HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Transgender Equality Inquiry, HC 390

Tuesday 8 September 2015

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Written evidence from witnesses:

- Action for Trans Health – 1st Submission
- Action for Trans Health – 2nd Submission
- Gender Identity Research and Education Society (GIRES)
- NHS England
- Trans Media Watch

Watch the meeting

Members present: Mrs Maria Miller (Chair); Ruth Cadbury; Maria Caulfield; Jo Churchill; Angela Crawley; Mims Davies; Mrs Flick Drummond; Ben Howlett; Jess Phillips; Tulip Siddiq; Cat Smith

Questions [1-47]

Witness[es]: **Jess Bradley**, Member, Executive Committee, Action for Trans Health; **Dr John Dean**, Chair, Clinical Reference Group for Specialised Gender Identity Services, NHS England; **Terry Reed OBE**, Co-Founder, Gender Identity Research and Education Society (GIRES); and **Steve Shrubb**, Chief Executive, West London Mental Health NHS Trust, gave evidence.

Q1 Chair: Good morning. Can I, on behalf of the whole Committee, thank you for coming in today to this, the very first public evidence session of our very new Select Committee, looking at issues to do with women and equalities? I know it takes an enormous time to prepare for meetings like this, so, from all of us, a huge thank you for taking the time out and for agreeing to come along to the Committee. Our inquiry, I believe, is very important, and we have had more than 230 submissions to this inquiry, which is extraordinary and just shows how important it will be. To have your evidence will add tremendous value to that, so, on behalf of the Committee, thank you.

Could I suggest that, before we start our line of questioning, you have the opportunity to introduce yourselves very briefly? I will remind you that we are going on for about an hour, so I may intervene through the questioning if I feel that we need to move on. Again, apologies from me if I appear a little abrupt at times. Perhaps, Jess, you would like to introduce yourself and your organisation, and then just move along one by one.

***Jess Bradley*:** My name is Jess Bradley. I am a qualified health impact assessor and I am on the executive committee of an organisation called Action for Trans Health, which is the largest UK-based democratic campaign for trans healthcare.

***Dr Dean*:** My name is John Dean. I am a medic. My primary specialisation was in family medicine. I worked as a general practitioner for many years, before working in specialised gender identity services. I am the clinical director of one of the seven gender clinics in England. My primary role with respect to today is that I am the chair of the Clinical Reference Group for Gender Identity Services, a committee that provides NHS England with advice about clinical matters for policy and commissioning with respect to gender identity services.

***Terry Reed*:** I am Terry Reed, trustee of the Gender Identity Research and Education Society. This was a charity we set up in 1997 following an industrial tribunal that we ran on behalf of our trans daughter, who had been tortured, literally, by her employers over a period of three years. Our charity is small, but we have about 400 members and about 80 corporate members. We give individual help to people, by phone or email. We provide training about 50 times a year, at a whole variety of organisations—academic, sometimes medical and employers.

> We provide e-learning, and have most recently done one for the GPs, which is on the Royal College of General Practitioners website now. We work internationally as part of the World Professional Association for Transgender Health, where we have funded translations of their standards of care into many different languages, including Russian, Chinese, Japanese, and are now doing Hindi and Arabic.
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> I am on the good practice guidelines committee and on the clinical reference group, under John's chairmanship.

***Steve Shrubb*:** I am Steve Shrubb, chief exec of West London Mental Health Trust. We have, I think, one of the biggest gender identity clinics in England.

Q2 Chair: Wonderful. Thank you very much. I am going to kick off the questioning and be slightly provocative to start with, to get the discussion going. In reading all of the evidence, I just wondered what people felt the attitude of the NHS was towards people with gender dysphoria. That is an open question, perhaps starting with John.

***Dr Dean*:** My experience, working with GPs and secondary care physicians, is that, overall, people working in the service try to be empathic; they are certainly sympathetic, but they lack a great deal of background knowledge about gender incongruence and dysphoria. It is something that is not covered in any detail in medical training. Certainly, when I trained 30 years ago, it was not, and, even today, medical students are very interested in what we do, but they get very little information about gender identity, gender identity developments and the differences and different developmental experiences people have that sometimes lead them to

need to use our services. Overall, they are empathic and try to be helpful, but hampered by a lack of knowledge about how to do that and about the services that are available.

Among clinicians, that is the attitude. Patients' experiences, though, are not just with clinical staff; they are with managers, administrative staff and all of the other important contributors to the NHS overall in hospital and out-patient services, who sometimes lack understanding of and sensitivity to the important issues and need to know more so that they can work with respect and understanding of differences related to gender incongruence.

Q3 Chair: I wanted to bring Terry and Jess in to give the lived experience of it, but before that, Steve, one in four NHS staff are not confident in supporting trans patients; that is Stonewall's research. Do you think that is accurate?

***Steve Shrubb*:** Yes, I do. Clearly, we have a service we are very proud of, and that is their primary call, but I run a mental health trust so I am very sensitive about stigma. In comparison, transgender individuals really do suffer stigma, and I absolutely acknowledge that there are significant numbers of NHS staff who are empathic, but, as they travel through our system, which is sometimes a complex system, I do not believe there is equality. Whether it is through lack of knowledge or through people's own views, service users tell me that it can feel as if they are not being treated equally.

Chair: You are very open in saying you do not think there is equality for trans people within the NHS.

***Steve Shrubb*:** Overall, that is my view. We can debate what percentage is due to lack of information, but I am just giving you my sense of what I pick up when staff talk to me and when individuals receiving care talk to me. While they will acknowledge that certain individuals go the extra mile, the overall sense is that it does not feel to me like they often are treated equally. That is my view, anyway.

Q4 Chair: That is incredibly helpful. Terry, Jess, how would you perhaps contribute from the other side of this discussion?

***Jess Bradley*:** At Action for Trans Health, a lot of our service users have complaints and we deal with those, so we definitely see the negatives more than we see the positives, but we do see a lot of trans people being denied treatment, whether that is on the basis that they present at a mental health clinic and the mental health clinicians think, "Okay, this is too complicated for us. We need to pass this on to somebody else." You find a lot of trans people are passed from pillar to post. A lot of GPs deny healthcare to trans people illegally, based on the fact that they do not agree with the choices that they have made.

There is this lack of understanding and lack of cultural competency around trans issues. We do a lot of training around sexual health. You kind of have the understanding that sexual health clinicians would be more open-minded about this sort of thing, but, generally, the understanding of trans issues is very poor. We have supported a lot of our trans members who have said they have presented at a sexual health clinic and they feel like they have had unnecessary genital examinations as a result of the clinician's curiosity. I do think there are quite significant areas to improve across the board.

Q5 Chair: You used a really interesting term there: a lack of cultural competency. Do you think that is something unique to the NHS?

***Jess Bradley*:** I do not think it is unique to the NHS, but we have commissioned some research into trans people's experiences of the private sector. Trans people generally have better experiences of private care, but are generally less likely to be out as trans within private care; this is when accessing transition-related care, really. It is certainly not an issue that is unique to the NHS; it is in private care as well and it is definitely a problem across all sectors of life.

Q6 Chair: Would you like to add anything, Terry?

***Terry Reed*:** I support absolutely what Jess has been saying. I have a quote here from something that was sent to you, and your office sent it to me, from someone who wanted to be anonymous. She wrote, "I have many health problems and dread going to some appointments. It is not unusual to have rude comments from staff, and we often get asked many questions that are not relevant—rare to find a doctor with even limited knowledge." She goes on to talk about suicidality. A few years ago, a survey was done on a mix of GPs and hospital doctors, and 84% of them responded that they did not think public money should be spent on lifestyle choices.

> I do think, in the medical profession particularly, the understanding of the condition itself does colour the way in which people respond and it has, as you know, been regarded, and is still in the ICD, under mental and behavioural disorders. There is some of that feeling still about the way in which people interact with trans people. That is beginning to change, and it hopefully will be de-psychopathologised in the ICD 11, but that is one aspect of it.
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> One of the things we find is that there is this general sort of ignorance about how to interact socially with people, so it is not all about their treatment. Very often, the reason they are reluctant to seek treatment is because of the use of the wrong names and pronouns, the wrong titles. Just recently, we had a doctor refuse to treat someone on religious grounds. It is relatively rare that they would actually say that out loud, but this doctor did: "I do not believe in this, so I will not treat, because of my religion." There is a whole range of reasons why trans people still experience difficulty accessing not just treatment for their gender issues, but any treatment across the board.

Q7 Chair: Indeed, Terry, we are going to come on to some of those issues in our later questioning. Before I move on to the next set of questions, I just wanted to catch up with John at the end of that. I saw you nodding quite vigorously. Do you disagree with any of what you have heard?

***Dr Dean*:** I agree with what my fellow panel members have said. I particularly agree with Jess's comment about cultural sensitivity. The NHS, to some extent, reflects the attitudes of society, and this lack of cultural competence extends across the whole of society, although, in the NHS, we should be taking a lead in that, in helping society make the necessary change so we do respect the dignity of and understand the needs of people with gender incongruence and gender dysphoria in the future.

Q8 Ruth Cadbury: Terry, you used the term "ICD 11", and something you said before that suggested that clinicians believe they have almost a legal right not to recognise trans issues. I just wondered if you could be a bit more specific.

***Terry Reed*:** Sorry, I should not have used acronyms; it is bad.

Ruth Cadbury: No, it is okay.

***Terry Reed*:** The International Classification of Diseases is where everything sits that can be treated, so if you are not in there, you do not get treatment, as it were. It is currently under mental and behavioural disorders. It probably will not be described as "transsexualism" as it is at present, but will be "gender incongruence", we think. That is a non-psychopathologising description.

Q9 Ruth Cadbury: Is that therefore an issue we should be looking at, or is there already work being done nationally or internationally on changing that situation?

***Terry Reed*:** Certainly, the international guidelines have a very benign and non-pathologising description. Yes, certainly in theory it should make a difference, because medicine is to a large extent predicated on what is understood about why conditions exist, on the etiology of them, and I do not think we are ever going to know what the etiology is in every individual case, but there is quite a lot of evidence now about the differences in development in trans people. That should make a difference to how we deliver treatment, but I am not in a position to say; it is more for John to say how it might make a difference to what kind of treatment and how it is delivered, if it is no longer falling under the psychopathological banner.

