The British Psychological Society
Promoting excellence in psychology

British Psychological Society response to the House of Commons Women and Equalities Committee

Transgender equality inquiry

About the Society
The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries
We are content for our response, as well as our name and address, to be made public. We are also content for the Committee to contact us in the future in relation to this inquiry.

Please direct all queries to:-

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About this Response

The response was led on behalf of the Society by:
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We hope you find our comments useful.

Dr Ian J Gargan CPsychol AFBPsS
Chair, Professional Practice Board

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The Committee invites evidence submissions regarding the following issues in particular:

	Terminology and definitions, and the availability and reliability of data, relating to the trans community
1.	Comments: The Society would recommend the plural term, *communities* in recognition of the heterogeneity of transgender and non-binary people who do not form a single community. Indeed the majority of transgender people are not members of a community of transgender people as such, but rather live their lives in ways which are generally unrelated to their transgender status (Barrett, 2007). In light of this heterogeneity, the Society is aware of a wide variety of terms which have been used, and are used for transgender people. Indeed the term transgender people itself sometimes includes people who have genderqueer or non-binary identities as an umbrella term; and sometimes does not. We are using it here to include people who identify outside of the gender binary. Language is constantly evolving to try to encompass this spectrum of identities and practices, with some terms being retained and some falling away. The Society believes that the availability of data pertaining to the transgender communities is weak (Richards & Barker, 2013; 2015). Most data is collected from self-selecting surveys of transgender people who are necessarily people who are willing to complete such surveys and to be open, (or at least to communicate), about being transgender. This means that the majority of transgender voices - those who do not wish to engage in this way – are not heard. This point is also pertinent regarding community groups and special interest charities who do excellent work, but who are not always representative of the totality of transgender people. The Society recommends that the Government consult widely, and beyond only established groups, to endeavour to reach these people. Some data is emerging from NHS gender clinics which capture the voices of these people before they leave such systems and are cared for in the primary care sector. But this research is patchy and mostly concerns the efficacy of the NHS Gender Clinics (i.e. Davies et al, 2013) and will of necessity not include people who are not in the process of transition.

	The relationship between the Government Equalities Office and other government departments in dealing with transgender equality issues and how the UK's performance compares internationally
2.	Comments: The primary problem of the place of transgender people within Government departments appears to be the lack of transparency; and especially accountability. It is extremely difficult to find out who is executively responsible for elements of policy and service provision within government. This is especially marked within the NHS and Department of Health. The Society has concerns regarding the lack of psychologists from many areas of engagement with Government departments who appear to see transgender issues as a purely medical matter. Psychologists take a holistic approach to people which includes their physical self, mental selves, *and social environment,* are especially well placed to assist trans people. Perhaps for this reason it is notable that, beyond the UK, the heads of the two largest gender clinics in the world (in Toronto and the Netherlands) are psychologists rather than medical doctors. The Society calls upon the Government to ensure that psychologists are engaged with, and in a manner which is not secondary to that of the medical profession.
	The operation of the Gender Recognition Act 2004 and whether it requires amending
3.	Comments: The Society is concerned by the fact that transgender people are excluded from Genuine Occupational Requirement legislation by the Act and would recommend that this be redacted to avoid distress to transgender individuals who are otherwise recognised in their acquired gender. **Regarding disclosure of transgender status for incapacitated persons under the Gender Recognition (Disclosure of Information) (England, Wales and Northern Ireland) Order 2005** At present Psychologists are not included under the *Disclosure for medical purposes* section of this Order which does allow disclosure (outlined elsewhere) by a Health Professional including: a registered medical practitioner; a registered dentist; a registered pharmaceutical chemist; a registered nurse; a paramedic or operating department practitioner; or a trainee for the above. The Society believes that Applied Psychologists who are registered with the Health and Care Professions Council (HCPC) should be included in this list. We note that several of the professions who are included in the Order are also accredited by the HCPC.

