

Written evidence submitted by GIRES to the Transgender Equality Inquiry

Author: Terry Reed OBE, JP, BA(Hons), MCSP, SRP, GradDipPhys

For issues around Marriage (same-sex couples) Act, the GRA and ‘spousal veto’ see Paula Dooley’s personal submission (GIRES Trustee).

Please note: the GEO’s Transgender Action Plan only partially addressed the Transgender Statement of Needs.¹ Less than half of the issues raised were addressed in the LGBT Equality Action Plan and the Transgender Equality Action Plan.

Terminology: Transgender (or trans) people have a range of gender identities and expressions that are not stereotypically associated with their assigned sex at birth. See section 4 below, and separate document on terminology and definitions submitted by Bernard Reed:

- 1) Prevalence and impact on service delivery for trans and non-binary people;**
- 2) The diagnosis of gender dysphoria: access to, and operation of, NHS Gender Services;**
- 3) NHS services for trans youth;**
- 4) The Equality Act 2010 in relation to trans people;**
- 5) Employment and workplace issues (including in the Armed Forces);**
- 6) Trans youth in education;**
- 7) Trans people in the courts;**
- 8) Human Rights Act 1998**

1. Prevalence and impact on service delivery for trans and non-binary people

The EHRC Technical Note found 1% had made, or intended to make, changes indicating that they had the ‘gender reassignment’ characteristic (n=10,000).² These data cannot necessarily be extrapolated to the whole population, but they are reinforced by the Clark et al study on High School students in New Zealand, a robust study on a random population (n = 8,166) in which 1.2% reported being ‘transgender’.³ Transgender adolescents, invariably remain so in adulthood.

Data published by the European Union Agency for Fundamental Rights (FRA 2014) are based on 2 questions:

- 1) ambiguity of identity [non-binary], and
- 2) incongruence of identity [trans]

The former produced larger numbers than the latter.

Question 1) The Netherlands reported assigned male 2.2%, and assigned female 1.9%; Belgium reported assigned male 4.6%, and assigned female 3.2%

Question 2) The Netherlands reported assigned male 0.7%, and assigned female 0.6%; Belgium reported assigned male 1.1%, and assigned female 0.8%.⁴

These figures indicate that about 1% of the UK population, some 650,000 people, are likely to be gender incongruent to some degree. So far, only about 30,000 have sought medical help for gender dysphoria. Dutch research indicates that around a fifth of the 650,000 will do so, amounting to a further 100,000 people.

Currently, referrals to NHS Gender Identity Clinics (GIC) are rising at 20% per annum; in the child and adolescent services (Tavistock gender identity development service) annual referrals are now doubling, and predicted to be 1200 in 2016. Recent reports indicate waiting times of 2-3 years for access to some of the adult clinics. The waiting time for genital surgery for trans women is 22 months; without additional services being commissioned, the predicted waiting time is 42 months by 2017 (NHS England). Plans to overcome this deficit, will still not achieve the 18 week rule for several years; it cannot be achieved, *at all*, for access to GICs.

This lack of capacity cannot be overcome unless service delivery is changed. We recommend commissioning local initiatives in primary and secondary care, working in tandem with the current specialised providers. (See below: Issues concerning diagnosis).

2. The diagnosis of gender dysphoria: access to, and operation of, NHS Gender Identity Services;

Medical services in the NHS, follow the WHO's International Classification of Diseases (ICD version 10) in which 'transsexualism' still appears under Mental and Behavioural Disorders. Therefore, treatment in the UK has, typically, been led by psychiatry. A psychiatric diagnosis is profoundly disempowering and, even though perceptions are now changing, many practices and protocols still often require patients to provide 'evidence' that 'proves' their 'diagnosis'. Gender dysphoria has been regarded in exactly the same way as 'homosexuality' was in ICD9, until its removal in 1992.

In 2013, the Working Group reporting to the WHO Executive Board wrote, with regard to gender identity, the *'psychopathological model'* should be "*abandoned, in favour of a model that reflects current scientific evidence and best practice*".⁵ The ICD11, likely to be published in 2017, is expected to re-classify the condition, describing it as 'gender incongruence' - a non-pathologising description. Removal altogether from the ICD is not an option, since gender dysphoria frequently requires medical interventions.