***Dr Dean*:** There has been a considerable change in scientific understanding and professional attitudes towards gender incongruence. One should remember that this particular experience was first described only in the 1950s, and that medical care as part of the mainstream, at least in the UK, evolved from the late 1970s and 1980s onwards at the clinic that is now hosted by West London Mental Health Trust, as very much a pioneering centre for that.

> There is diversity of opinion among the small number of health professionals and doctors who work in this field as to the precise etiology and nature of gender incongruence. From my personal view, I see this as a developmental difference. I do not use the word "disorder", although having this developmental difference certainly does not confer a great advantage over people who experience it, and it is influenced by genetic, endocrine, immunological and environmental factors. It has mental health implications for some patients, but not for all. It is not, in law in this country, recognised as a mental health problem, and I do not perceive it as a mental health problem, but people who are affected by it suffer considerable stress, from family, from peer pressure, from the response of society to them, and that can lead them to experience mental health problems as a consequence.

***Steve Shrubb*:** Far be it from me to tell you what you might do, but I would underline that it is important that in the various diagnostic frameworks this is not in some way, either directly or indirectly, seen as a behavioural or mental health problem. If you just stop for a moment and think about the challenges that individuals have during their lives, then it is not surprising that they are vulnerable to a whole range of mental health problems, but anything you can do

that reinforces this journey away from a label that suggests fundamentally this has a mental health issue would be extremely helpful.

Q10 Jo Churchill: That partially answers what I wanted to ask. For me, reading some of the submissions, there was confusion even within an individual over perhaps how they would like to be referred to and so forth. You have just intimated that, even within clinicians, there is confusion as well. My question is, how do you look for those key drivers that change cultural competencies? Do you see what I mean? Everything is so multifactorial on both the individual's side and the clinician's side. How do you get to the nub of the issue and drive the change? That was the really helpful thing that you just said, Steve—that just highlighting is one way of moving it forward—but how do you pull it together?

***Steve Shrubb*:** Having said that it should not be linked to mental health, there are some lessons we can learn from mental health. The campaign, Time to Change, is absolutely beginning to overturn attitudes towards mental illness, and we need, I think, to put energy behind a similar campaign. They recently have been featured on the BBC, on a Radio 4 programme. There is an awful lot we can do by having the conversations, and, when I say "we", not me or NHS staff, but individuals going through the process. Will it change it overnight? No, but it seems to me the more that people can relate to this, the more that people describe the processes, the more that people talk about a life that is enjoyable and has potential, the better it is. I sound very confident; it is a long, frustrating journey, but that is what we all need to do.

Q11 Mrs Flick Drummond: I just wanted to know what training you think should be given to NHS professionals. Should it be at medical schools and for nurses, etc? How can we change the training in the NHS, Dr Dean?

***Dr Dean*:** This is something that the General Medical Council would have significant influence over, because they provide guidance as to what should be contained within the curriculum. Awareness of gender identity and gender identity development—distinguishing it from sexual identity, noting the interactions between the two—should be a fundamental part of medical training. That is going to take a long time to feed through into those who are currently in practice, so it is important that it is incorporated into continuing professional development activities for existing practitioners.

> Importantly, there are so many things competing for medical practitioners' time in terms of professional development that it is difficult to get them to prioritise it until they are confronted with a patient for the first time. That is happening with increasing frequency, as more people feel that they can reveal their gender incongruence and their discomfort surrounding that to health professionals and seek help. As I am sure we will discuss later, the number of people seeking help is increasing dramatically, so it is no longer appropriate for any doctor to say, "This is a terribly rare condition. It is very specialised. I do not have to know about it. It is something for specialists." Trans people are people and want to be treated like other people, and want to be able to access healthcare, in primary care and other parts of the NHS, just as other people, and that is possible and appropriate.

***Steve Shrubb*:** There are some small practical things NHS organisations can do. We have quite rightly been urged over the last few years to do far more around diversity and disability. All of our staff that are inducted into my trust go through that, and it is part of their regular ongoing training. We need to make sure this issue sits alongside race, culture and gender; we

need to make sure it is there. It is a small thing, but the NHS can be reminded to get its house in order and to ensure that those induction, preparation and support programmes cover this really important issue and that much of the teaching, if I can use that term, is done by people with a lived experience rather than it being taught. There are some very practical things, and I think the NHS can be reminded that this needs to sit alongside, equally, a lot of the work it does in supporting and developing staff around the broader diversity agenda.

Q12 Maria Caulfield: I just wanted to move on. I have a couple of questions, firstly about access to NHS gender identity services and whether there is a standard pathway that should be followed nationally. If there is not, is there much of a variation across the country as to access to services and how people can gain access?

***Dr Dean*:** There is a standard pathway described in the interim protocol and service guideline for gender identity services, which was implemented in October 2013. That would allow general practitioners to make direct referrals to the gender identity clinic of the patient's choice—any of the seven that are within England. That is the theory, but the practice is not always quite so straightforward. As Jess has already mentioned, patients sometimes have difficulty persuading their general practitioner of the veracity and the need for referral.

Also, I have to say that some clinical care groups will advise their GPs not to refer directly, and I can think of at least one where they require patients to be referred to a psychiatrist for an assessment first, which is against NHS England policy and probably illegal as well. We draw that to their attention, but the practice still goes on. There is a need for some change.

Q13 Maria Caulfield: That is very helpful. My background is as a nurse. I have worked in a breast cancer clinic, but we did have people coming for breast surgery, whether it was breast augmentation or breast mastectomy, and we had no training whatever. My role was really to talk people through the physical aspect of the operations, what to expect, post-op recovery and that sort of thing. It was a while ago, but there was no training whatever, and that was not just for the doctors and nurses; that was for all the admin staff as well, so I completely agree with everything you are saying.

***Dr Dean*:** Clearly, the focus of our care must be the patient, the person seeking help. It is also very scary for the health professional for the first time, when they have had no training and possibly very little understanding, particularly in the past, of gender incongruence and even how to talk to someone: "How do I call you? What pronoun do I use?" There is understandable sensitivity about this. It can cause deep offence to patients if that issue is not properly addressed.

Really, some very straightforward training, widely available for all people working in the health service at every level, would address that. That would be at least a good starting point, so we can take the tension out of the discussion to some extent. There are still many other things we need to get right, but, if we can talk to each other with respect and understanding, that would be a very good starting point.

Q14 Maria Caulfield: Absolutely. My second point was what problems people have accessing the gender identity services. Obviously there is a huge discrepancy or difference in time to referral across the country, and then, once you are referred, you have to have this

two-year real-life test as well. That is what we hear, whether or not that is used as an excuse in terms of delaying access to treatment. Do you think that patients, as happens in other European countries, being able to self-refer and bypass the GP system would be helpful, or are there other, more pressing problems that we need to address first?

***Dr Dean*:** With respect to self-referral, I believe that has been possible in Scotland, and, speaking to colleagues in Scotland, they did not see that as a particular problem. How it would work in England, I do not know. Certainly, it is something that, if it were to be considered, ought to be piloted at least to begin with.

Chair: Why?

***Dr Dean*:** If we introduce a new way of accessing the system, in a system that is already stressed because it does not have the capacity currently in place to meet the demand of people who are already coming forward, we need to find out what the impact of changing the access is going to be on everybody in the system. I do not have any problem with self-referral, but, if we say you can self-refer, that requires people who do self-refer to be able to gain access to treatment in a reasonable time scale, and we cannot guarantee that for people who are referred from general practitioners and other health professionals at the moment. Self-referral has the potential to make that worse. As an aspiration, it is something that would be good for the future.

***Steve Shrubb*:** This is a whole-system problem. Let me just put some figures on the table, because I think it is extremely sobering. The NHS is great at finding the wrong solution for the wrong problem. It has a glorious history. This is my 40th year; I retire in eight weeks, so I have been doing a lot of reflecting on the glorious history: 50% to 60% of all referrals come into the service—colleagues behind me actually do the work; I am just the chief exec—and about 120 referrals per month, so 1,500 referrals a year. People are waiting currently between 12 and 18 months. To see the solution as pumping people through the current system more quickly is just not the way to go. The whole of the NHS and social care needs to operate as a system.

> Having said it is tough for people receiving the care, it is pretty damn tough for the staff providing it. Just pushing people through our clinic without primary care and other bits of secondary care doing their bit is going to move the bottleneck further on. We need a fundamental debate about this. Where else would it be acceptable for someone to wait 18 months? In mental health, we are passionate about parity of esteem. If you are going to treat this the same, then you have to have a whole-system approach. If you do not, then self-referral is going to actually make the process worse.
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> GPs' and primary care's response to this issue is extremely variable. Although I can take you to a number that are absolutely excellent, I can take you to a number who would appear not to have an interest, so we really should think. My God—waiting list initiatives? The NHS has had some fantastic waiting list initiatives that have not had the desired effect. It has to be a whole system.

Q15 Chair: Maria mentioned the real-life test. You are concerned about capacity issues. I am concerned about what impact the real-life test has on people's lives. Jess, do you think that is a helpful way of helping people think about this or not?

***Jess Bradley*:** I do not think the real-life-experience test is in any way helpful. When you think about what it means to be a woman or a man or something in between, there is no one way of being a woman; there is no one way of being a man. What trans people often have to do is conform to stereotypical ideas of what a woman or a man looks like to the practitioner, in order to access treatment. For non-binary people such as myself—people who do not identify within the gender binary itself—there is no unitary understanding of what a non-binary gender looks like, so how do you have a real-life experience of having one?

Real-life experience is often proved with changing your name or through interaction with some sort of officialdom. If you do not change your name, for example if you are a non-binary person who is particularly happy with the name that they were given at birth, then how do you prove that you are non-binary? There is a whole bunch of hoops you have to jump through in order to pass the test of real-life experience, which is not particularly useful for the patient, and, to be honest, I think wastes a lot of time within the system.

