Women and Equalities Committee

Oral evidence: The Government's consultation on conversion therapy, HC 878

Wednesday 24 November 2021

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Watch the meeting

Members present: Caroline Nokes (Chair); Elliot Colburn; Jackie Doyle-Price; Kim Johnson; Anne McLaughlin; Bell Ribeiro-Addy.

Questions 31 - 48

Witnesses

I: Dr Sheikh Ramzy, Director, Oxford International Islamic Information Centre, and Imam, Oxford and Oxford Brookes Universities; Simon Calvert, Deputy Director for Public Affairs, The Christian Institute; Danny Webster, Head of Advocacy, Evangelical Alliance.

II: Jayne Ozanne, Director, Ozanne Foundation; Dr Ilias Trispiotis, Associate Professor in Human Rights Law, University of Leeds; Rev Dr Helen Hall, Associate Professor, Nottingham Law School.

Written evidence from witnesses:

Examination of witnesses

Witnesses: Jayne Ozanne, Dr Ilias Trispiotis and Reverend Dr Helen Hall.

Q1 **Chair:** Can I thank our second panel for joining us for this session on conversion therapy? We have Reverend Helen Hall, Jayne Ozanne and Dr Ilias Trispiotis. Please could each of you in turn give us a very brief introduction?

Reverend Dr Helen Hall: Thank you for having me. I am Helen Hall. I am an associate professor at Nottingham Trent University in law. I specialise in law around religion, belief and human rights, particularly in relation to children and other vulnerable people within faith communities. I have expertise in the law around exorcism. I am also an Anglican priest.

Jayne Ozanne: I am Jayne Ozanne. I am a gay evangelical who has survived 20 years of conversion therapy. I chair the Ban Conversion Therapy coalition and I convene the legal forum that produced the Cooper report, chaired by Baroness Helena Kennedy and involving some of the most senior human rights lawyers in the UK.

Dr Trispiotis: I am Ilias Trispiotis. I am an associate professor in human rights law at the University of Leeds and specialise in European human rights law, discrimination law and law in religion. I have published articles on conversion therapy, and the human rights implications of conversion therapy and its ban. I am a member of the legal forum on banning conversion therapy.

Q2 **Chair:** How would you define conversion therapy, please?

Jayne Ozanne: The definition that we would recommend, which was recommended in the Cooper report and follows the UN and other countries' definition, is any practice that seeks to change, cure—i.e. the intent is to believe that someone is ill—or supress someone's sexual orientation or gender identity. That is the broad definition. When we talk about religious practice, we have two recommended caveats: that they must be directed at an individual or group of individuals and that they must have a predetermined purpose.

Reverend Dr Helen Hall: I would endorse that. The only thing I can usefully do is to stress the significance of the predetermined purpose and the intent that there must be an outcome that is envisaged, i.e. as described.

Dr Trispiotis: I fully agree. This is a definition that the official UN report on conversion therapy, which was published in 2020, also adopts. It is the definition of conversion therapy that the memorandum of understanding that was signed by the NHS and the leading regulatory bodies for clinicians and medical professionals adopted as well in 2017.

Q3 **Chair:** Helen, do you see any difference between therapy or practices that aim to change somebody's sexual orientation, as opposed to those

practices that might seek to change someone's gender identity?

Reverend Dr Helen Hall: Obviously, on one level there clearly is a difference that can be talked about, which enabled you to phrase the question. However, in terms of seriousness and effect, there is not any difference. What we are looking at, in both cases, is that, if we are dealing with a situation in which you have a predetermined outcome that this is what you are going to do to the person and this is what you are putting forward, the empirical evidence is that the impact on that person can be harmful and is likely to be so.

Q4 **Chair:** In the LGBT survey, more transgender people reported having experienced conversion therapy in a healthcare setting, as opposed to a non-healthcare setting. Why do you think that is the case?

Reverend Dr Helen Hall: I would not claim to have specific expertise on that. That partly depends on self-perception, reporting and how the questions were put in the survey that you are drawing the information from, does it not?