Doctors predicate medical services on their understanding of the 'diagnosis' so this impacts all aspects of medical and social care. It is therefore timely that The Lancet is preparing several articles about transgender healthcare, including a short paper on 'biological correlations' of which a trustee of GIRES is a co-author.

The World Professional Association for Transgender Health's Standards of Care (WPATH 2011) provide a non-pathologising description: "*The expression of gender characteristics that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon that should not be judged as inherently pathological or negative*".⁶

In light of this understanding, access to hormone treatment need not *inevitably* involve psychiatric or highly specialised assessments - the UK Good Practice Guidelines (GPG) allow a range of clinical backgrounds: “psychologists, psychiatrists, counsellors, therapists”, but also “GPs, endocrinologists, nurses, etc.”⁷

We also recommend consideration of the ‘informed consent model’ as practised in the following USA clinics: Callen Lorde Community Health Center⁸; Fenway Community Health Transgender health program⁹ ; Tom Waddell Health Center.¹⁰ These clinics conform to the international standards of care.¹¹

Access to trans health services, needs to be prompt and local, involving lower travel costs, less stress, and therefore less need for mental health treatments, and less risk of self-medication. Specialist services would still have a significant role to play in preparation for genital surgery, and in cases where co-existing conditions are present, with particular attention to ‘secure accommodation’ where trans people are poorly treated.

These measures would help to address the lack of capacity. Other strategies, already underway, would need support from NHS England: GMC endorsement of primary care; training across the board, for specific treatments, and also general treatments in the wider NHS services. (Preparation is underway within NHS England to provide training in conjunction with the Royal College of Physicians. E-learning for GPs is now available on the RCGP website.¹²)

3. NHS services for trans youth;

Medical intervention for children and adolescents has lagged behind overseas expertise in the long-term and well-researched practices in Amsterdam and elsewhere. Intervention with hormone-blockers in early puberty, to suspend the development of unwanted secondary sex characteristics, was not introduced here until 2011. Until then, where possible, treatment was accessed in Boston USA, and later Hamburg, but others suffered the “psychological torture” associated with pubertal changes that are foreign to them,¹³ and the NHS had the added cost of later treatments such as hair removal and chest reconstruction. Initially, blocking treatment was only available from 12, rather than the early stage of pubertal development, incurring unnecessary delay and psychological trauma. Hormone-blockers are now given around the onset of puberty, if assessments have already been completed.

Those who seek treatment at a later stage of pubertal development need urgent intervention, but it takes 4 ½ months to access the clinic; assessments take 6 months; hormones are only prescribed after 12 months of hormone-blocking, and never before 16. Even when eligible for hormones, the young person has a further 6 months of assessment by the endocrinology service. That amounts to a 28 ½ month wait for treatment. By contrast, the Harvard Medical School can, when appropriate, get a young person onto hormones within a week.¹⁴ In the UK transfer to adult services can occur from the 17th birthday. Consequently, hormones may not be prescribed at the time of transfer. Assessments are then repeated unnecessarily over many months; there is no clinical justification for this. The WPATH standards of care offer important insights.

*“Refusing timely interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al 2010)¹⁵, withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents”.*¹⁶

While waiting for treatment mental health deteriorates, self-harm and suicidality are common. Young trans people, especially those assigned female at birth, may adopt starvation as a way of stopping menses and breast development. This may be wrongly interpreted as ‘classic’ anorexia’, and the cause of the not-eating is not addressed. Delay also occurs for those with co-existing autistic spectrum disorders, because specialists in this field are not available within the current provision, to assist in the interpretation of the needs of this group.

Those who have sought treatment elsewhere or who, in desperation, have self-medicated are, under present protocols, excluded from the current UK service provision. This would appear to be unethical.

4. The Equality Act 2010 (EA) in relation to trans people

The EA is proving to be a powerful tool in addressing the needs of trans employees, service users in health and social care, and students of all ages. The current wording, can be understood to protect the wider group of non-binary individuals, who only undertake ‘a part of a process’. However, resistance from the GEO who deem non-binary individuals to fall outside the EA scope, has given rise to great anxiety among those whose do not fit the now out-dated, highly restrictive, terminology: ‘transsexual’.