Q16 Chair: The real-life test is not very useful for the patient, then. What do the doctors or medics think about it?

***Dr Dean*:** I understand what Jess means by real-life test, real-life experience. It was certainly part of the international guidelines of the past. I can certainly understand that people coming to use gender identity services still feel that they are being given hoops to jump through and that a test exists. The requirements to access treatment do not apply equally across every individual part. What I think is commonly understood as a period of real-life experience, which we today call a period of living in a gender role congruent with a gender identity, these days is 12 months, not two years, and it applies to eligibility for referral for genital reassignment or genital reconstructive surgery only. With respect to other aspects of treatment, such as hormone therapy, specialist psychological therapies, there is not a specific time condition or time limit. It only refers to genital reconstructive surgery.

Chair: Why?

***Dr Dean*:** Medical practice in the UK tends to be standards-of-care-driven. That ranges from things like guidelines provided by NICE. In this case, there are UK good practice guidelines, which were developed over a period of 10 years, between 2003 and 2013. They set out broad guidelines that need to be interpreted on an individual basis, because it should not be one size fits all—you do what the guidelines say and there is no other option—but, for most patients, we do follow the guidance that is given in the UK good practice guidelines. They were developed by a group of representatives of several professional organisations and medical royal colleges, not just medical organisations, and representatives of the patient community and their supporters. Within that document is the guidance that patients, generally speaking, should have a period of 12 months living in a congruent gender role before they are referred for genital reconstructive surgery, and we follow that, but it does have to be interpreted individually.

I can only speak personally. I have to say there is quite considerable diversity of opinion between different clinicians and different clinics. All seven gender clinics in England arose out of the special interest of an individual a long time in the past. There has not been a lot of planning of their development, and there certainly is no training pathway for medical practitioners or others who work in this field. It is very much learning by

apprenticeship, working with other people and observing. People working in this field generally in the past have come primarily from psychiatry, but more recently genitourinary medicine and family medicine as well. As there is not a standard approach or a standard training in how the guidelines are interpreted, there is certainly room for variation in interpretation, so, where you go to different clinics, you may get a different answer with respect to real-life experience.

***Jess Bradley*:** Potentially, one of the things we should be looking at shifting practice towards, instead of looking at this arbitrary length of time, is whether the patient has support networks to cope with the changes they are about to make. I think this necessarily involves moving towards another model of treatment called the informed-consent model, which is less pathologising than the current standards. It involves the clinician and the patient coming together, discussing things, the patient taking responsibility for the actions that they have and the clinician ensuring that the patient has the support networks in place. I think this would be a significantly better service and offer better patient experience, but also involve significant cost savings to the NHS.

***Terry Reed*:** I completely agree with that. I think there needs to be a more holistic view taken also. Historically, family members have not really been included very much in this, although there is the research showing that lack of family support is a predictive factor for regret. If the NHS is going to be paying for the treatment, it makes sense that they would broaden the scope of what they are doing a bit and provide that added ingredient.

I absolutely see the difficulties for non-binary people, and there is another aspect of this. Steve was talking about all aspects of equality. It would appear, we are being told, that despite the fact that the public sector equality duty would cover the provision of medical treatment, it is not clear that the gender reassignment characteristic is deemed to cover non-binary identifications. That is extremely worrying and does not make sense, because they are undertaking a part of a process, but we are told constantly, "No, there has been no case telling us this, so we have to wait until a legal case is run to see whether they are covered."

Q17 Chair: That is an important point. I want to just drive this home. I am not hearing anybody saying that the real-life test is great; I am not hearing that anybody is advocating a two-year test; yet that is exactly what we ask people to have if they want to have a legal gender reassignment, or am I wrong?

***Dr Dean*:** You are right. Generally speaking, the period of living in a congruent gender role forms a part of a care pathway, which has several parts running in parallel. People also do not come into the care pathway at the same point. Some people have within them dysphoria—a deep sense of uncertainty and discomfort surrounding how their body has developed, and how society and family expect them to live their lives—and want to make a change, but are fearful of making that change for a whole range of very understandable and reasonable reasons. They need preparation and help in making a transition. They have an idea of where they want to get to, but find it difficult to get there, to make that step.

Other people come to gender clinics who have lived effectively as a man or a woman, or in a non-binary role, for many years. They may have obtained hormone therapy or had access to other interventions, either through the private sector or through self-medication, and may be living very happily and may have lived very successful lives. For them, it is

more difficult to argue, "On top of us all knowing that you have lived like this for the last five years, you have to live for another year." I would quite agree, on a personal basis, that the guidelines should be interpreted to make allowance for that previous experience.

Where people enter the service, they have a period of assessment, which is not like diagnosing the common cold. Like many other health problems—diabetes, asthma, many other health conditions—you need to gain an understanding of the condition and how it affects the patient over the course of two or three consultations, over a reasonable period of time. I do not think we do it over a reasonable period of time, but that should be part of it. We need to be clear that the patient clearly understands the implications of what they are asking for, the risks, benefits and limitations of the various interventions, which include hormone therapy, to educate them about hormone therapy, to prescribe hormone therapy, to monitor it. Speech and language therapy and hair removal are essential to many binary and non-binary people's experience. It is during that time that this period of living in a congruent gender role is going on.

The informed-consent model is very interesting. I have to say that healthcare is gradually moving towards more of an informed-consent model as there is greater emphasis on respect for personal autonomy and freedom of choice, but it is generally not part of British medical practice. The analogy would be, if someone wanted an antibiotic for a sore throat: "Doctor, thank you for telling me about all the public health and other implications of it, but I want to have the antibiotic anyway," and the doctor being required to give it to them. That is a fairly crude analogy, but we do need to take a broader view about the implications for the individual in the future and for society at large when we are making these decisions.

***Steve Shrubb*:** An arbitrary time limit makes no sense. It may well be that supporting someone through hormone replacement therapy, through a whole range of things, actually does take more than a few weeks, but an arbitrary time limit makes absolutely no sense. In all other areas, we should be moving to a much more patient-centred approach. Undoubtedly, there may be some people who need support that goes from 18 months to two years, but you are quite right to highlight this doublespeak that appears to be going on. It makes no sense at all, and it does put this particular bit of the NHS service at odds, increasingly, with other approaches that are taken.

***Terry Reed*:** The real-life experience has never been regarded as diagnostic, so its use in that way is a little strange. It is understandable that everyone is very scared of doing genital surgeries—obviously virtually irreversible—but what we have moved forward on is hormone treatment. Believe it or not, hormone treatment was also contingent on a change of gender role in all circumstances, but it no longer is; it is not contingent on role change. Our guidelines specifically say that people should not have to take this step in order to access them. Some people will stay on hormones for ever and not do anything else. They might not change their gender role at all, ever. Certainly, chest reconstruction for trans men does not, in the guidelines, require you to be living in role.

***Dr Dean*:** Or have hormones.

***Jess Bradley*:** I would just like to stress that the real-life-experience test is probably one of the main things that builds mistrust between clinicians and patients. In our recent research into non-binary people's experiences, we found that 20% of non-binary people were

self-medicating hormones, most of them unmonitored by clinicians, at potentially huge risk to their physical health. We know that the process of undergoing transition is incredibly stressful and the mental health impacts pre and during transition are at their highest, and that is when trans people are most likely to commit suicide. It is really just to underpin that this is having very real health impacts on trans patients and is a matter of urgency.

Chair: That is incredibly helpful. Thank you.

***Terry Reed*:** It nearly killed our daughter and it did destroy her life, so it is not a small thing. Now, I know things have changed a lot since the 1990s, but, none the less, the potential for complete disaster if somebody is forced to do this is there.

Q18 Jess Phillips: This picks up on some of the issues about what people have to go through, the hoops people have to jump through. I just wonder if those from clinical backgrounds could talk us through some of the other clinical preconditions to be met by a patient before they can undergo gender reassignment treatment. Then can we hear from the real-world experience about how that is working and whether those preconditions stop people accessing NHS services? To the example you gave about the antibiotic, for every analogy I suppose there would be a flipside: if somebody wanted to have an abortion, you would not make them live with a baby for a year before they were allowed to make that decision. When talking about one's body and one's choice, there is always a flipside.

***Dr Dean*:** There are dangers of analogy, aren't there?

Jess Phillips: I just thought I would throw that one at you.

***Dr Dean*:** There is clearly a need to establish greater trust and understanding between the clinicians who are trying to help people with gender dysphoria. I feel the perception that there are hoops to jump through does need to be addressed, because it is a very reasonable perception. If you have an experience of gender dysphoria, you have concerns about your gender identity, your body and your place in society, or you have concerns about gender, that is all you need to have to be referred to a gender identity clinic. You need to be over 17 to be referred to an adult gender clinic, but there is also a children and young person's service for those under the age of 17.

> With regard to hoops within the service, for access to advice, counselling, specialised psychological therapies, if they are appropriate for you and you want them, there is no precondition to that. For hormone therapy, guidelines say you need to be of the age of majority in the country in which you live. That is an interesting question: is that 16 or is it 18? You can get the contraceptive pill under the age of 13. It is another one of those things where you cannot give an arbitrary answer. You need to have a well established diagnosis of gender dysphoria. Really, those are the preconditions for hormone therapy.

Q19 Jess Phillips: Just so that I can understand, I could walk in to my GP's today and say, "I have always felt like I was a bit confused about my gender and my identity." How long would it take for me to get treatment?

***Dr Dean*:** Your GP is unlikely to say, "Yes, I know all about this. I am happy to start treatment." That would be quite an unusual experience. The GP would probably say, "This lies outside my area of expertise, and I would therefore want to refer you to a specialist

service for advice." Hopefully, they would say, "Here are the seven clinics. Which one would you like to go to?"

Jess Phillips: None of them is in my area.

***Dr Dean*:** Yes, there are problems with geographical distribution. You would be referred to a clinic. The different clinics have different assessment protocols. We do not have a uniform one yet, but that is something that NHS England specialised commissioning is addressing. An audit has recently been conducted to look at all the operational policies, what actually happens, appointment by appointment, at each clinic. It has just been undertaken. We will be looking at that information as to how we can improve patient experience and ensure we are more consistent. Rather than a uniform and unimaginative approach, we want to improve and learn the good things from each clinic so that we provide a better service overall.