Jayne Ozanne: I think the Government's research is clear that trans people, sadly, are twice as likely to be offered or to go through conversion therapy. Our own research, which we conducted last year with Stonewall, Mermaids and the Ozanne Foundation, showed that the forms of conversion therapy tended to be far more violent and far more abusive, in terms of physical and verbal abuse, were likely to be conducted more by a family member or indeed in a medical profession, but also occurred in religious practices.

If you ask what the difference is from the point of view of someone practising them, they all have the predetermined purpose. If you ask what the difference is from those receiving them, it is likely to be far more aggressive for a trans person than it is, sadly, for someone going through LGB conversion.

Q5 **Chair:** Can I ask each of you in turn the same question that I posed to panel one, which is about recognised psychotherapy talking therapies and religious talking therapies? What do you think the differences are?

Jayne Ozanne: The Government's research shows that 51%, i.e. the majority form, of conversion therapy happens in a religious context and therefore it is more prevalent. Our own research, again, showed that, in recent history, a much smaller number of people have gone through the medical professional forms of conversion therapy. The vast majority happens in a religious context.

The word "therapy" is a misnomer. There is no form of therapy in this. It is practices that are aimed at trying to change, supress or cure someone's sexual orientation or gender identity. In a religious context, it will occur over years. It is not just the actual practice; it is the length of time that you are subjected to that. From my own experience, I will explain that I spent a lifetime seeking a cure, a change to my sexual orientation, because I believed who I was was sinful and unacceptable.

It is that long-term, constant messaging that who you are needs to change, that you seek that, that you are told that your prayers are not being answered because, sadly, you do not have enough faith, you are not being open enough or you are not being godly enough. That constant messaging to someone who, oftentimes, is someone who wants to do good, who wants to be right, who wants to be a good Christian witness, is crushing. If that happens to a younger person, particularly a child, that will, sadly, have significant mental health implications for the rest of their lives.

Sorry, I have taken us slightly off course. Ultimately, the space that allows someone to explore and accept who they are, whether that is in a religious setting or a medical setting, is good and proper and should be encouraged. It becomes a practice that needs to be banned where there is a predetermined purpose in either of those two settings.

Reverend Dr Helen Hall: I would agree that it is the practice rather than the context that is the problem. If something is sufficiently serious to warrant the intervention of the law, that must be so, regardless of the context in which it is happening, because we should not lightly take away people's freedom in any setting.

It is also important to stress that the medical therapeutic world has moved away from anything that might be described as conversion therapy, because it operates on the basis of empirical evidence. It spent a long time in the 19th and 20th centuries trying to do these things and it was discovered time and again, and with very respectable research from the best universities around the world, that it was violating the basic principle of "do no harm".

Dr Trispiotis: I completely agree. Legitimate talking therapies do not have a predetermined outcome in mind. The Government proposal actually put it very well. Legitimate talking therapies do not start from the basis that being LGBT is a defect or a deficiency. Actually the MOU from 2017 that the NHS signed as well fleshes out what legitimate support means in this context. Legitimate support is evidence-driven and has no agenda that favours one gender identity or sexual orientation over another. There is no agenda and no predetermined outcome. It is evidence-driven and inherently non-discriminatory.

Q6 **Anne McLaughlin:** Good afternoon and thank you for your patience. I think it was me who kept the questioning going bit too long earlier on. I am going to start with Jayne, but if either of you wants to come in on this that is absolutely fine. Jayne, do you think conversion therapy will always cause harm? If you do, what evidence has persuaded you of that? If you do not, are you aware of any cases where it has led to a positive outcome?

Jayne Ozanne: The 2018 faith and sexuality survey, which the Ozanne Foundation ran, had over 460 people who claimed to have gone through conversion therapy. It is true that a very small percentage—I think it is about 3%—thought that it had worked, but 97% felt it did not work and

showed very significant harm that they had been subjected to. Just because you think something might work, it does not allow you carte blanche to continue to commit quite horrendous abuse.

Conversion therapy, in all its forms—there is no gentle form of conversion therapy—is deeply psychologically damaging. It can also be physically damaging. We have heard of cases of forced rape or physical beatings, but, on the whole, it is the psychological damage, which is now really well documented at a UN level, by the ILGA World report, by the OutRight Action International report, by the UK Government's report, by our own report, by the testimonies now of hundreds of survivors who have gone through it, primarily in a religious context.

