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To our Members of Parliament

Re: Debate called by the Petitions Committee on e-petition 613556 to 'Ensure trans people are fully protected under any conversion therapy ban'

We are writing to outline some of our concerns relating to the debate on June 13th to address the decision not to include, at present, the concept of gender identity or transgender people in the proposed ban on conversion therapy (CT) outlined in the recent Queen's Speech. We wish to offer the following observations to assist in informing the debate.

Purpose

Our purpose in writing is to highlight the relevant issues from our perspective in an open and frank manner. For the avoidance of doubt, Gay Men's Network supports the Government's position to "press pause" on including gender identity or what has been described as 'transgender conversion therapy' in any ban, though precisely what this is has yet to be defined. The current proposed policy (we have not had sight of draft legislation yet) seeks only to ban CT as it relates to sexual orientation. We agree that much more work and scrutiny is required before a sensible ban can be extended beyond that. We agree that there are complex issues to interrogate before legislating about gender identity, these issues include, but are not limited to, medical, legal, social, and, critically in our view, the safe-guarding of adolescents and children – including in clinical settings.

In her interim report[1], published in February 2022, Dr Hilary Cass identified safeguarding failures at UK gender clinics. This is self-evidiently a serious matter. Given the matters set out in the Cass Review and elsewhere (see below), the only responsible course of action for Government is to wait until Dr Cass's review is complete before considering whether one can sensibly legislate in this complex and

important area. Rushed and ill-conceived legislation serves no one, least of all people experiencing, and seeking support for, feelings of discomfort with or disconnection from their sexed body.

Homophobia as a safeguarding risk

We remain deeply worried about clear evidence that homophobia (both direct and internalised) represents a safeguarding risk at gender clinics in the UK. The well-publicised tribunal of Sonia Appleby (*ET Appleby v The Tavistock and Portman NHS Foundation Trust 2204772/2019*)[2], who was the lead safeguarding officer at the NHS Tavistock and Portman (The Tavistock) gender clinics, includes witness statements given in evidence. The tribunal found that the clinic was "*ignoring that boys and girls who want to change sex might simply be gay*". In addition, five clinicians resigned from the Tavistock in 2019 having expressed similar concerns, indicating in a subsequent report to the Times Newspaper (June 2019) that "*it feels like conversion therapy for gay kids*"[3]. It is clear from this and other reports that there is, at best, a casual attitude in UK gender clinics to the possibility that anxiety stemming from sexual orientation was and remains a significant factor in young people seeking their services. Two clinicians from The Tavistock (noted in the same Times article) reported a dark joke among staff that "*soon there would be no gay people left*"[3].

Far from being a joke, as a group dedicated to advocating for gay men, we regard such matters as deeply concerning. One of the most salutary among the many pertinent findings of fact in the Appleby Judgement is this observation: "*Some clinicians are concerned that young people who might be homosexual presented as misgendered or are* ***unduly influenced by social media campaigning on trans identity***" (our emphasis)[4].

The NHS website contains a page entitled "*Think your child is trans or non-binary?*"[5] which suggests openly to parents that a child's play that does not conform to expected masculine or feminine behaviours is not "normal". The page, (chillingly in our view), goes on to resolve this problem by suggesting to parents that the cause for the unwanted, "gender non-conforming" behaviour is, in fact, that the child's (indeed all people's) "gender identity" lies on a spectrum and may not align with their sex and its associated norms. This line of reasoning completely ignores the documented and clinical evidence that most children who display "gender variant" behaviour grow up to be gay or lesbian if left alone to do so are now, in some cases, rushed into a treatment pathway in UK gender clinics.

We welcome the recent Government announcement that there will be a Public Inquiry into these attitudes among gender clinics and the subsequent risks posed to

young people who are very possibly wrestling with the manifestation of their sexual orientation as well as broader concerns expressed by the Secretary of State for Health. For example, why has there been a 5000%[6] increase in young girls being referred to the clinics since 2015? To us at GMN, and to many other gay and lesbian people watching the enthusiastic acceptance of the concept of "gender identity" and how it is deployed to pathologise any gender non-conforming behaviour – in many cases **our** behaviour – it is hard not to feel that a rush to affirmation is what sits behind a growing viewpoint that this amounts to "transing the gay away".

Risk to clinical practice

It cannot be overlooked that the campaign to have the concept of gender identity included in the proposed legislation seeks to ensure that the "affirmation only" approach to treating patients presenting with gender identity disorders is the only clinical option pursued. Indeed, Dr David Bell, formerly of the Tavistock, warned in 2018 that the campaign to include gender identity in a ban on CT" was "*likely to become a Trojan horse for transactivists who will use it to put pressure on any clinician who does not immediately affirm a young person's statement about their identity"*[7]. Furthermore, the interim findings of the Cass report[1], highlight the concerns of clinical staff that they already feel under pressure to "*adopt an unquestioning affirmative approach"* even before any legislation has been implemented.