> There is a period of assessment, which would normally consist of at least two consultations. There is a huge amount of information to take in from the patient, to understand about their gender-identity-relevant health, their networks of support and what their aspirations are, and to communicate to them the risks, benefits and limitations of the various interventions that they want. Some people come incredibly well prepared, with huge piles of stuff that they have read off the internet, and others have no idea and are scared to death. It is difficult to give a standard case, but there will be an assessment process, which would usually involve two clinicians and probably take place over a period of about three months, at the end of which, if they wanted hormone therapy and they were of the age of majority, had the correct etc., then we would recommend it.
>
> One of the problems we have is, when we recommend it, we are reliant upon their general practitioner to prescribe it. Therein lies the rub, because there are whole areas of the country where GPs are currently not willing to prescribe hormone therapy on the recommendation of a specialist.

Q20 Jess Phillips: Is that because of the cost?

***Dr Dean*:** It is a range of things: cost is one; concerns over their lack of training and experience in the field. My advice in that situation would be, "Well, get trained." Again, it is something that seems to have just caught them off balance at the moment, among so many other changes going on, but we do need GPs to prescribe and to be able to continue prescribing. Patients spend four or five years with a specialised gender identity clinic, and hopefully, in the remaining of their three score years and 10, they are going to be looked after by GPs, so it is very important that GP services adapt so that they can deliver the appropriate healthcare and ongoing support for patients as well. I will stop, because it takes rather a long time to explain this.

***Steve Shrubb*:** I agree with all of that. The harsh reality is that the capacity and the lack of a system means that you do not go through the process. We can describe it on paper, but there were 1,210 people waiting for a first appointment in the clinic that our trust provides in January 2015. There are 5,080 patients on the books, of which 3,500 are active. What is amazing is that the vast majority—because we regularly ask them—give very high ratings in terms of quality. The real issue because of all the fragmentation in the system—GPs, primary care not wanting to do it—and the harsh reality is that, if you walked into your GP and said, "I have been struggling with this for the last 12 months," it is a lottery.

***Terry Reed*:** Twelve years, even.

***Steve Shrubb*:** It is a lottery how you move through the system. Referrals have gone up by 20% a year in the service that we provide. It is worth making a special note for children and adolescents, because there are very few—in fact, I only know of one, the Tavistock and Portman—who are known to have a degree of expertise in it. Of course, as always in the NHS, you can describe the pathway, but the reality, if you are on that pathway, is very fragmented.

Jess Phillips: I suppose the same could be said of lots of NHS services. Especially where referring from primary to mental health services, there is a drop-off rate, one would have thought.

Chair: We are going to be covering youth services at a subsequent session, but you make some important points. I am very conscious of time, so we might need to keep it crisp.

Q21 Ruth Cadbury: In the context of NHS resources, which is presumably an issue of itself, to what extent is the solution more specialist services, and to what extent is the solution back to where we started around better education and information for NHS staff, and not just clinicians? This increase in referrals will carry on increasing as we get more characters in mainstream soaps, etc., playing trans roles and so on, with that bit at the end of the programme: "If you would like to find out more information, please contact…" That little public information bit is for people watching who might consider that it applies to them as potential patients, but to what extent can you collectively and your colleagues support the people in the NHS with that additional information? They will also want to seek support in order to help their own practice. I think we established at the beginning that the resistance, for the most part, is not prejudice, but lack of information and support for people working in the NHS likely to be meeting patients seeking help and support, either at the beginning of the journey or subsequently.

***Steve Shrubb*:** The answer is the same as the answer that has been put forward to help the NHS generally: we are talking about a whole-system change. The NHS England specialist commissioners have given our service significantly more money, but if they gave me £1 million tomorrow—they are not, by the way—I could not ramp up, for the reasons that colleagues have talked about. There are a number of things we need to do. We need to start training now for the extra capacity in a year to two years' time.

Chair: Don't worry about the bell.

***Steve Shrubb*:** Whenever I mention being given more money, a bell rings. Actually, it is normally a hooter rather than a bell. Again, ramping up the capacity of the super-specialist bits of the NHS is not the solution. As we have heard already, far more needs to be done in primary care: speech therapy, language therapy. All of those things need to be done locally. All we are doing is channelling through a gateway. You have heard very eloquent descriptions of why this needs to be treated like any other problem, and any other problem with the NHS at the moment recognises how you build capacity across a system, not in one part of it.

***Terry Reed*:** Steve talked about the 20% rise in numbers in the clinics. We think that 100,000 people are likely to come into the system seeking some degree of help. It is a lot of

people, and we are nowhere near plateauing. We are going to have to continue to find other, more imaginative ways of dealing with the people who are not able to get into specialist services, and to run other things in parallel with them, so that we do make some inroad into helping people at that front end of the issue, because that is when people are at their most vulnerable, their most desperate to get treatment, and that is when we are failing them

Q22 Angela Crawley: My question is particularly on the point you have just made. Could you clarify the key gender identity services that you feel the NHS should or could provide to make the transition easier for people who do identify as trans?

***Terry Reed*:** I agree with Steve; there needs to be much more done at local level. We need to be innovative. We maybe need to use the third sector more, in some of the broader services, to support families and individuals. Training at every level is important. Absolutely all clinicians of any sort need some level of understanding so that we do not get this issue of people not knowing how to use correct pronouns or at least to ask and be polite. People will not want to even have treatment if they get the social interactions with clinicians wrong, so I think there needs to be training at several levels. You need to train everybody up to a certain level, then perhaps a slightly more specialised level and then at a higher level—a kind of three-tier training.

That is what the NHS should be doing, but we should be starting now by providing that training, because, if we want to use clinicians at local level, then they have to have some idea of what they are doing. It is hard to say that there is any one thing you can do at local level, but we definitely need to focus on what we can do alongside clinics so that we are not trying to just push more people through that specialist system.

***Steve Shrubb*:** It is a general observation, but the NHS could do a lot more generally if it looked at digital technology, at telemedicine. In any speciality where you have very few people with the skills, where you have a lot of lived experience, thinking a bit more about how we use digital applications is not going to solve the problem, but can help with training and help support people at distance. We are not likely to be able to grow 500% more special psychiatrists, psychologists, speech therapists, but we can use them in a different way to grow capacity elsewhere in the system.

***Terry Reed*:** It is also important to say that specialists, according the good practice guidelines, do not have to be mental health specialists; they can be specialist endocrinologists, GPs, nurses and other trained professionals.

***Jess Bradley*:** I completely agree about training across the board at every level. Because it is so specialist and small, there is a sense when I work with doctors that they do not know that they could even train in that area or go into that area, because they do not have that background knowledge. Trans people, when they are at the end of their pathway, want to be released from a GIC cling-on to being within the GIC's care, because they know that, when they go to their GP, the GP could easily just turn around and say, "Actually, no, we need to talk to your GIC." It is like, "Well, I was released from the GIC into your care three years ago. Why do I have to talk to them?".

On the point of working with the third sector, essentially, the trans community and trans support groups have been subsidising the NHS in providing a lot of services for the trans community for a number of years, but it would be really good to see more formal

relationships established, although the funding needs to be there. Trans people now are doing this labour for free, and it puts a lot of pressure on groups like Action for Trans Health. When we are trying to navigate the same system again, the resilience is not really built in there.

Q23 Chair: One point is worth clarifying for the Committee. Can you explain the distinction between core, additional core and non-core services?

***Dr Dean*:** I was rather afraid you were going to ask me that. Yes, of course. I have another point I would like to make afterwards, but, to answer your question, these are described in the interim protocol and service guideline, which is the commissioning document that currently informs NHS England specialised commissioning's gender identity services: what clinics are expected to provide. This is a temporary document whilst a definitive service specification policy is being produced, and that is in the approval process at the moment.

Core procedures are specialised psychological therapies, which all clinics are meant to either provide or arrange for from another provider: hormone therapy, genital reconstructive surgery, speech and language therapy, male chest reconstruction surgery and epilation of facial hair and donor site epilation; if you are having a penis or a vagina fashioned, you remove the hair from the skin that is going to form that. Those are the core services.

Additional core services are revision surgery for breast and genital surgery and voice modifying surgery, where people still have problems with a very distinctively male voice despite speech therapy, which is a minority of people but it is available. Non-core services are services which are not funded through specialised commissioning but should be available through CCGs.

Now, in April 2013, NHS England came into existence, a new organisation. It has done a huge amount in a very short period of time, but, unfortunately, different policy documents evolved at different times, and there was not always cross-checking that one conflicted with another. Unfortunately, the interim protocol conflicts with another policy that says CCGs cannot fund any gender reassignment procedure, which meant that things like breast augmentation and thyroid chondroplasty—getting rid of the Adam's apple—fell between two stools. Those are the non-core procedures, which cannot be dealt with by the normal individual funding request on the basis of exceptional need because there are more than five a year, which is the limit for an IFR request, so they are dealt with on a case-by-case basis by NHS England area teams.

Hopefully this is language that will disappear when the new service specification and protocol is enabled, which hopefully will not be too much longer. I keep saying that, but hopefully it will be within a few months, so it is not forever.

Can I also address your point as to how we might improve services? System change and more imaginative ways of doing things are absolutely at the heart of this. Our general practitioner colleagues work incredibly hard, and I think the principal reason why they have difficulty in taking this on board, particularly with respect to hormone therapy, is not to do with money; it is partly to do with training; but it is also to do with workload. There are so many things that have been pushed out from secondary care for GPs to do. I was a GP myself, so I quite understand why they find it difficult to take something on quite

quickly, but I think, over a period of a year or two, hopefully that will change, because we do need to work in partnership with them.