	The Society acknowledges that some members of the transgender communities feel that the restrictions on disclosure should be tightened. Indeed we are aware that the spirit of the restrictions has not always been respected by other professions within the healthcare sphere. Notwithstanding this, the understandable wish to tighten such restrictions must be balanced against the need for appropriate care for transgender people who lack capacity to consent – care which may be provided by Psychologists in cases where the person lacks capacity under the Mental Capacity Act 2005 or the revision to the Mental Health Act in 2007. The Society believes that the original Gender Recognition Act 2004 only foresaw times when people were physically unconscious – rather than lacking in capacity in other ways. While the Society wholeheartedly supports the feelings of people from the transgender communities with respect to a general expectation for the right to privacy, this would, of course, not be pertinent to the case of severely disabled transgender people with a significant intellectual or psychological disability who does not have capacity to consent; and therefore necessarily required their responsible Psychologist to make decisions on their behalf. In addition, we note that the Gender Recognition Act 2004 and the Order 2005 predate the Mental Capacity Act 2005 and the Mental Health Act 2007. These pieces of legislation, alongside the move of applied psychologist accreditation to the Health and Care Professions Council from the British Psychological Society, radically increased the amount of responsibility afforded to registered Psychologists - not least that of being an Approved Mental Health Professional - which at the time of the Gender Recognition Act 2004 and the Order 2005 was assumed to be the province of Medical Practitioners and Approved Social Workers. The law as it stands therefore fails to take all this into account - In effect it makes Psychologists legally responsible for roles it would then be illegal for them to fulfil. The Society believes that this needs to be addressed.
	The aspect of the Marriage (Same Sex Couples) Act 2013 which is referred to as the "spousal veto"
4.	Comments: Distress is not inevitable when a person is in a relationship transitions, but this can be the case in some instances. The Society's remit extends to the mitigation of distress and as such we call for greater provision of services for transgender people, and those close to them, to mitigate this distress rather than a simple veto.

	The effectiveness of the Equality Act 2010 in relation to trans people
5.	Comments: The Society believes that more effective implementation of the Equality Act 2010 and support for transgender people who wish to avail themselves of it is needed. The Act itself is well drafted; however the implementation is lacking leading to marginalisation and distress for transgender people.
	Employment and workplace issues (including in the Armed Forces) affecting trans people
6.	Comments: Applied embers of the Society have noticed significant discrimination against some transgender people in the workplace. This is quite often at the level of junior management and any assistance the Government could bring to support and require such managers to respect transgender people's rights will be welcome. One issue of particular note is that employers frequently do not allow staff to take time off for psychological and medical requirements relating to their transgender status, when they do allow staff time off for non-transgender related matters. Making this a specific offence may be helpful.
	Transphobia (including the portrayal of trans people in the media) and hate crime against trans people
7.	Comments: Transphobia can cause marked distress in transgender people which can reach clinical levels (McNeil et al, 2012). This can be in the form of rank abuse, but more commonly is in the form of micro-aggressions such as misnaming, using incorrect pronouns etc. Education, especially in schools and colleges should help mitigate this.
	Issues affecting trans people in the criminal justice system
8.	Comments: Some transgender people in the criminal justice system have been unfairly

	discriminated against in terms of the provision of access to transgender related healthcare services. This should be addressed as a matter of Department of Justice policy. Conversely, psychologists working with forensic patients are aware of a number of cases where men convicted of sex crimes have falsely claimed to be transgender females for a number of reasons: • As a means of demonstrating reduced risk and so gaining parole; • As a means of explaining their sex offending aside from sexual gratification (e.g. wanting to 'examine' young females); • Or as a means of separating their sex offending self (male) from their future self (female). • In rare cases it has been thought that the person is seeking better access to females and young children through presenting in an apparently female way. Such strategies in no way affect risk an indeed may *increase* it. Some people falsely believe that taking oestrogen and blocking androgen in males will reduce risk of offending, however this is not necessarily the case. Consequently the Society recommends that the Government give appropriate assistance to transgender people within the criminal justice system; while being extremely cautious of setting law and policy such that some of the most dangerous people in society have greater latitude to offend.
	Issues concerning the diagnosis of gender dysphoria, including the operation of NHS Gender Identity Clinics
9.	Comments: As stated above there is limited data on this, although one large study from within the clinics themselves finds satisfaction to be high (Davies, 2012).This study has the advantage that the people involved are current patients rather than ex-patients who experienced different protocols and regimens as are found in many online studies. There are however, significant issues with waiting times which urgently need to be addressed due to the cost to the exchequer alone in caring for people waiting for these vital treatments. This is quite aside from the key issue of the human suffering being caused by these unnecessary waits. Regarding the diagnosis of gender dysphoria – the Society recommends an approach consisting of *formulation* rather than simply diagnosis. In this approach the holistic totality of the person's life is considered and how best to act from that is determined. It should be noted that even when diagnosis is used, the appropriate treatment does not follow from that. There are a number