The transgender field includes those whose gender identity is completely incongruent with the sex they were assigned at birth, and also all shades in between, and outside, the gender spectrum. Those that do not conform to the binary model are, by definition, ‘non-binary’ and in a few cases, non-gender. All of these individuals *may* experience gender discomfort or dysphoria, and take steps, however small, to reduce or eliminate this incongruence; they should therefore be regarded as meeting the criteria for inclusion under the gender reassignment characteristic. The essential factor here is not the label: transsexual, transgender, non-binary, but rather the process, however modest, through which individuals seek to overcome their discomfort.

If the EA is found to exclude a large part of the broader trans population (see FRA figures under Prevalence above), then the Act appears to be undermining its own equality objectives. Non-binary/genderqueer individuals have appeared in the UK official Department of Health documentation from at least 2008.

Extract from the 2008, Department of Health, Guidance for GPs:

“...it must be recognised that individuals will experience their condition differently and respond to it differently. Some people will regard themselves as neither man nor woman and may prefer to live androgynously, or they may regard themselves as ‘gender queer’ (any gender experience or expression that is not recognised as ‘typical’) [...] clinical responses should be flexible and should recognise the personal need for some feminising or

*masculinising treatments, without the need to follow one particular pathway or arrive at one specific destination.”*¹⁷

In support of our position, we cite two pieces of evidence:

- a) The Technical Note on monitoring that Glen and Hurrell (EHRC) produced when looking to devise a question that revealed whether or not a person had the gender reassignment characteristic resulted in a question which clearly indicates that the EHRC were seeing the process rather than the labels, as being key to establishing the scope of the ‘gender reassignment’ characteristic in equality law.

*Have you gone through any part of a process (including thoughts or actions) ... or do you intend to? (This could include changing your name, wearing different clothes, taking hormones or having gender reassignment surgery).*¹⁸

- b) An ACAS hearing, where an individual who was unconventionally trans and fell under the non-binary description, was found to be protected because she had undergone ‘a part of a process’. This does not amount to ‘case law’. It does, however, provide an example of reasonable people coming to an inevitable conclusion.

Yet the GEO and some lawyers insist that a ‘case’ must be brought, so that the interpretation of the wording of EA can be confirmed or otherwise, thus creating a ‘precedent’. This is costly, stressful, time consuming and, in the view of many, utterly unnecessary in order to clarify this point. (Two of GIRES Trustees have direct experience of the devastating effects of the tribunal/court process, even where the case is won -*Chessington World of Adventures vs Reed, 1997*).¹⁹

Government and EHRC guidance clarifying the intention not to exclude those who experience degree of gender dysphoria, and therefore undergo ‘a part of a process’, would overcome the nervousness of lawyers, and of non-binary people themselves, who appear to be in legal limbo?

The argument that they *may* be protected, in some circumstances, by the ‘perception’ of others, is not satisfactory because this was intended to protect those who are, for instance, harassed because they were, *wrongly*, perceived to be transgender.

5. Employment and workplace issues (including in the Armed Forces)

Many employers, including the armed forces, are responding well when an employee, or military person transitions. However, many employers do not have pre-emptive policies in place even when required to do so in accordance with the Public Sector Equality Duty. A frequently seen problem is, inevitably, toilet facilities. The GEO and the EHRC, should clarify that employers must **never** demand that trans people use toilets (even as an interim measure) that are not consistent with their gender role and presentation.

The negative impact of breaching a trans person’s privacy is discriminatory under the Equality Act both in the private and the public sector, and is reinforced in the public sector by the Human Rights Act 1998 (Article 8).

However, the change of name and title in binary IT systems which were not designed to accommodate such changes, are often unlawful. For instance, in 2014, the High Court ruled that the DWP's policies for retaining data which identified someone as transgender were discriminatory and breach privacy.²⁰

Current data storage systems can be damaging:

A teacher whose details appear in the DfE Intranet changed his name, John Davies (not real name) to Jill Davies by Deed Poll, when transitioning to live as a woman. The school changed her name in all school records. Two years later Ms Davies planned to relocate, and applied for a job in the new area. Prior to her interview, the Principal of the target school accessed Jill's employment history on the DfE Intranet. The name and title were female, but the sex marker was (1) indicating 'male'. The Principal assumed rightly, that Jill had a trans history.