We also need to try to deliver care more equitability geographically. At the moment, we have seven gender clinics unequally distributed around the country. That is what we have at the moment, and, whilst we are trying to sort out the current problems, there has been a moratorium on establishing new services. GPs will have more confidence in delivering specialised services when they are supported by specialists to help them gain the skills and confidence to manage more and more patients. Over the next five years, I hope, as we have a special service that can start to meet demand adequately and match capacity demand, we can also help to educate, support and encourage our GP colleagues to take on parts of the care process, and particularly those parts after patients have completed their transition and treatment with us and need help for the rest of their lives, and they feel better empowered to do that.

NHS England's problem, as I perceive it as a clinician, not speaking on their behalf, is not so much about resource as the lack of people out there to do the job. They are investing at the moment in more surgery provision, particularly for feminising genital reconstructive surgery, because there are big waiting times beyond the 18-week referral-to-treatment target, which we want to deliver as soon as we can, but there just are not enough surgeons. It is not money; it is lack of surgeons, and that training is being dealt with.

The same is true for gender identity clinics. We do not have enough clinicians, doctors, psychologists, psychotherapists and other health professionals working in those services to match capacity with demand and then to be able to do that outreach work so that primary care can do the job it is so good at doing, which is providing consistent, lifelong care of the highest quality.

***Terry Reed*:** In terms of cost, if we are not able to treat people's gender dysphoria quickly, we will be running the risk of huge costs for their mental health care, because that is when their mental health deteriorates rapidly.

***Steve Shrubb*:** The way to build capacity—we should not miss this—is not GPs; it is primary care. I absolutely agree. GPs rarely, in my experience, say, "I do not want to do this because I am going to earn an extra few quid"; they fear being overwhelmed. What we should be doing is building capacity in our specialist services to outreach and support primary care. We have done that in almost every other area of healthcare. The reason why you see more patients with mental health problems in primary care is not because the GPs have suddenly gone, "Hooray"; it is because more resources have been put there.

We are not actually asking the GPs physically to take on an extra 100 patients; we are wanting to resource primary care so that it can play its part. We need to start the training now, because it will take a relatively long period to bring the individual professionals through the system. We talked a lot about people with lived experience. The other thing, as CEO, that I am very concerned about is the staff actually providing the services. There is a sense that they feel overwhelmed, because they are attempting to stem what feels like this never-ending wave. A 20% year-on-year increase is, when you think about it, enormous.

Q24 Angela Crawley: That neatly brings me on to my point. We have talked a bit about the key issues, the key patient experiences, but, in terms of the capacity, what the NHS are currently doing to address that and the question of quality, is there an issue of the quality of data in terms of the prevalence, and what is the NHS doing to address these issues so that you have the data you need to get good services and to increase the capacity?

***Terry Reed*:** Certainly the prevalence issue is the major issue that the NHS is facing in this field at the time, but I suppose it depends what you regard as quality in terms of treatment. It may be that it would be better-quality provision if it were local, if people were not having long, expensive, stressful journeys to make to get to a clinic, if more of it could be done locally. There have been a couple of local initiatives—Calderdale was one, and I know of another one—but there is a question of the funding, because there is no funding for something happening outside the specialist services. That is where it goes: it goes to the clinics, so somebody can have a wonderful idea, and I know the people who are trying to do this, and they have some endocrinologists on board and they would love to do it, but they do not know how that is going to be funded, because the CCGs will rightly say, "This is not our job to fund, because it is part of centralised funding".

***Steve Shrubb*:** Data is really important. We need a consistent way of gathering data so that we have a better understanding. There are six or seven clinics, and perhaps if you started again you would not have them in the same places. 50% to 60% come into our clinic, and that skews the data, so it is really important to raise that issue. We need a consistent data set that is open and transparent, not just kept within the NHS; I think that is really important.

> It never ceases to amaze me, the level of the quality. We serve 2,500 patients. Their views on the clinical quality were extremely high. They had slightly lower views on the administrative quality, if I am honest. I think the quality in real terms is very high, but we really do not have a good grip on the data, and it becomes difficult to plan, doesn't it, if you do not have a consistent grip on the data? When the specification is out—and, like you, I hope it will be out very soon—we may well see the Calderdale experience, which was 2006, a long time ago, where we actually see services delivered based on need and geographical access, rather than what is happening now. We are not data blind, but we do not have sufficient data to be able to understand this.

Chair: I apologise to everybody; we are overrunning, but there is obviously a lot of information to get through here.

***Jess Bradley*:** Very briefly, I think that we need gender identity monitoring across all NHS services so we can use that data to look at a whole bunch of stuff, such as health inequalities. I just wanted to pick up this point about the administration of gender identity clinics. I do not think I have met a trans person who has not had their referral lost or a letter lost, or had trouble getting in touch with a gender identity clinic. It is a huge problem in terms of the capacity of clinics to deal with trans patients. It is one of the biggest things affecting trans people's lives, because there is a huge amount of anxiety about whether they have sent their letter to get hormone treatment to their doctor and the doctors have not seen them. It is just completely routinely rubbish, to be honest.

Chair: We like frankness on this Committee; that is fine. I can feel there is a lot more you want to say on this matter, but could I suggest that we move to Ben's line of questioning?

Then, if there are additional things that people want to say, please feel free to write to us after this session today. It is incredibly helpful.

Q25 Ben Howlett: In relation to this question, I suppose it does feel a little like an AOB anyway because of the amount you have covered. Terry, you mentioned earlier on about the holistic approach to trans and trans people as well. This is more of a question in relation to accessing other general medical services. Is there a feeling, as representatives, that there is a problem with accessing general medical services, and what do you believe are the main reasons for those difficulties?

***Terry Reed*:** The difficulty that many people have is the one I mentioned earlier, where people are not treated sympathetically; they are not treated politely even, so they are very nervous about accessing treatment at all. One thing that has happened over the years is that, when they are referred for treatment that is completely unrelated to the gender issue, nonetheless the GP will write a whole page about the gender background of this person when they are being referred for carpal tunnel syndrome or something. It is a fixation that this is the important thing about this person.

We have even in the past heard of somebody with possible cervical cancer being referred back to a gender identity clinic for a further psychiatric assessment before being sent to an oncologist. There is a fixation about trans being the only issue to do with this person, so there are many reasons why people do not try to seek services, and it is usually to do with this kind of misunderstanding of the condition and not knowing how to refer to people. A lot of it is about the social interactions, which are unpleasant for people, so there is a whole range of things.

Of course, one of the other issues, which is understandable, is that, once your sex marker is changed, you tend to fall out of the screening programmes that might still be appropriate for you. It is a little harder, perhaps, for someone to have prostate cancer diagnosed because people will not be thinking in those terms. That is the kind of thing that happens, or cervical cancer in a trans man. Also, trans men being pregnant and having babies is something that people are not familiar with, so it is kind of scary if you are in that situation. You think you might be treated inappropriately, so people tend not to go forward for help. Well, you obviously have to, ultimately, in that situation. It is largely about social interactions.

***Jess Bradley*:** Definitely. We call it the "trans cold": if you go to your doctor's with a cold, it will be a trans cold. Quite literally, my housemate has had a throat problem for the last year or so and was taken to ear, nose and throat, and the doctor diagnosed her with transgender problems; those are literally the words that he wrote on the piece of paper, and obviously she was there for her throat. This obsession, fixation and arguably objectification of a person's trans status is totally across the board for all services.

Reproductive justice services are a big issue. We have been supporting some trans people who had had their gametes stored at great expense, in terms of both money and expending the time they had to wait for hormone treatment, only then to be taken to an ethics committee to see if they were ethically fit to have children, based upon their trans status. This is really a problem across the whole board.

***Dr Dean*:** Ultimately, we need to normalise this: that trans people—non-binary or binary—are people and deserve the same respect and access to care as everybody else. I can recall, 10 years ago, talking to group of doctors, and one of them came up to me: "Well, I do not treat homosexual people". He was unaware of having anyone who was gay or lesbian, or at least that is how he perceived it. Things have changed a lot in 10 years, but I hope it is not going to take 10 years to get to the same situation where being trans or non-binary does not result in an eyebrow being raised when it is not the most important thing about that person's life; the person is the most important thing. That societal change needs to be led by the NHS. Many of the things we have spoken about, I hope, will take us in that direction.

Chair: A very helpful summary—thank you.

Mims Davies: I just wanted to make a point. We are obviously picking up on the NHS and treatment side, talking about people, but we are dealing with people going through adulthood. I was just thinking about where we are with schools and education, and opening up minds at that age, because a lot of what you go through in your adulthood is formed through your schooling and the boxes that you may be put in or feel you have to go into. I just wonder, in this Committee, if we could look at that side of things, because, ultimately, a lot of the outcomes that have been described very eloquently and beautifully today are to do with attitudes that we can do something about if we are talking about long-term change.

Chair: We can try and draw that out when we talk more generally about younger people, but you are right; education is a huge part of it. It was a fascinating session today. Thank you very much for being our first group of people coming to talk to us about these issues in our very first public session. Thank you very much for your time. I apologise again for not keeping us to time, but I think everybody felt that the discussion was so valuable that it was worth perhaps stealing a few extra minutes. Thank you very much.

Examination of Witnesses

Witnesses: **Helen Belcher**, Director, Trans Media Watch, **Professor Neil Chakraborti**, Director, The Leicester Centre for Hate Studies, and **Chief Constable Jane Sawyers**, National Policing Lead on Transgender for Equality, Diversity and Human Rights Co-ordination Committee of the National Police Chiefs' Council, gave evidence.

Q26 Chair: Good morning. Can I apologise for the fact we are starting the second session a little late? Thank you so much for being with us today for the second half of our first public session of the newly formed Select Committee. We have a number of colleagues who have got questions for you as we develop our thoughts in this area. Can I start by thanking you for taking the time out of what I know are very hectic diaries and for all the preparation I know you will have had to have done as well? A huge thank from every Member of the Committee. Can I start by asking you to introduce yourself and your organisation and then we will move on to a series of questions from colleagues on the Committee? Thank you.

Helen Belcher: Thank you, Chair. I am Helen Belcher; I am one of the founders and directors of Trans Media Watch. We are a charity that works with the UK's media to try and get them to report intersex and trans issues with accuracy, dignity and respect. I have a number of other roles as well, but that is the one you are interested in today.