	of treatment approaches, including no interventions, which might be appropriate depending on the patient's circumstances. **Regarding the 'informed consent' model.** Many transgender people advocate for the 'informed consent' model. This is, in reality, a number of different approaches ranging from something similar to that which most clinics are undertaking at present, to a model in which the type and timing of treatment is determined solely by the patient, if they are capacitous, irrespective of harm. The moderate position is that capacitous patients should not have to prove themselves to clinicians in order to access treatment. Many people point to this being practiced in the US and elsewhere where three or four sessions of counselling are all that is required. This supports the right of the patient to choose, and to make their own mistakes if they chose poorly. There are two issues with this: First, at present clinicians are responsible to the Society and HCPC for any recommendations they make irrespective of whether the patient has also consented. Indeed it has always been, and should always remain the case, that clinicians act and make recommendations in what they believe to be the best interests of the patient, even if the patient does not always agree. The patient may seek a second opinion; may make a complaint, etc., but to ask clinicians to always agree with patients simply on principle undermines the very heart of the role of the clinician in providing safe practice. Secondly, the Society is aware that many of its members are not acting privately as in the US, and that when patients are seeking non-private services they are being financed by a third party – not uncommonly the NHS. In this instance it would seem reasonable for clinicians to endeavour to ensure that that which is being asked for is necessary and efficacious; so as not to spend someone else's money on what the patient wants, but may not need. Consequently the Society welcomes an approach which allows the greatest amount of patient autonomy while still allowing clinicians to ensure clinically appropriate provision of services.
	Access to gender reassignment treatment under the NHS
10.	Comments: The Society recognises that the waiting lists for services are currently far too long and that this often causes significant distress for transgender people. The Society also recommends greater transparency in the commissioning system.

	Trans people and wider NHS services
11.	Comments: The Society believes that transgender people often have poor service within the wider NHS. Occasionally this is due to simple transphobia, but more commonly it is because NHS staff are uneducated with regards transgender needs. This can mean that transgender specific needs are not attended to – for example that transgender people are not referred quickly to Gender Clinics when necessary; But also that transgender people are considered to be 'too specialised' when in fact any competent clinician could assist them – for example depression following a bereavement. One area of key importance is that of GP prescribing of hormones and androgen blockade for transgender people. GPs, acting on psychologist and other professional recommendation, may prescribe for transgender people. Indeed it will likely be necessary for them to continue to do so for the rest of that person's life, along with associated blood tests, etc. Some GPs are, however, not doing this and are not referring to people who do. This is seldom reported as an explicit objection to transgender by the GP, but given the responses of healthcare staff reported in McNeil et al, (2012) and elsewhere, it is likely that this is the case in some instances. Governmental assistance in ensuring transgender people are not being unfairly treated by GPs would therefore be most welcome.
	NHS services for trans youth
12.	Comments: Similarly to adult services, NHS Services for transgender youth are greatly underfunded. One key area of concern is that of gamete storage for transgender youth who will lose reproductive capacity through treatment. At present a 'postcode lottery' exists regarding gamete storage which is immoral.
	Issues concerning trans youth in the education system
13.	Comments: Transgender youth in the education system are frequently bullied - with schools appearing to take a mixed approach. Some schools blame the bullies and put into place robust anti-bullying measures; whereas some schools blame the victim and suggest that they change their presentation and behaviour in order to be 'safe'. This can of course cause great distress to the transgender child

	involved (Shaw, et al, 2012). Governmental intervention which reiterates the rights of transgender youth and requires the education system to stop bullying rather than gender diverse behaviour would be welcome.
	Issues concerning trans youth and social care services (including looked-after children)
14.	Comments: Some young people engage with a different gender to that which commonly matches their birth assigned sex as a means of moving away from a painful past, but this is rare. Consequently many looked after children who are gender dysphoric will be transgender. This is not to say that they will remain so as (whether looked after or not) the majority of gender dysphoric youth will not persist with their dysphoria into adulthood (Steensma et al, 2011). Nonetheless, young dysphoric people should have access to assessment and treatment in a timely manner which is sometimes lacking and policy which reflects that would be welcome. Indeed this problem of referral for treatment extends beyond looked after children to those people (child and adult alike) who have learning disabilities, major mental health difficulties, etc. Guidance and outreach to these groups and to groups from diverse cultures would be welcome. **Regarding transgender parents.** One key area of concern is that of the response of social services to a parent's transition. Despite the evidence showing that having a parent who transitions in no way harms their children (Di Ceglie, 1998; Freedman, Tasker & di Ceglie, 2002) there have been many instances of social workers and others in social services taking the view that the transition will harm the child and so restricting or refusing access. Here again bullying of the child is sometimes cited as a reason in a way which would not be the case in instances of other forms of diversity where bullying might, or does, occur. (It also potentially leaves decisions on access to children in the hands of the neighbourhood's seven-year-old bully). Similarly in custody cases, many transgender people are afraid if they reveal their transgender status this will be seen poorly and they will lose their children. The Society calls upon the Government to draft legislation and policy to ensure that transgender parents are granted access to their children which is irrespective of their transgender status.

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