Jill has a gender recognition certificate (GRC), but this did not protect her from being 'outed'.

6. Trans youth in education

The Department for Education (DfE) needs to take a strong lead in helping schools, as well as exam boards, to co-operate in registering children in the name that accords with their gender identity, in providing new certificates and so on. Schools should be advised that requesting a GRC, as some do, is entirely inappropriate.

In further and higher education 47% of LGBT students felt unable to talk to their tutors about concerns related to their gender identity or sexual orientation, 19.1% complained about the 'insensitive curriculum content'²¹ (Skills Funding Agency, 2011). 28.5% trans students report negative treatment from tutors and lecturers because of they are trans (the Forum).²²

The numbers of very young children transitioning in primary school are increasing rapidly, so information and reassurance needs to be given at the earliest stage. The 'Penguin Land' stories,²³ for instance, will help teachers to put simple messages across to children.

The DfE has not been enthusiastic about including atypical gender identity development in the curriculum. Schools usually avoid it until they are faced with the transition of a young person, yet this should be included at all levels of the syllabus, and be celebrated in the same way as other protected characteristics. Schools should be able to provide material for teachers and parents as well as pupils.²⁴ Special attention should be given within PSHE to the bullying of vulnerable groups which include young people that identify as lesbian, gay, bisexual or transgender, as evidenced by Ofsted in their 2012 report 'No Place for Bullying'.²⁵ All teachers should be trained to support young LGBT pupils, and to recognise and tackle transphobic bullying, including cyberbullying,

The Civil Society (CS) alternative report to the Committee on the Rights of the Child – England, pointed out that the parliamentary report 282 concluded that '*young people consistently report that the sex and relationships education (SRE) they receive is inadequate*'. GIRES supports the recommendation that PHSE be made statutory, with SRE as a core

component, and same-sex families and health and relationships issues for lesbian, gay, bisexual and transgender young people be included, with no opt outs for ‘faith’ schools and Academies and no rights of withdrawal for parents.²⁶ The PHSE Association’s LGBT recommendations have been submitted to, but not yet endorsed by, the DfE.

7. Trans people in the courts;

Trans people are frequently ‘outed’ in court situations to create, deliberately, a negative view of them, whether their trans history is relevant or not. The Gender Recognition Act s22(4)(e) has been misused to achieve this.

Sir James Munby (President of the Family Division) has responded to a request from GIRES by issuing a statement with regard to this point in family proceedings.

In specified circumstances, section 22(4) of the Gender Recognition Act 2004 permits the disclosure of what would otherwise be “protected information” about an individual who has applied for a Gender Recognition Certificate.

The effect of section 22(4)(e) is that “protected information” may be disclosed “for the purposes of proceedings before a court or tribunal.” The facts of the individual cases in which the disclosure question will arise are likely to vary widely. In some instances it will be relevant to the issues to know that an individual has a transgender history.

In others it will be entirely irrelevant. Disclosure should not be permitted in those cases where it is unnecessary and irrelevant to the issues. There is a need for judges to be aware of and astute to the issues.²⁷

The government should prompt **all** civil and criminal courts also to avoid this error. It is, in any event, a breach of Article 8 Human Rights Act 1998, whether or not a GRC is held.

Special measures may need to be taken in recognition of the vulnerability of trans people appearing in court.

Transphobia is an aggravating factor which should be reflected in higher penalties. Police and CPS must ensure that relevant evidence is taken seriously, especially when ongoing behaviours by, for instance, neighbours, could amount to a ‘course of conduct’.