Professor Chakraborti: Hello. I am Professor Neil Chakraborti; I am a professor of criminology at the University of Leicester and director of the Leicester Centre for Hate Studies.

Jane Sawyers: Hello. My name is Jane Sawyers. I am the Chief Constable of Staffordshire Police, but policing nationally has 12 committees around various areas that co-ordinate policing activity nationally. One of those committees is the Equality, Diversity and Human Rights Committee, which has a number of sub-committees, one of which is the LGB&T sub-committee and I am responsible for the LGB&T sub-committee nationally.

Chair: Thank you. I will invite Tulip to start our questioning and, if you do not mind, we have found it easier just to use first names if that is okay.

Q27 Tulip Siddiq: Thanks very much for coming in. I am just interested in what each of you think is the definition of transphobia. I do not know if Helen wants to start.

Helen Belcher: For me, transphobia is the irrational hatred or fear of trans people in the widest sense. My personal view is an awful lot of what is labelled as "transphobia" is more a lazy or institutionalised cissexism. Cis is the opposite of trans, so cissexism is kind of an unthinking adherence to a binary-gender model where your gender is immutable; it does not change.

Professor Chakraborti: I would have very similar thoughts to Helen on this. I would describe transphobia as an irrational fear, hatred or revulsion towards people who do not conform with society's gender expectations. That would include people who describe themselves as transgender, transsexual, transvestites or cross-dressers. It is that irrational fear part that I think is crucial, because that is what I think the phobia suffix describes: that irrational fear or hatred.

Jane Sawyers: I am similar again, but quite simply put for me: a fear or dislike directed at people who are trans.

Q28 Mims Davies: This is to Helen in terms of how you are monitoring press coverage. Can you tell me about the patterns that you have found and how the coverage has perhaps, hopefully positively, changed over time and perhaps not so, and areas that we perhaps need to be focusing on and working with?

Helen Belcher: It depends rather on how far back you want to go, but if I start at Leveson and work on from there. At Leveson, in the evidence that I gave on behalf of the charity to the inquiry, we presented three main problem tropes, as it were, that the press use to represent trans stories. Lord Justice Leveson added a fourth one, which was outing of trans people. We then had cause to make a second submission because almost immediately the press had another couple of goes in problematic areas.

The history has been that there was the huge outrage over, first, the outing and then the sad death of Lucy Meadows, the primary trans teacher. That was the point where I think the press suddenly thought, "Oh, hold on, there is actual effect on real people here". We then had a quietish year until Kelly Maloney was outed last August. From there we have had a series of supportive outings in the press's terms, despite what Lord Justice Leveson wrote in his report, until Caitlyn Jenner revealed herself to the world at large. That is the point where press coverage has started to try and look for new angles. We have had a very large concentration on "This person is trans", "This person is transitioning"—so the process of realigning your gender from one to another. It is only relatively recently that the press is starting to broaden that circuit, but there are very few pieces around things that you heard just now, in terms of healthcare and access to healthcare, there are very few discussion pieces around discrimination in employment, education issues and so on.

There has been a positive shift. I would like to hope that the outings are probably near an end, because there is not really anywhere else they can go with them. I would like to think that the press is starting to take an interest in the issues that actually affect trans lives. We are noticing a little bit more coverage of intersex and non-binary issues, but our concern there is very much that it is on the same sort of lines as we have seen trans issues covered, which is: "Gosh, this person is not binary", or, "This person is intersex". The concern we always had was that the press were using the trans communities as a "Thank goodness we are not like them" kind of model and that once trans people became a little more assimilated they would move on and pick on other marginalised and vulnerable groups, so we really want trans people to be the last of those exemplars in that area.

Q29 Mims Davies: So it is almost like a shock and awe tactic of, "Wow, this is so weird" or "so wonderful" or "so remarkable" that people are going to take copies off the shelves, rather than think about the emotional and physical problems that people are going through?

Helen Belcher: The media in general has had a very strong emphasis on the transition narrative. When I do talks about this I talk about the butterfly syndrome, so you have the chrysalis and a beautiful butterfly emerges. The same sort of thing happens very often in television documentaries, where you have somebody wheeled into an operating theatre and a beautiful woman comes out at the other end. It is a very strong dramatic narrative, but real

life is not like that and you will have heard bits this morning about how it is a process. There is a process of realisation; there is a process of self-acceptance; there is a process of coming out to those around you and interacting with the world, and it takes time. It is not an immediate switch. That is where a number of trans people really do object to terms like "sex swap" or "sex change", because it indicates an immediate or whimsical decision. I cannot say that nobody has ever done it on a whim, but it would be incredibly unlikely that people do this and make this kind of life-changing decision on that basis.

Q30 Mims Davies: Moving forward, how effective do you feel the regulation of the press is in dealing with this kind of journalism around transphobic portrayals of people, rather having an understanding of the basis of the process that people are going through?

Helen Belcher: We have had conversations with the old Press Complaints Commission and with IPSO. The issues we have I think are twofold. We had a Labour Party Parliamentary candidate in the general election just gone, Emily Brothers, who revealed that she was trans and then you had the problematic piece in *The Sun*, which said something like: "The problem is, being blind, how did she know she was trans?" or "How did she know she was the wrong sex?". She dealt with part of that in good humour, saying, "Well, presumably when Rod Liddle turns the light off he does not know that he is a man anymore", but that was only part of the problem.

After negotiations broke down with *The Sun*, we took the rare step of taking the complaint to IPSO. IPSO found that it was a clear breach of Clause 12, discrimination, but we had raised a number of others issues, including the victimisation of the complainant because they had published a piece that they claimed was an apology in January that ended up having another go at Emily. We raised this with IPSO and to date IPSO has just ignored it; it just has not engaged with that issue at all. That is problematic because we know that a number of trans people, as people in general, will not take forward complaints because they want the story to die and so a lot goes unchallenged. Anything which then is seen to be further victimising or further unnecessary exposure will act as a major deterrent. The fact that IPSO has not even engaged on this issue is a major deterrent to people raising complaints.

The other issue is around the Editors' Code, in that the problematic pieces that we see now tend to be couched against a very abusive or inflammatory language against groups of trans people. Rod Liddle again wrote a piece in the *Sunday Times* in July in which he did not name a specific individual, so no individual could complain and there was no route to redress. We have noticed now that the last few problematic articles which use that kind of language have all used that approach and that is a loophole that we really would have hoped IPSO—if they really were an independent regulator—would have taken steps to correct but we see no signs of that at all.

Q31 Mims Davies: Finally, again to Helen, on the issues around portraying trans people in the broadcast media: how effective has Ofcom been as a regulator in terms of portraying the broader issues and the positives around this?

Helen Belcher: To be honest, we have not had a lot to do with Ofcom after our meeting with them in 2010. We have had more to do with the BBC and raising complaints with the BBC and there we have a problem because the standard BBC reply is, "Thank you very much for

your comments. We will forward them on to our production team" and it ends there, so you never really hear anything back

> With independent broadcasters, there seems to be a series of little issues, none of which are necessarily important enough to take on their own merits to a complaints process, but overall generate a kind of feel around trans people. There is not actually a huge amount of coverage around trans people on the broadcast media. I go back to the BBC again: the BBC does tend to like to manufacture debates, and when trans people are involved in those debates, the debate invariably moves to around the validation of the veracity of a trans identity and that then creates problems. So *Woman's Hour* is a particular issue where every revelation that somebody is trans tends to get met with complete incomprehension by the presenting team, some more than others.
>
> In terms of regulation as a whole, in line with what you heard about health actually, there is an awful lot of ignorance; the base level of understanding is very low.

Mims Davies: Okay, that is very helpful, thank you. That is all from me.

Q32 Mrs Flick Drummond: I have just been reading that, it seems, transphobic hate crime is not actually registered as a crime as such. Is that correct? What I want to know is, Neil, how would you define transphobic crime? Then I would like to ask a question to the police about how they deal with it.

Professor Chakraborti: There are various definitions presented around different strands of hate crime. One fairly recent definition and one which carries a great deal of weight within the academic and practitioner communities is a definition presented by the College of Policing in 2014. They presented some updated hate crime guidance that refreshes the previous guidance from ACPO and, as such, carries a great deal of weight within the criminal justice system itself. That definition sees transphobic hate crime as any criminal offence that is perceived by the victim or any other person to be motivated by a hostility or prejudice towards a person who is transgender or perceived to be transgender. It is quite a mouthful as a definition, but the key point is that there is no reference to hate within that definition. Hate crimes are not all about hate; they do not need to be motivated by hate. Hostility or prejudice are the key facts. Equally, the perception of the victim or the witness, or a family member is key. It is not up to police officer discretion when it comes to recording a hate incident or a hate crime; it is the perception of the victim that is key. There is a definition of transphobic hate crime that is widely used within the criminal justice system and I would say that is it.

Q33 Mrs Flick Drummond: Do you find that you have been able to use it effectively in the police?

Jane Sawyers: Yes, that absolutely is the definition that we work to. If I could just do some figures for the moment—and I will not do much of this—of 44,500 hate crimes recorded in the National Crime Statistics for 2013-14, about 1% of those, 555, were transphobic hate crimes, so there is a transphobic hate crime.

Q34 Mrs Flick Drummond: What are you doing to help the police understand the issues about trans people and deal with them sympathetically? What training is there?

Jane Sawyers: Yes, training actually is the key. There is some very recent work done in Nottingham, which interviews police officers and supports the work that my portfolio has

been doing around officers and training. Officers do not like training in practical issues; officers and staff actually like training on hate crimes using online packages. The experience that people are saying is that actually they have a diverse friendship group, a diverse work group, but most people do not know anybody who is trans and have not dealt with anybody who is trans. Therefore, talking to members of the trans community, being able to hear life experiences or something as simple as understanding what language is correct to use actually helps officers. There are pockets of that around the country happening in various forces. What there is not at the moment—and my portfolio is working with the College of Policing on this—is national transphobic hate crime training.

Q35 Mrs Flick Drummond: And you would think that that was essential?

