in particular.

Q150 **Laura Trott:** But it is something that your Department is very concerned about and will be looking at if it comes through as part of your process.

Gillian Keegan: Yes, absolutely. When you look at the rise of self-harm with young people, anecdotally again, the call for evidence is going to be very helpful. People say the reason it has grown is that there are a lot of sites that are almost glamourising and normalising some elements of it. It is the same with suicide and suicide prevention sites. There are certain sites that show you how to do it. One of the key things with suicide is having the means. That normally makes it a step too far, but when you have sites that help with those means, it is very concerning.

I am sure that when you listen to young people, and when I go into schools and listen to them, they all mention the internet. It is not only

the internet, but other social media platforms, sharing WhatsApps and being ostracised or bullied via WhatsApps. Rumours are spread anonymously about people. That is all very much impacting young people's mental health, and I am sure that the call for evidence will show that very strongly.

Q151 **Laura Trott:** I have a final question, to which I expect the answer is yes, but it is one of those issues that has bubbled around for a huge period of time. People have been asking for action for longer than I can remember. Is it now a priority for the Department to make some changes specifically around the regulatory regime for non-surgical cosmetic interventions?

Gillian Keegan: Yes. There are a number of priorities. It is a Department with a lot of priorities, obviously—catching up with all of the electives that we need to catch up with, mental health, putting the right services in place and trying to meet that growing demand. It is something that is part of the Health and Care Act.

We also have to integrate health and social care. We have to reform social care. We have a lot of priorities, and it is a very busy Department. Of course, it is very important. It had a lot of impacts from the pandemic, but it is there, and it is in the Bill. The consultation will come forward. It will take a bit of time because, obviously, you need to consult first and then consider what policy is going to have the right impact. It is there in the legislation, so it is clearly a priority. We obviously have to work through the processes, but it is clearly a priority. But there are many things in the Health and Care Act that we need to get on with.

Q152 **Chair:** I have some brief, final questions, following up on what you have been saying. First of all, the online harms Bill is obviously a very important piece of legislation for you as mental health Minister. As I understand it, we are going to make getting the balance right between freedom of speech and preventing online harms—both very important priorities—the responsibility of the social media companies. Why would that not be the responsibility of elected politicians rather than people in California?

Gillian Keegan: That is the question and the debate that is raging at the moment. It is really being managed by my colleagues in DCMS. It is their Bill and they are obviously taking the lead on it. I suspect that is a lot of the debate that we still have to come.

Chair: I wondered what your view was.

Gillian Keegan: My concern, as the Mental Health Minister, is that at the moment, basically, larger sites would be within the remit of the Bill, and a lot of the content that I am concerned about is on smaller sites. That is a big focus for me. Some of the sites we were just talking about are not large sites. They are pretty niche sites.

Q153 **Chair:** My colleague, Luke Evans, makes a very powerful case that altered body images on social media, for example on a Facebook page,

should be required to be labelled as a way of avoiding some of the body image issues that we have been hearing so much about in the course of this inquiry. Do you agree with that recommendation?

Gillian Keegan: I do not have a view yet. I know that there is the OAP consultation, which is on until 1 June. With any of these things—

Q154 **Chair:** Do you have an instinct? I appreciate that you cannot make Government policy on the hoof, but I am interested in whether you have an instinct about the issue.

Gillian Keegan: I think my instinct is really just as a businessperson. How do you enforce it? How do you make sure it is real? How do you make sure it is a system that you can rely on and trust? That is just my first businesslike approach to thinking about something that broad.

Q155 **Chair:** You are sympathetic with the objective, but you just want to make sure that, if you did it, it would be enforceable.

Gillian Keegan: I think I am sympathetic with wanting young people, and other people, to be protected from the harms that can be caused and for their mental health to be more resilient. As to whether it is the best way or not, I think there is a long way to go about what is the best way to navigate that.

We talked right at the beginning about trying to get a balance between tackling obesity and not causing undue distress to people who have mental health eating disorders and mental health conditions around eating. It is a very difficult balance. With this, we have to get a balance that is fair and right. It really is my colleagues in DCMS who are taking the lead on that, both in the consultation on advertising and the online harms Bill. I am sure we will all have an ability to input to that in some way, shape or form.

There will not be simple answers. It is the same as when we started. There will be no simple answers. It will be about trade-offs and getting something that is workable and scaleable.

