Written evidence submitted by Dr Katie Clyde and Dr Lucy Griffin [GRA1320]

Submission to the Women and Equalities Select Committee

We are two doctors , part of a wider national and international network of clinicians, campaigning for improved care of gender questioning individuals within primary, secondary and tertiary services (1). Our combined clinical and academic expertise covers the generation and interpretation of medical evidence, the development and evaluation of interventions for marginalised groups, and care of transgender and gender questioning individuals in general psychiatric settings.

We share concerns about the wellbeing of gender questioning people, particularly young people. However, while many people and some organisations presently advocate more rapid pathways into legal gender recognition for transgender individuals, we urge the committee to be cautious given that the issues are complex. Gender incongruent young people may find themselves channelled down a route to social transition, medical intervention and formal legal gender change rapidly rather than taking a more curious and questioning approach which allows them to explore their gender neutrally.

We wish to give evidence on the following questions:

1. Should the requirement for a diagnosis of gender dysphoria be removed?
2. Should there be changes to the requirement for individuals to have lived in their acquired gender for at least two years?
3. Should the age limit at which people can apply for a Gender Recognition Certificate (GRC) be lowered?
4. Are the provisions in the Equality Act for the provision of single-sex and separate-sex spaces and facilities in some circumstances clear and useable for service providers and service users? If not, is reform or further guidance needed?

1. Should the requirement for a diagnosis of gender dysphoria be removed?

We are particularly concerned that the broader psychosocial needs of children, adolescents and young people are being overlooked, and the potential harms of rapid affirmation underplayed. Given the high rates of comorbid conditions in young people presenting to gender clinics (2,3) and adults living with gender dysphoria (4) it is potentially harmful to eliminate the need for an assessment and diagnosis of gender dysphoria before legally changing gender markers. Young people with complex psychological and mental health comorbidities should be supported using a holistic framework, with treatment offered that is neutral and supportive.

It is already well established in existing research that desistence (the phenomenon whereby a young person with gender dysphoria identifies as transgender but reconciles with birth sex at or after puberty prior to medical intervention) rates for children presenting to gender clinics are high, in the region of 60-80% (5). What is not known is the impact of affirmative care and social transition on this figure. It is plausible that affirmative care will increase rates of persistence as the child / young person commits to the transition; it has been suggested that social transition 'fixes' the child's gender identity (6).

Certainly, those who start puberty blockers are extremely unlikely to desist (7) suggesting that this treatment in itself increases the likelihood of persistence of gender dysphoria into adulthood.

There is a growing community of detransitioners, (those who identify as Trans and undergo social transition and medical transition). One notable online community of detransitioners has over 16 000 subscribers (8). The paucity of published research into detransition in spite of this is

striking. Factors such as comorbid conditions, trauma and coming to terms with same sex attraction are cited as reasons for initially identifying as trans in surveys of detransitioners (9). Presently, there is a worrying lack of published clinical research demonstrating predictive factors in order to better identify those who may benefit from transition and those who may be harmed.

Removing any requirement for a diagnosis prior to applying for a GRC may mean this opportunity to treat comorbid conditions is lost and a transgender identity fixed on prematurely. Therefore, medical harm might be caused through the administration of cross sex hormones, and surgical interventions such as mastectomy and genital surgery.

Moreover, there does not appear to be any way to reverse a GRC if an individual detransitions, meaning they may be forced to live legally as a gender which they no longer feels fits their identity (10).

2. Should there be changes to the requirement for individuals to have lived in their acquired gender for at least two years?

For those who do decide to legally transition, the expectation that the person 'live in their acquired gender' for 2 years allows time to demonstrate the development of a stable sense of identity over a period of time. This would seem sensible given that the effect of a GRC is to permanently and irreversibly change the individual's gender markers. There is evidence that the human brain continues to develop well into one's twenties and that identity might well not be fixed before the age of 25 years.

3. Should the age limit at which people can apply for a Gender Recognition Certificate (GRC) be lowered?

We believe that any attempt to lower the age requirement should be viewed with extreme caution. Young people can apply for a GRC from the age of 18. Well beyond this age, identity continues to develop and form. The advantages to having a GRC at this age are questionable, the potential harms considerable.

4. Are the provisions in the Equality Act for the provision of single-sex and separate-sex spaces and facilities in some circumstances clear and useable for service providers and service users? If not, is reform or further guidance needed?

The Committee also seeks views on practical issues in the interface between the Equality Act 2010 and the Gender Recognition Act. We would like to draw the Committees attention to the difficulties healthcare providers encounter when trying to interpret this interface as well as the conflicting rights within the Equalities Act (specifically 'sex' and 'gender reassignment') Given that there is no workable definition of 'gender reassignment' that enables providers to distinguish a trans patient from any patient who might wish to be cared for on an opposite sex ward for a variety of reasons, it is not apparent how single sex provision can be realistically delivered.

There is a pressing need to resolve this tension when considering the provision of safe care in specific healthcare settings such as psychiatric inpatient facilities. Given the high rate of sexual trauma that female psychiatric patients have experienced, it is essential that the safety, privacy and

dignity of this group is maintained. A 2017 CQC survey reported 1220 sexual incidents occurring on mental health wards over a three month period (11). The majority of perpetrators were male. Where Trans prison policies have been implemented without Equality Impact Assessments on the safety of women, egregious abuses have occurred (12).

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November 2020