Jane Sawyers: Yes, absolutely.

Mrs Flick Drummond: Are there any plans to put it in place?

Jane Sawyers: Yes. There are things in the meantime that we want to do. Since I took over the portfolio in November last year, I have done a lot of research around the charitable sector organisations and other organisations that work in relation to all of LGB&T. A lot of them do actually have training packages that policing could use while a policing package is developed nationally and we have not done that at the moment. Organisations like GIRES, Galop and Gendered Intelligence all have training packages that the police could access and the intention is to do exactly that.

Q36 Mrs Flick Drummond: I had an incident actually in my surgery last week where I think the police sort of wrapped it up with a mental health problem as well, which may or may not be the case. I think that was the perception from the person who was trying to deal with the police; they were not really listening to them on the other grounds that were a trans person. I think training needs to be fast.

Professor Chakraborti: We deliver training to practitioners at the Leicester Centre for Hate Studies, so we deliver training to police forces, to probation services, to the Crown Prosecution Services and to local authorities. One of the challenges that those bodies have when they come along to training is that they really want training and they enjoy the training, but budgetary pressures make getting the training hard. Exactly as Jane says, it is about identifying ways to draw on the expertise of different bodies within the public and third sectors and try and roll that out as widely as possible. I think some forces are better than others when it comes to that, but it is a real challenge.

Helen Belcher: I have just some very quick comments. A comment came out in the previous panel about using trans people to give that training. That is asking an awful lot of a few hundred trans people if you are expecting them to train the entire NHS and now the entire police force, and then we are trying to work on the entire media industry as well. With the best will in the world, that is not going to happen, so there needs to be different ways to do that. Second, we do get people coming to us having had connection with the police in some way, shape or form. Some are very positive; some are quite negative. The issue with the negative ones is they tend to get a lot of traction and the good experiences do not. The negative ones tend to all rely on the fact that the police involved expect the trans person to be easily identifiable as trans and that is not always the case.

Mrs Flick Drummond: No, in this case it was not. Thank you.

Q37 Jess Phillips: I was just interested when you started to quote the figures from conviction rate statistics that you might have, and how much of this clear increase in reporting, potentially, has actually led to any action. I know that in other areas of hate crime it is always difficult, but I was interested when you said that it is the view of the victim and not the discretion of the police officer. With the greatest will in the world, that has just never, ever been my experience in cases. For police officers there used to be awful lot of form filling in lots of different areas of crime, especially inter-personal crime, and now these days because of the lack of resources there is much more discretion placed on the individual police officer. I just wondered what the conviction rates were and what your comments were on that.

Professor Chakraborti: If I can make an initial comment and then Jane will presumably be able to talk about conviction rates. When we are looking at prevalence of hate crime—any strand of hate crime, not just transphobic—it is very difficult to quantify. Police-recorded figures are very useful in one respect because they tell us how many people are reporting hate crimes, but they do not give us an accurate measure of how much hate crime is taking place because the vast majority of victims do not engage with the criminal justice system; they do not report. We are consistently urging people to report, but those pleas often fall on deaf ears for a variety of reasons. I would be happy to talk about barriers to reporting if you would like. I think it is very important, first, to just be really clear on official figures; we can quite happily trot out official figures, but it will never give you an accurate gauge of how much hate crime is taking place.

Jess Phillips: I would wager hardly any of those ended in any sort of conviction. That would be my guess.

Professor Chakraborti: The conviction rate is roughly around 2-3%. That is across the board, not just for trans.

Q38 Chair: Can we just be really clear before we move on to Cat's line of questioning? Jane particularly, from a policing angle, do you think the law actually protects all trans people?

Jane Sawyers: It is always very difficult for police officers to talk about the law because we enforce it, obviously, not make it.

Chair: I often find that you therefore have a much better point of view.

Jane Sawyers: Then you have given me permission to go ahead. I think Members will be aware that the Law Commission made some recommendations in relation to a wholesale review by the Government of legislation in relation to hate crime. I have to say as a portfolio holder I absolutely support that. There are all sorts of laws that have arisen and come into being, for good reasons, because of various incidents, but they do not give parity across the five protected characteristics. For instance, aggravated offences under the Crime and Disorder Act are only race and religiously-aggravated offences. Stirring up hatred offences, under the Public Order Act, are only race, religion and sexual orientation. So if you are either transgender or disabled, how on earth can you ever believe that the law is fair in relation to

you? So, yes, my clear response to that would be that policing would support the Law Commission's recommendations into the review of hate crime.

Q39 Cat Smith: Neil, I would be really interested if you could also continue to answer that question around legal protection from hate crime and the sentencing provisions that are available.

Professor Chakraborti: Up until recently there was considerable disparity the various protected characteristics. Things started to change in 2012; that is when the Criminal Justice Act 2003 was amended to allow enhanced sentences to be imposed in cases involving hostility on the basis of transgender identity. At one level, that helped to introduce a degree of parity, but as Jane has rightly said, there is disparity in two distinct areas. One, there is no provision for aggravated offences when it comes to transphobic incidents, so they are not separate standalone aggravated offences as we have with racially or religiously-aggravated offences, so there is an anomaly there.

There is also an anomaly when it comes to the stirring up of hatred. At the moment, there is no criminal offence to stir up hatred on the grounds of transphobic hostility. Again, as Jane has said, there was an opportunity to do something about this last year with the Law Commission's review of our current suite of hate crime legislation and, in their wisdom, they decided against extending the current suite of legislation. In their justification, they seemed to agree in principle with the idea of creating aggravated offences, but recommended a further Government review, so it is kind of parking the issue a little, if I can be frank. When it comes to the stirring up provisions I think they also made reference to the fact that there was not a practical need for such legislation and I am not sure that is the case. What Helen has talked about already and will continue to talk about, I think will reinforce the need for some kind of legislation to cover the stirring up of hatred,

It seems a little bit puzzling that we have disparity. It is great that we do have some legislation, but I think it was a missed opportunity to agree a degree of parity that would send out that really important message of equality across all strands.

Helen Belcher: We put in a submission to the Law Commission on the hate crime aspect. I was invited to go and talk at one of their symposiums and we argued for full parity, as Neil has just explained, and we were quite disappointed, actually, that the Law Commission decided on the basis of so few convictions that parity would not achieve anything. It seemed a very odd basis on which to make that decision.

The other two things to bring up here are that hate crimes, stirring up hate, might be applied in some of the press pieces that I referred to earlier. Also, there are those trans people who have not transitioned, so they are part-time trans people; they live one gender most of the time for work, but in another gender for events or particular things. A lot of those people will find it very difficult to report hate crime on a transphobic incident, because for a lot of them you may find that they keep it a secret from their spouses. The moment they get the criminal justice system involved suddenly all of that secret is out and huge emotional upheaval and turmoil could then ensue. The vast majority of trans people, like complaining to the press regulator or to Ofcom, simply do not want that exposure so they will not report it. Until we get rid of the stigma around trans, which again you talked about earlier, it is going to be very difficult to increase reporting rates. Not impossible, but difficult.

Q40 Cat Smith: How would you say that confidence is in the trans community in the criminal justice system being able to deliver justice when they have been victims of hate crime?

Helen Belcher: I do not have anything to base this on other than my personal hunch, but I would suspect not high generally. I think that people would feel there is a lack of understanding occasionally within any police that they encounter, very often within the lawyers that they encounter and the legal procedures that they then encounter. There are three hurdles of understanding to go through and I think that trans people in general do not tend to believe that there is a very high level of understanding anywhere, so you would not necessarily expect in those three areas.

Professor Chakraborti: Can I come in there because I led some research on this earlier this year? The Equality and Human Rights Commission invited me to examine barriers to reporting amongst LGB&T victims of hate crime. One of the issues we really drilled into was levels of confidence in the criminal justice system and what those barriers to reporting might be, and it will not surprise anybody to know that levels of hostility were very high. There were a great number of hate crimes experienced by our sample, but very few of those cases were reported.

When we drilled down and asked people, "What are the issues?", as Helen has already said, there were very low levels of confidence in the criminal justice system. Primarily, it was not because of any deep-rooted sense of resentment towards the police which might exist amongst other sections of minority communities, but rather they just find the whole process time-consuming, draining and confusing. They felt that frontline practitioners often overlooked the everyday challenges of what it is like to be trans and how much courage and resilience you need to report your experiences to a third party. Many of the victims we spoke to just normalised their everyday victimisation; they thought, "Do you know what? This is just something I have to put up with. What is the point of telling anybody because they are not going to do anything about it?".

Some people feared reporting because they did not think they would be taken seriously by the police and they thought that actually might reinforce their sense of victimisation, so it might be secondary victimisation in a way. Many just wanted to see more rapport, more efforts made, not just by the police but by the criminal justice system more widely to engage with the trans community, not through so-called community leaders or in a tokenistic fashion, but actually to really get out there and to engage and to be at one with the trans community. They felt that just was not happening at all. There were a whole host of other factors they cited but they were probably primary barriers.

Q41 Cat Smith: Neil, did any of your research go into the different areas of the UK in that we obviously have different justice systems in different parts of the UK?

Professor Chakraborti: I have just looked at England and Wales. I have not looked at other jurisdictions I am afraid, although the research body of evidence that exists draws similar conclusions in Scotland as well.

Q42 Chair: Some of the evidence we have had would suggest that non-binary people particularly might have some concerns about the way the law is currently framed. What would your view be on that, in terms of protection?

Professor Chakraborti: I would make two points. The first is that actually when we speak to members of the trans community, a lot of them are not aware of the laws that exist. They are not actually aware of the term "hate crime" or they do not have that understanding of hate crime. Many do, but many do not. Before we assume that the only solutions are legal remedies, I think we have to acknowledge the fact that many people just are not comfortable with the idea of coming into contact with the legal system. There is that side of things, but those who are aware of the laws and who want to talk about the laws find that disparity that we have just talked about quite disturbing. The problem with the laws as they stand is that they kind of pit minority groups against one another unwittingly, and that is not a great place to be. It creates hierarchies of victims, so that is a bit problematic.