This is a world where those religious leaders refuse—forgive me, but you have heard that this afternoon—to recognise the harm that is being caused and ask for the right to continue with that harm. It comes from a deep belief that being gay or transgender is sinful and wrong. I am a member of the General Synod. We are not sitting here trying to change someone's belief. We are asking for the right to protect people from practices that will cause them harm.

I want to correct some of the things that have been said earlier. We are not saying that preaching should be banned, that someone expressing their belief should be banned. We are saying that any practice aimed at an individual, with a predetermined purpose to try to change them, should be banned, because of the harm that has known to have caused. We are talking about suicide. Of course, there is mental health depression. Sadly, there is self-harm. There is suicidal ideation.

It is actually the level of suicidal attempts, which are even higher among our trans community, that should get us really concerned here. I am deeply concerned that there does not seem to be a greater desire to engage with that level of known harm.

Dr Trispiotis: I completely agree with everything Jayne said. The official UN report on conversion therapy from last year includes references to many peer-reviewed studies that show that conversion therapy can cause grave and lifelong psychological and physical harms. Such evidence comes from many different jurisdictions and regions, but there are also global studies. The UN report specifically refers to the recent survey with 8,000 respondents from 100 countries, in which a staggering 98% of the 940 persons who reported having undergone conversion therapy testified to having suffered damage, such as suicidal thoughts, permanent physical harm, suicidal attempts, depression, anxiety, shame and self-hatred.

The World Psychiatric Association in 2016 has declared that there is no scientific evidence that sexuality can be changed. I mentioned already the 2017 MOU that the NHS has also signed. All those sources are evidence-based.

Reverend Dr Helen Hall: First, I am aware of some recent empirical research from an Australian university, Macquarie University, with, again, similar findings of the harm in a specifically religious context. Secondly, I can say that, as a priest, on many occasions, almost on a regular basis, I have people talking to me who are distressed that they have been through this and they ask for my help. I have never once had a person come to me and want to pray for thanksgiving that they feel it has worked and it has been a joyful experience. That is anecdotal, but it is my experience.

Q7 **Anne McLaughlin:** Do you agree with the Government's proposals that adults should be allowed to voluntarily engage in conversion therapy if they are given all the relevant information about what the therapy and practice involves and all the information about the known risks?

Jayne Ozanne: No, I do not agree. This is a very serious loophole, which will condemn thousands, if not tens of thousands, of people. There are two elements to it. One is consent and one is informed consent. I know both my colleagues are probably more able to speak legally to that. If informed consent had been allowed, it would not have protected me or indeed the vast majority of people who completed our survey.

We know that, in the faith and sexuality survey, 5% of people had voluntarily gone through, whereas 2% had been forced. In the trans community, it is even higher, so far more people volunteer, because you believe it is the right thing to do. Everyone around you believes it is the right thing to do. You are taught that it is the right thing to do.

From a point of view of informed consent—as I say, the legal arguments will be made—for me, that resonates with being asked to give informed consent for a medical operation. You go to hospital. You are given a form. You are supposed to be told what the success rate of the person who is conducting that research is, what the impact will be if you do not have that operation, what the empirical evidence for that operation working is.

All those three things are not going to apply within a conversion therapy context. You cannot be told what the impact is if you do not go through it. You cannot be told what the empirical evidence is. Most importantly, the person signing that form does so, on the whole, believing that the person in power over them, the doctor, has their best interests at heart. You go with a predisposition to consent, and that is my fear here. It really will cause a loophole that will not protect people from what we know will cause them long-term lifelong problems.

Reverend Dr Helen Hall: I will speak to the consent issue. Generally speaking, the law is not willing to recognise something as operative consent if there is a huge imbalance of power in the situation and the person ostensibly giving their consent is going to suffer likely demonstrable harm as a result. In these kinds of situations in the faith context, there is inevitably an imbalance of power and there is systemic pressure.

Yes, a person may come to this voluntarily. They may even ask for it, but they are doing this in a context where they have had the message: "If you do not do this, you will not be an acceptable member of this community". Effectively, the love and approval of your family and peers, and your social affirmation, are contingent upon doing this. Possibly you having a place in paradise after your death is contingent upon this. The pressure that places on individuals means that they cannot give what is truly free consent.