Taking an affirmation-only approach in any clinical setting runs counter to the standard process of clinical assessment and diagnosis. We note that NHS guidance changed recently to favour a more 'cautious' approach. However, the Cass report interim findings are worrying - that "*there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations"*[1]. If that is the climate before a ban on CT that includes gender identity, we can only assume the situation for clinicians will be much worse afterwards and their ability to apply best clinical practice will be significantly impeded should such legislation be introduced. We note that the Government have assured the public in their Consultation that this is not what is intended but we remain concerned and worried, given the facts established in Appleby and the interim findings of Dr Cass. So far, no one has yet defined gender identity or what constitutes transgender CT, which we find somewhat bewildering.

Despite assurances from powerful lobby groups that a ban on CT including gender identity would not criminalise therapists or exploratory therapy, this is clearly still a risk. We note with concern a recent attempt by the CEO of Stonewall to suggest that a well-respected psychiatrist, Dr Az Maxwell Hakeem, was engaging in "trans conversion therapy" by simply providing talking therapy to a patient. The GMC have

unsurprisingly decided to take no further action in this case, but it stands as a chilling example of how clinicians will become political targets by those who believe gender ideology to have a place in medicine.

In addition to ideological pressure on clinicians, a second major risk for clinical practice is the lack of any stable definition of gender identity to begin with. Nowhere in the Government's consultation paper on CT is a clear definition provided or what gender identity conversion might look like or which "gender identities" such treatment would impact on. What little detail there is, is provided by the Government in their glossary to the consultation regarding gender identity. It is self-referential and does not focus solely on what would have been understood as transsexual identity but instead covers any number of gender identities and expressions, including non-binary gender identity. When lobby groups further extend the possibilities of gender identity to include "genderfluid" identity, and state that a person's gender identity can change of its own accord throughout the course of his/her life, how can it be possible to suggest that such a characteristic is at once so fixed that any attempt at changing it would be futile and abusive while also being so fluid as to be in a state of constant flux? This inconsistency (one of many), which lies at the heart of the concept of gender identity, should be enough to make legislators think very carefully before taking action that would, without doubt, lead to an extreme narrowing of clinical possibilities for patients experiencing distress. Indeed, it may serve only to exacerbate current safeguarding risks around homophobia.

We further make the point that legislation based on gender ideology is apt to bring the law into dispute by reason of absurdity. The present "Ban Conversion Therapy" national campaign claims that a small percentage of "asexual" people have experienced conversion therapy. We regard that policy position as ludicrous and a crass insult to homosexuals who have experienced real conversion therapy.

The growing number of desisters

Given the very sudden change in the demographic and sheer numbers of patients presenting with gender identity disorders since 2015, we must also consider the experience of those who have gone through with a process of transition including puberty blockers, cross-sex hormone treatment or even surgery, and come to regret their decision. Having realised their mistake they seek, as best they can, to reverse the damage done. Sadly, this is often impossible to do, particularly when the person has had surgical intervention. As a result, we will, and are, seeing growing numbers of, mostly, young people left with irreversible changed bodies and serious medical and psychology issues connected to that.

A recent study published in the Journal of Homosexuality[8] looked specifically at the experience of detransitioners found that a quarter of their 237 participants started medical transition – cross-sex hormones and/or surgery – **before** the age of 18. In that cohort the average age to begin medical transition was 20.7 years. The average age of detransition was 23. Less than three years after embarking on an irreversible medical pathway, the participants regretted their decision. Considering prior social transition, the study found that, among their cohort, detransition occurred within five years of being initiated.

Of the participants in the study, over half of them had at least three diagnosed comorbidities (out of 11 conditions investigated in the study) including depression (70%), anxiety (63%), or autistic spectrum disorders (20%) to name a few. This observation is sadly borne out by the response from 70% of the participants that the reason they detransitioned, was a realisation that their sense of gender dysphoria was related to other factors.

It is clear from this study, and indeed from the Tavistock's own figures, that including the concept of gender identity in a ban on CT practices would only reinforce the affirmation-only model. Since this approach is already very strongly encouraged, a ban would make it even more difficult for concerned therapists to explore alternative reasons why a patient might present with feelings of gender dysphoria. Even if the proposed legislation left the door open for "exploratory therapy", the climate which a ban would create for clinicians, due to the highly subjective nature of what is or is not "conversion therapy" in the context of the already movable feast of gender identity – as demonstrated by the case of Dr Az Hakeem – would create a *de facto* ban on anything other than affirmation. A poorly defined ban would risk compounding an already complex landscape.