Q43 Chair: Do you think there is a particular provision that needs to be made for non-binary people—people who are choosing not to define themselves by a particular gender? Do you think there is a particular issue there or not?

Professor Chakraborti: No, my particular issues would relate to the laws that we spoke about before—creating an offence of stirring up hatred.

Chair: Which would apply to everybody?

Professor Chakraborti: At the moment it does not apply to trans people, so if I could wave a magic wand and introduce one law that would be it.

Helen Belcher: There is an issue around what is called intersectionality because trans people are not just trans in isolation. You might have trans women of colour or Muslim trans women, and so if they are subject to a hate crime and you start apportioning out, "Is it a transphobic hate crime or is it motivated by religion?", which box are you going to tick? There are issues if you start segregating reason.

Q44 Chair: Just before we go on to the final round of questioning, another thing that come out some of the evidence I read on the legal side and I am taking the opportunity to pose it to you, is access to single-sex spaces. I think a number of us on the Committee have worked to try and develop an approach where you might be able to have a space which is simply for a woman to be in. How does that fit within this context of transgender people, people who choose not to define themselves by gender? How do you think we tackle that? Do we need to do something within the law to be able to cope with that? I am not sure if I articulated that very clearly, but do you get where I am going?

Professor Chakraborti: Yes I do. It might be one for Helen because within the context of hate crime I am not so sure it is directly relevant.

Chair: I am just thinking more of legal protection. Is there anything there that we need to consider as a Committee? I am not just thinking particularly of hate crime.

Helen Belcher: I think the issues are more in terms of what is the motivation behind the crime, rather than how to categorise it. Trans people, intersex people and non-binary people need safe spaces and will identify and the issues then become whether somebody is, in the widest sense of the term, policing the entrance to that safe space. If you have, say, a trans woman who does not necessarily meet what society expects a woman to look like suddenly being barred entry because actually she is a man, that is very harmful personally. But then I

do recognise that there is the kind of flipside to how you then prevent people you do not want entering that space. I do not know if there is an easy answer to that one.

Q45 Chair: And it may be a question for a different time. Moving on to our final line of questioning, it is really from me. I have actually done quite a lot of work on making revenge pornography a crime, which it is now. One of the things that came out of those investigations was that this is not a problem simply for women; it actually quite a large problem in the LGBT area as well. Helen, how do you feel things are going in terms of the online world and particularly social media in terms of transphobic hate speech? Maybe you might want to comment more generally because I know you have obviously got quite an experience in this area.

Helen Belcher: Trans Media Watch has been helping two specific projects: one on hate crime and one on preventing online abuse. The aim of the online abuse project is to try and empower to people to know how to prevent it in the first place but then how to report it and action it. There are some very interesting discussions around online media and the internet and they kind of boil down to whether you deem social media, such as Twitter or Facebook, a broadcast mechanism or a conversation between people. Which side of the fence you drop will kind of determine how you want to monitor and regulate those areas. If it is a broadcast medium then different rules properly apply than if you consider it as a conversation between a group of people.

Twitter had an example a few months ago where they promoted a Tweet that encouraged trans people to kill themselves and quite how that got past Twitter's reasonability check I do not know. Since that point they seem to be a little more cautious. I am not yet clear how effective reporting mechanisms are within Twitter to report abusive or hate speech and how quickly that can be dealt with. In Facebook, we found that it is hard to get pages which promote particular hate views or harmful images taken down. It can be very difficult to engage with these companies because they do not have a very big UK presence and their culture is very much biased towards the US and they have a whole raft of different sensitivities. Facebook also has this real names policy, whereby an account can be challenged and then you have to verify that the name of the account is your real name. For trans people that can cause particular problems, say, at an early stage in transition or, if they are not full time, they may have a Facebook account in their other-gendered persona. We note that the German government is currently challenging Facebook on its real names policy and we also know that Facebook has problems with Gaelic names, for example, which affects people in places in Scotland and Wales.

Also bear in mind that a lot people will read the press pieces that we talked about earlier online and it can be very difficult to get those taken down. That raises issues for people in, say, employment checks or checks for accommodation. If somebody Googles and suddenly there is a whole raft of very personal, possibly inaccurate data, that can adversely influence a decision to let a flat or employ somebody. Especially if the complaints process takes a period of time as well, where those pieces are then left unchallenged and unchecked until the regulation has had time to do its job, which is typically long after the problematic interest has subsided.

In general, we feel that there are ongoing issues with a cross-social media, in places like YouTube as well, where there are problems around victimisation of complainants. There is a very much hands-off approach to editorial responsibility or publication responsibility,

so they are aggregating that to the person who has posted the offending piece. Again, the common message I have said throughout is that the understanding of trans and intersex issues is very low and sadly is lower within American-based companies than it tends to be here. But even in the UK, where you have subsidiaries of a US office, they tend to be driven very much by US policy. So even though they have a local office which should be a little more sensitive and accountable to local needs and attitudes, sometimes that is not the case.

Q46 Chair: Neil, what is illegal offline is illegal online as well. Why is this not working in the way that it should?

Professor Chakraborti: It is a problem. There are so many challenges within online hate speech in terms of the policing of it and the regulation, but one of the big challenges from a legal perspective is balancing freedom of expression against freedom from hatred. Where do we draw the line? Do we criminalise—?

Chair: So under certain circumstances it is okay?

Professor Chakraborti: It depends where we draw the line. At the moment, when it comes to criminalising hate speech, with most strands of hate speech it is not unlawful to insult or to abuse a particular group. Where the line is drawn is where those words or that behaviour is threatening. It is different when it comes to racial hatred, but across all the other strands that is where the line is drawn. To insult or abuse might be unpalatable and undesirable, but it is not illegal. When it comes to transphobic hate speech, there is no law and that is what I find quite frustrating—why we do not have similar provisions to the provisions governing the incitement of hatred on the grounds of sexual orientation, for example, or religious hatred where we criminalise threatening words or behaviour.

It is a high burden of proof. There not only needs to be threatening words or behaviour, but the prosecution need to prove that the perpetrator intended to stir up hatred. It is a high burden of proof and quite difficult to find evidence all the time, but nonetheless those laws exist and they send out a powerful symbolic message to those particular communities. I do not see why the same could not apply when it comes to transphobic hate speech.

Q47 Chair: You are an expert in this area. Why do you think the legislation was drafted in this way? It is anomalous?

Professor Chakraborti: Hate crime legislation has been drafted in a very piecemeal fashion. If we could start again I am sure we would do things very differently. It is almost as if we waited for a tragic event to occur before we prioritised something, whether it is the Lawrence case and the criminalisation of racial hatred, the Jody Dobrowski case where we start to then prioritise homophobic hate crime, and so on and so forth. As a result, the creation of law has followed tragedy; it has followed campaigning and advocacy, rather than people actually sitting back and working out a more systematic way of formulating law-making in this fashion. The end result is that we have piecemeal laws and we do not have parity across the strands.

What we do have is a set of legal provisions that is far better than in most countries, to be honest. We have laws and we have protection in this country. That is very, very

important, but I am sure that if we could start again we would use different terminology and we would have different sets of legal provisions.

Chair: Jane, do you want to add anything to that?

Jane Sawyers: Just specifically in relation to online crime. I suppose, as with every other crime, the introduction of online and what it brings with it does not just cross force boundaries and national boundaries; it is international boundaries. Hate crimes can be committed on the internet; there is no question about that. If credible threats are made and there is a hate element, hate crimes can be committed, but if they are committed by somebody who is thousands and thousands of miles away, it is really difficult to start to police those things happening. I am with Helen, I have to say, that some of the providers of the internet services are the ones that need to take some action in relation to who is allowed to use them.

Helen Belcher: A line of defence very often is comedy. If we encounter something that is hateful, the response is almost always, "Oh, it was just a laugh. It was a bit of a joke; we did not mean it seriously". Neil has talked about the barrier of evidence; well, that would be the defence. How do you then counter that? How do you then prove a malicious intent when they are saying it was only a joke?

Professor Chakraborti: That stems back to when the incitement to religious hatred provisions were drafted. Comedians like Rowan Atkinson were very strong on that campaign that it should not be a criminal offence to ridicule a religious belief. It should be when it comes to an ethnic identity, but when it comes to religion that should not be a criminal offence. That threshold is really applied to sexual orientation.

Helen Belcher: It is a very difficult boundary and we try very hard not to act as censors, not that we have any power to act as censors. We try very hard to point out the issues of particular use of language and particular themes and how that shapes perceptions and how that can misshape perceptions as well. Comedy is probably the hardest area to draw those boundaries and make those distinctions in.

There is an example in *The Last Leg* on Channel 4 a couple of weeks ago. They had a session on Caitlyn Jenner and the Halloween costume that has been presented, supposedly again, as a kind of joke. The three guys were kind of struggling to work out why this was problematic and it took a Canadian comedienne to nail the issue, in that it is making trans people the target of humour rather than laughing with trans people. That mirrors the conversation I actually had with the head of comedy at Channel 4 a couple of years ago, where I said, "Why are you still trying to laugh at trans people? Why are you not engaging and laughing with trans people?" and that is what *Boy Meets Girl* on the BBC will hopefully be trying to do. But then last week again on *The Last Leg*, you had the comedian start to skirt around a trans joke until Adam Hill suddenly realised, "This is where it is going; this is not going to be good" and very quickly steered the conversation away.

So it is the kind of self-censorship, because we all self-censor. There are a whole bunch of things that if I were to sit here and say I would be carted off. The notion of a completely free speech is completely hypothetical and does not exist in reality. We all talk within pre-determined societal arrangements and comedy obviously is always trying to push those boundaries and that is where the problems can start to occur. The point I was making

earlier was that comedy is used as a defence, when actually there was no comedic intent, and quite how you prove the lack of comedic intent is also problematic.

Chair: Have colleagues got any further questions? That was an incredibly helpful session. Thank you for bringing your expertise into our discussions and if there is anything else you feel you want to contribute after the session has ended, please do drop us some further notes. I think we have got some evidence from you already. Thank you very much for your time. It is really, really helpful in our deliberations. Thank you.