If you permit what is effectively false consent to be allowed, you are actually undermining rather than promoting liberty. Actually, it is the liberty of religious people that is being undermined, because it is not atheists who are coming for this. It is harmful for them and it is not true consent.

Dr Trispiotis: As Helen and Jayne said—I completely agree—consent, as it is defined in the relevant case law, in order to be valid, has to be, first, voluntary and, secondly, informed. Let us start from the "informed" part of informed consent. The consultation documents rightly note that, to have informed consent in this context, a person must be given all the information about what the therapy involves, including the short and longer-term risks.

Informed consent in this context would require that a "therapist" should tell the recipient of the "therapy" that there is scientific evidence, some would say incontrovertible, that conversion therapy can cause grave and lifelong psychological or physical harm, and that there is incontrovertible evidence that conversion therapy does not work. To fulfil the condition of informed consent, therapists must tell the recipients that what they are about to do to them puts their health at great risk and that it does not work. It would be difficult to imagine a situation where a therapist would offer the victims such information.

I agree with Helen completely about the religious setting and the pressure that is inherent in that context. However, to make a broader point than on religious settings, I would add that conversion therapy depends on and reflects the longstanding social stigma on LGBT identities. It is a pressure that LGBT people are under, to question their identity, which heterosexual cisgender persons do not really experience. It is in this and because of this context that LGBT people find themselves under duress in which they believe and are told by their communities that their sexuality or gender identity is inferior to others and that it has to be fixed. Controlling and coercive behaviour is inherent in all forms of conversion therapy, because of this context.

Jayne Ozanne: The legal forum that I mentioned earlier behind the Cooper report has put out a special note on consent, which I can happily make available to the Committee. The extra point that has not been raised so far is that the law does not allow for consent when there is a significant risk of vulnerable people being harmed.

The best example we use often is that of seatbelts. There are a lot of drivers who feel that their driving is very safe. They might drive in an area of the country where they are not likely to meet another car. Why can they not consent to not wearing a seatbelt? The law is there to protect the vast majority of people who could be vulnerable to an accident. Yes, it is possible that a couple of people might give informed consent. Actually, I do not think it is, but people will argue that it might be. Ultimately, the law does not allow for that, because it would put too many people at risk of harm.

Reverend Dr Helen Hall: That is a very useful point. Perhaps another analogy would be that, theoretically, we could imagine that a 15 year-old might consent to sexual intercourse with somebody who was 21 or 22, but there are good reasons why the law has drawn a line and said no, because it is important to protect the majority. That drive to protect means that we limit the theoretical autonomy of a minority of 15 year-olds to consent to sex.

Q8 **Anne McLaughlin:** You were all talking about the definition of informed consent. Ilias, do you think the definition of voluntary, as the decision to either consent or not consent to an act, must be made by the person and must not be influenced by others? Is that workable?

Dr Trispiotis: It is not. It has disadvantages as a definition, especially in this context we are discussing today, where there is a longstanding social stigma and pressure on LGBT identities. This, inevitably, is a tremendously powerful social influence for the individuals who are questioning their LGBT identities.

Jayne Ozanne: I would have consented. I voluntarily sought out conversion therapy. I willingly went and looked for places I could go globally and I know many others were like me. I thought it was the right thing to do and the Christian thing to do. As Helen has already pointed out, the cost of not doing it was, as I found out when I came out, exceptionally high, because you are rejected by all those close to you. Luckily, I was financially independent, but many are not. When your whole social structure, your financial structure, your home position, is dependent on you being obedient to the norms in your society, it is very hard to go against that.

You will have seen the testimonies. In the Government's own research, thousands of people put themselves through this because they believed it was the right thing to do. It is only after years of going through it that you realise the actual deep psychological harm. For me, I ended up in hospital twice with my body literally cracking under the strain with then full-blown mental breakdowns. I was one of the lucky ones really, because I came through that. Many do not.

We need to understand the pressure that is put. Again, you heard that earlier, quite clear evidence of pressure to conform to the cultural and religious norms around you.