8. Human Rights Act 1998

The Human Rights Act is frequently relied on, in conjunction with the Equality Act to support fair treatment in employment, health and social care, education and goods and services. We support Joshua Rozenburg’s arguments in The Guardian 2014 September 1st ‘Human rights legislation in the UK: a cut-out-and-keep guide’.²⁸

15 August 2015

¹ Statement of needs: <http://gires.org.uk/support-archive/trans-community-statement-of->

[need](#)

² Glen, F and Hurrell, K. Technical note: Measuring Gender Identity (2012)
www.equalityhumanrights.com/sites/default/files/documents/technical_note_final.pdf

³ Clark, TC, Lucassen, MFG, Bullen, P, Denny, SJ, Fleming, TM, Robinson, EM, Rossen, FV. (2014) Health and Well-Being of Transgender High School Students: Results From the New Zealand Adolescent Health Survey; <http://www.ncbi.nlm.nih.gov/pubmed/24438852>

⁴ European Union Agency for Fundamental Rights' (FRA) comparative analysis of EU LGBT survey data.2015; <http://fra.europa.eu/en/publication/2014/being-trans-eu-comparative-analysis-eu-lgbt-survey-data>

⁵ Report to WHO Executive committee,
www.ghwatch.org/sites/www.ghwatch.org/files/B133-6_LGBT.pdf

⁶ World Professional Association for Transgender Health, Standards of care (2011).
http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926

⁷ Good Practice Guidelines for the assessment and treatment of gender dysphoria in adults (2013) www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr181.aspx

⁸ Callen Lorde Community Health Center 2011 at www.callenlorde.org/documents/TG_Protocol_Request_Form2.pdf;

⁹ Fenway Community Health Transgender health program 2007 at
www.fenwayhealth.org/site/DocServer/Fenway_Protocols.pdf?docID=2181

¹⁰ Tom Waddell Health Center, 2006 at
www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf

¹¹ Op. Cit WPATH

¹² E-learning for GPs is already available on the RCGP website¹² at:
<http://elearning.rcgp.org.uk/gendervariance>

¹³ Kreukels, BPC and Cohen-Kettenis, PT (2011) Puberty suppression in gender identity disorder: the Amsterdam experience, *National Review Endocrinology* 7, 466-472.
doi:10.1038/nrendo.2011.78

¹⁴ Spack NP, Edwards-Leeper L, Feldman H a, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. 2012;129(3):418-425.
doi:10.1542/peds.2011-0907.

¹⁵ Nuttbrock, L, Hwahng, S, Bockting, W, Rosenblum,A, Macri, M, Becker, J. (2010)

Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research*, 47(1), 12-23.
Doi:10.1080/00224490903062258

¹⁶ Op.cit WPATH

¹⁷ Guidance for GPs, other clinicians and health professionals on the care of gender variant people (2008) NHS, Department of Health. www.gires.org.uk/health/department-of-health-literature-project

¹⁸ Op.cit Glen and Hurrell (2012)

¹⁹ Chessington World of Adventures v Reed:
http://www.bailii.org/uk/cases/UKCAT/1997/1063_96_2706.html

²⁰<http://uktrans.info/legislation/71-significant-court-judgments/152-the-queen-on-the-application-of-c-v-secretary-of-state-for-work-and-pensions-2014-ewhc-2403-admin>

²¹ Skills Funding Agency (2011).
[Sexual_Orientation_and_Gender_Identity_Equality_in_Adult_Learning-_Published_August_2011.pdf](#)

²² The Forum; <https://sgforum.org.uk/>).

²³ Access to lessons for children of all ages: <http://www.gires.org.uk/education/classroom-lesson-plans>

²⁴ Elearning for middle and senior schools and their teachers, school nurse etc. for middle school children: www.nlms.content.nesc.nhs.uk/sabp/gv).

²⁵ Ofsted (2012) 'No Place for Bullying'. <http://www.ofsted.gov.uk/resources/no-place-for-bullying>

²⁶ House of Commons Education Committee, Life lessons: PSHE and SRE in schools, Fifth Report of Session 2014–15, *11 February 2015*

²⁷ Sir James Munby: <https://www.judiciary.gov.uk/announcements/gender-recognition-act-2004-protected-information-relating-to-a-person-who-has-acquired-a-gender-recognition-certificate/>

²⁸ Joshua Rozenburg <http://gu.com/p/4x6hj>