Q156 **Chair:** I have two final quick questions. You mentioned the mental health support teams that are being rolled out for schools, which we strongly supported in our CAMHS and mental health report recently. What is the status on mental health leads in schools? Part of that policy is not just the mental health support teams, but that DFE was going to make sure we trained up at least one teacher in every secondary school to be an expert in understanding early signs of mental illness. Where are we at with that?

Gillian Keegan: It is a DFE lead in particular on that, but they are training up those leads. The mental health support teams in schools are there to support those leads as well.

The way the system will work is that the mental health support teams will have a group of about six to eight people. There will be clinical psychologists and psychiatrists. They will oversee a number of schools,

which will have mental health leads in each one of the schools, to be able to escalate to. It will be the next stage for the mental health support team. It will be there for leads in the schools and for mental health support teams within the schools, or counsellors. Some schools have counsellors. It will be there for them and they will be able to draw on the mental health support teams. They will look after eight to 10; it depends on the volume of people in the school. That is the model. We should have rolled out to 35% of the schools by 2023-24, which is a year earlier than we planned.

Q157 **Chair:** I appreciate it is another Department, but could you possibly write to the Committee and just tell us where we are at? It is not so much the mental health support teams but the mental health leads in schools, which is the other part of that policy.

Gillian Keegan: In terms of the volume of how many have been trained?

Chair: How many we are training and how many schools will have one by the end of the Parliament. That would be brilliant.

Gillian Keegan: I will certainly be happy to do that.

Q158 **Chair:** I want to go back to our previous panel, just to really understand where you are at. We had a very interesting debate. Dr Angela Meadows felt very strongly that we should have a Health at Every Size approach that avoided any kind of stigma attached to body weight. Tam Fry from the National Obesity Forum was strongly championing weighing children throughout primary school so that you can identify people who are both overweight and underweight. I wondered where your instincts were as mental health Minister on which of those two approaches is the right one in terms of minimising mental illness.

Gillian Keegan: It is very important not to label children. That is something that can carry a lot of harm with it. However, you need to get the balance right to teach people—young people in particular—healthy eating habits and healthy exercise. There is a lot of activity in this area. All of us will see a lot of activity in schools, changing the type of food in schools and the walking a mile, and so on.

The nuance will be in between. It cannot be as simple as one or the other. Some of my cousin's kids have come home from school with this little thing saying they are obese. It has caused quite a lot of shock actually because they did not think they were obese, and they do not think they are particularly overweight. It is important that we teach people resilience in their mental health—that is the most important thing—and that people can come in different shapes and sizes. Ultimately, what matters is that you are healthy, both in physical and mental health. We have a long way to go for all of the things to support people during that journey. I think, again, it is nuance and balance, and we have to get that balance right.

Q159 **Chair:** We are really concerned that we have not had a response from

the Government to our report into learning disabilities and autism. As you know, the Government get two months to respond. The response was due last September. We are now eight months late. I know that we have had a pandemic, but that is a very long delay. We believe there are 2,000 people in secure units with their human rights being breached because they should not be locked up. They should be living in the community. When are we going to get the response?

Gillian Keegan: I will come back to you on that. I actually started the role in September, so that kind of thing happened beforehand. I would like to take the opportunity to assure you that the 2,080-odd people who are in-patients have been a huge focus of mine from the moment I turned up in the job. We have a focus where, for those in segregation, each of their cases is being reviewed. For everybody, there is a case review as well. For those who are in segregation we have a senior intervener, because they are more complex cases, to try to bring everybody together and to get people on a path where they can be treated and put in a much better facility.

Building the right support in the community is a delivery board that I have been chairing. I do not know perhaps whether they are waiting for that, potentially. I do not know why the report has not been responded to. I will find out, but there is a lot of work ongoing to enable that to happen.

Q160 **Chair:** Obviously, we have a big concern that it has taken eight months. The central recommendation in that report was that the Government should ban long-term admission to assessment and treatment units, which is the root cause of people ending up being parked in those units, which breaches all of their human rights and is completely unfit for a civilised society. Are you open to that recommendation?

Gillian Keegan: The reason that has not been implemented so far is that we do not have other support systems in place. You need the right support in the community, otherwise people end up backed up in prison because half of them are forensic— You have to get the right result.

There are a number of things happening in the reform of the Mental Health Act. What you are talking about is a pragmatic view, but also something that will change behaviours. I am still working through how we get that balance right, but I am very alive to what could start to create that difference there.

Chair: We look forward to that response. Our recommendation, by the way, was for non-forensic cases. We understand that point.

Thank you very much indeed for your time this morning, Minister Keegan, and Zoe Seager. Thank you for joining us. Thank you, colleagues.