Anne McLaughlin: Thank you very much for your time. It cannot be easy to have to sit and talk about these things all the time in front of other people, so thank you very much for that.

Q9 **Elliot Colburn:** I would like to explore this issue of religious freedom in a bit more detail. Ilias, as succinctly as you can, what kind of religious practices would you envisage being counted as conversion therapy?

Dr Trispiotis: In one sentence, only practices that are directed to an identifiable individual, with the aim of changing or supressing their sexuality or gender identity.

Elliot Colburn: Jayne and Helen, would you both agree with that?

Jayne Ozanne: Yes. If you want examples, that ranges from prayer to fasting, deliverance and exorcism ministries. Those are the ones I am most familiar with. I have been hit with a Bible. I know people who have been pinned down. I also know people who have just spent hours in private prayer. The psychological impact of doing that for 20 years is huge, because it says who you are is sinful, you feel ashamed and you feel unlovable.

Reverend Dr Helen Hall: I would endorse Ilias's definition and say that it is meeting those criteria, not the context in which the criteria are met, that determines whether it is conversion therapy.

Q10 **Elliot Colburn:** We have had a lot of evidence and indeed heard some in the first panel about religious practices that people do not feel should be encapsulated as part of this ban. I think the words "gentle prayer" were used quite a lot in the first panel. Helen, are there religious practices that you think should be protected from the scope of this ban?

Reverend Dr Helen Hall: I do not think the ban should have a religious exception, if that is what is being asked, no. Do I think that there are plenty of religious practices that will not be caught by the ban? Yes, of course there are plenty that are not caught and will not be caught, for instance general doctrinal preaching from the pulpit. It is not directed towards an individual. That is clearly not going to be caught.

Having a religious exception would be deeply problematic, because, as I have discussed, the imbalance of power is such that individuals cannot make a free choice to accept or reject these practices. Therefore, if you were to allow a religious exception, that would be a lacuna where these practices could continue to be carried out. If we are realistic, the overwhelming majority of contexts in which these things happen are religious. The respectable, therapeutic medical world has moved away from them.

Jayne Ozanne: We, as a panel, I think made it clear in the Cooper report that any form of prayer or pastoral counselling that seeks to create a safe space where someone can explore who they are and come to a point of peace with who they are should be welcomed and encouraged. It is when that has a predetermined purpose that we have a problem. It is important to note that the Church of England has condemned conversion

therapy. The Methodist church has condemned it, as have the Hindu Council UK, the Dhamma Center, the leading Buddhist centre, and the Quakers. An increasing number of religious groups now themselves recognise the harm and have called on the Government to ban.

Q11 **Elliot Colburn:** We have heard a lot particularly of concern around this idea of private prayer, gentle prayer, however you want to define it, images of a one-to-one conversation of just teachings about what a particular religion may have to say about LGBT identities. There seems to be this question of predetermined outcome. That has been mentioned a lot. Can you envisage any difficulties applying or proving that in law, when it comes to bringing cases against those who practise such a conversation? I think that is where some of the concern in the first panel came from. Perhaps you can give us some of your thoughts.

Jayne Ozanne: In the Cooper report, we recommend, and I think the Government have picked up on this, a two-pronged approach, where we look at civil law, i.e. protection orders, and criminal law. The criminal law would be best used and focused on institutions, on large groups that continually, flagrantly abuse the law. Civil protection orders are there to look at individual cases, where the state steps in, if needed, to protect.

Society has had to learn how to deal with spiritual abuse, which is what this is, in many ways. We have seen that with forced marriage, female genital mutilation and corporal punishment. We have had to learn how to warn and to look at what I call the civil approaches, before then going down a criminal route, but it has been possible to give a clear indication in law as to what is and is not acceptable. That is what we are seeking here. That is why we need this legislation. It is exactly the same.

Reverend Dr Helen Hall: It is true that, even with the civil route, you will ultimately need a criminal sanction if a civil protection order is breached. That is the point. There are sometimes evidential difficulties, but that is the nature of abuse that goes on behind closed doors. If we did not intervene in abusive situations that go on behind closed doors, we would have a very ineffective and non-human rights compliant legal system.

Dr Trispiotis: I have nothing to add really. Whether a particular form of prayer falls within the definition of conversion therapy would be a highly contextual judgment. It will boil down, perhaps, to its motivation. This is what the predetermined outcome test refers to, but that is not new in law. This is exactly what happens in cases involving harassment, for example, and abuse. They are highly contextual judgments that the courts make habitually.

Q12 **Elliot Colburn:** That is really helpful. This is the last question from me. What would be your response to the arguments that this could prevent spiritual leaders from providing much needed support to LGBT+ people in their community or preaching their faith freely? Using an example from the first panel, there is the idea that, if someone was to come forward, if this ban was passed, they would instinctively turn around and go, "No, I

am not going to talk to you, because I could spend five years in jail if I do on this issue". If I could get your view on that, that would be fantastic.

Dr Trispiotis: Once again, religious practices, prayer, any religious services that provide acceptance and support to someone and encourage the exploration of a person's sexuality or gender identity, are not conversion therapy. They would not fall within the definition of conversion therapy in the proposed legislation. This space for support would not be restricted by the proposed legislation. What would be restricted would be practices that are looking to change a sexuality or a gender identity to a more preferable sexuality or gender identity, namely heterosexuality or a cisgender identity. Those would be the only ones that would be covered.

Jayne Ozanne: I was going to say "or supress". The truth is that there has been an awful lot of fake news, stirring things up. I have seen headlines saying that I am calling for the Lord's Prayer to be banned. Honestly, I am a Christian too. We are suggesting that we need a space where people can be safe to be open about who they are and seek prayer for coming to a point of peace. We have made clear that the predetermined purpose is what needs to be banned.

Ultimately, matters to do with sexuality and gender identity are really quite intricate and are best left to professionals. I am not saying we should mandate this, but I would hope that, if a church leader was approached by someone who was truly struggling, they would suggest that they got some psychological therapist trained help. That is the best context, the medical professional who is trained to deal with this, rather than someone who is, sadly, perhaps trying to help, but can often cause more harm than good. You cannot mandate that. These are really sensitive issues. I will leave it at that.

Reverend Dr Helen Hall: I think similarly. I would echo Ilias's point. You are certainly not going to be caught, and there is no risk that you will be caught, as a religious person, a religious leader, who has someone come to you in crisis who just wants to talk to you and wants care and support, provided you do not behave in a way that is trying to push someone in a direction with a predetermined outcome.

If, however, people are, from a position of religious power and authority, responding to someone who is in crisis, maybe even suicidal, by implying that they can help them to change their sexuality or gender, that is abusive, problematic and needs to be stopped. You will not fall foul of the law unless you do something that is clearly in that category and therefore is something that can damage someone's mental health for life and perhaps even cause them to end their own life.

Q13 **Jackie Doyle-Price:** Jayne, I could see you nodding when I was talking earlier about spiritual comfort versus harmful practices. That is where we are, are we not? We are all wanting to outlaw anything that will cause harm, but we do not want to outlaw anything that will give people comfort, help people work through who they are and so on. When we are talking about the practices we are referring to, they are actually quite

obviously harmful practices. Are we dignifying them by calling them therapy?

Jayne Ozanne: I agreed with you. "Therapy" is completely the wrong word. We use "therapy" if we have to use it at all. The Cooper report makes quite a strong case right at the start that we should talk about conversion practices. "Therapy" seems to imply that it is in a therapeutic environment and that it is good and helpful. In Australia, the Victoria Bill made quite a clear statement on this too. It is a complete misnomer to call it therapy and it gives it a dignity, as you say, that it does not deserve.

Q14 **Jackie Doyle-Price:** I am pleased to hear that. A lot of the problems we get into in this space are a lot about language and it conveys different things. Dr Hall, how well do the Government's proposals address issues within the family context and around parenting, in particular as children are growing up and parents are reacting to that? Do you think the Government's proposals actually deal with those issues in a good enough way?

Reverend Dr Helen Hall: I do not see any reason for concern that they are going to enable or cause the state to step into family life, which is a concern that has been raised. The basic threshold in the Children Act will continue to be the bar, effectively, in that parents do not have rights, of course. They have responsibilities. That is the mainstream thrust of our law at present and that is an appropriate way of couching it.

Parental responsibility is a margin within which parents can act, because it is accepted that they are likely to be the people best able to help their children grow up happy and healthy. If it is being exercised in a way that is putting children at risk of significant harm or causing significant harm, that is already the point at which the local authority has both a right and a duty to intervene. I do not see anything in the proposals that is upsetting that balance, if that makes sense.

Q15 **Jackie Doyle-Price:** Effectively, there are provisions within the current law to enable intervention if there was a risk of conversion therapy in the household.

Reverend Dr Helen Hall: Yes, although of course it is helpful to have it specifically flagged that that is a problem in law, if you see what I mean. The definition of significant harm is extremely wide. There is room for debate about it. The point I was trying to make is that it is not as if we are introducing an extra level of oversight into family life. It is simply clarifying that this is harmful. Therefore that is something that may cause intervention.

Q16 **Jackie Doyle-Price:** I am going to come to you, Jayne, and specifically address the issues of gender particularly. Within a family environment, as children are growing up, gender is quite an elusive concept really. Is there a risk that, by having transgender included in this law, this would also stop parents from addressing these issues in a suitable way?

Jayne Ozanne: There are two different things there. If I can come back a minute, in the research that we did with the faith and sexuality—and I will come on to gender—we know that parents were a significant agent in either forcing or advising someone to go through conversion therapy. I think about 37% of those who had been forced through conversion therapy had been forced through by their parent; 30% had been advised to. Within the trans community, it will be much higher. The research showed us last year that, in 41% of people who had been put through conversion therapy in the trans group, it was done so by their parent.

I think what you are touching on is that a parent's duties and roles, as I understand it—I am not one—are to create a safe space at home where people can explore. We are making a stand against anything that stops someone exploring and tells them that they have to be a certain way or else. All the evidence is showing now that some children know at a very early age that they feel they are in the wrong body. Some will take a lifetime, often, to get to a point of peace.

Everyone is different and therefore we need to have a child-centred approach that allows them to explore and to come to that point of peace. That is where the medical profession is best placed to help identify what is going on in that child's life. Stopping a child being able to explore is also extremely problematic, to be honest. By that I mean that stopping them having access to care or medical professional support would be a concern.

Q17 **Jackie Doyle-Price:** Having looked at this in detail, the care pathways, particularly for children, are very much designed around an exploration of what gender is. There are often comorbidities with other things, autism being a particular example. It can be symptomatic of something else that is going on. The pathologies are very different between boys and girls. This is where good therapeutic pathways are absolutely crucial. One of the concerns I have about any legislation is that reference to therapy could be seen in that context. From your perspective, we must make sure that we are not discouraging parents from making any referral to that kind of exploration, which is very different from a journey about sexuality, actually.

Jayne Ozanne: The pathways are different, but actually the problem is the same. There is the impact on a child of being told that they cannot express themselves or be who they believe themselves to be, and of being forced down a route that they know is wrong for them. There is that mental anguish as well as the physical force that can be used. We heard horrific stories among particularly trans children of them being beaten, being locked in rooms, being starved. The abuse that many had undergone was far more acute than what we heard among children within sexual orientation research. Sorry, I am not being as clear as I need to be.

The important thing is that children are allowed to explore. To your final question to me, whether the ban should cover trans people, yes, most

definitely, but we need to be clear about the definition of what we are trying to ban. That is things with a predetermined purpose.

Q18 **Jackie Doyle-Price:** I guess the most important criterion for you—if I am summarising all of you correctly—is this existence of the predetermined purpose. We should make sure that a care pathway or a therapeutic intervention that was designed entirely about exploration is explicitly excluded from all this. That would be your intention.

Dr Trispiotis: That is right.

Reverend Dr Helen Hall: Absolutely, yes.

Chair: That was a very clear answer to finish. Thank you, all of you, for agreeing on that. Can I take this opportunity to thank the panel for the evidence you have given us this afternoon? As I said to the previous one, if there are any issues that you feel you wish to raise with us that have not been covered in writing, please do, remembering that we will probably want to write as part of the Government consultation, which closes on 10 December, so please give us enough time. Thank you very much.