The tragic conclusion to the story for the majority of the participants in the study, supported by commentary from on-line de-trans forums, is that having embarked on their detransition, these people experience great difficulty in obtaining the help they needed with their detransition process. They are effectively abandoned by the medical establishment and LGBTQ+ community who had previously given them such wholehearted support during their transition. Rather than being embraced and supported by the community, people who detransition are treated as apostates. Dr. Cass is also alive to these issues and so another reason presents itself, in our view, to await her team's expert work and recommendations.

Legal complexities

We have already touched upon the lack of clear definition as to what the Government mean by 'Transgender Conversion' or 'Gender Identity Conversion'. Given what we have set out in this letter about the undue influence of gender identity lobbyists/activists and the fact that there is no prevalence or evidence of what some have described as 'gender identity' conversion (without any clear definition), undoubtedly makes the task of legislating an extraordinarily complex one.

During the Petition Committee hearings in November 2021, it is clear that even Government Ministers do not yet fully grasp what any legislation would look like and fully appreciate the wide-reaching implications of poor legislation (we note, in particular, the Parliamentary Committee Meetings held on 24th and 30th November 2021 which are instructive). Indeed, the EHRC make the same points as we do in their response to the Government Consultation. They point out the need for more detailed consideration before finalising any legislative proposals and the need to fully understand the implications of such legislation. The EHRC response also criticised the robustness of the Government consultation document due to its lack of clear definitions of "conversion therapy" and "transgender" – concepts central to the discussion – and the paucity of evidence about conversion therapy in the context of gender identity. Our own response to the Consultation makes the same observations.

In terms of the criminal law, there is already comprehensive legal protection against torture and inhuman treatment (stemming from Article 3 of the ECHR). Therapy, including violent physical acts, such as 'corrective rape' or treatment which could be defined as torture or inhumane are already criminal offences in UK law. If one cannot define 'gender identity' or 'transgender conversion', then it would be dangerous indeed to disturb existing law or add to it without being able to define the crime. Given this, we envisage problematic trials and enforcement by agencies such as the Police or Social Services, where people's liberty might be at stake or family homes disrupted. This would be particularly chilling for clinicians, as we have outlined.

We foresee complex, legal and regulatory issues in terms of how clinicians would have to be monitored/regulated and absent clearly defined terms there is a high risk, in our view, that clinicians might be susceptible to unjustified criminalisation, civil claims and professional discipline if poorly defined legislation is enacted. Bad legislation would risk creating a tension between a CT ban and good clinical practice – defeating the whole object of a CT ban. If best clinical practices have not yet been established (per Cass) how can any Government possibly legislate on which practices to ban? Quite simply, you would be putting the cart before the horse. No responsible Government could possibly legislate on such a basis.

We note that the EHRC have also highlighted complex considerations in relation to the impact on the Equality Act 2010 and Articles 8,9 and 10 of the European Convention on Human Rights, to name a few. Quite apart from any impact on existing child protection legislation, criminal law and other clinically complex decisions such as Gillick competence.

The Government would essentially risk writing gender identity into law, much of which is not based upon any scientific or reliable research and is of itself said to be fluid and changeable. The result would be enacting philosophical beliefs from academia and conflating those with medicine. We fail to see how such a law would work in practice let alone one which criminalises clinicians for undertaking appropriate medical care. In essence, we worry about ideological influence and the inevitable confusion that would cause. We take the view that organisations such as The Good Law Project would seek to crowd fund vexatious litigation or private prosecutions. All of which would be highly undesirable, let alone costly.

Summary of key points

It is our belief that a rush to legislate on the inclusion of gender identity in the proposed ban on CT without first seeing the full Cass report would simply exacerbate existing concerns we and others have raised in relation to homophobia as a safeguarding concern. Since the interim Cass report is already suggesting a shake-up for GIDS services at a national level and the Secretary of State for Health has demanded a review of the impact of treatment for gender dysphoria in children, it would be inappropriate to make any legislative decisions at this point. The desire should always be to provide the best possible healthcare to vulnerable young people with appropriate safeguarding in place, and not be influenced by the opinions of powerful lobby groups.

There is, clearly, insufficient data or evidence in relation to gender identity itself or what would constitute CT in that context. Any proposed legislation would be unable to clearly define its central concepts. Considering this lack of definition, we fail to see how any meaningful legislation can be passed.

It is our view that hastily pushed through legislation poses a very real risk to good clinical practice and legitimate clinical care. The potential for the criminalisation of professionals through vexation litigation led by lobby groups, simply for using their medical judgement and adopting a cautious approach to treatment would be an unintended consequence of legislating before we have far more data on the topic.

Furthermore, we need to develop a far greater understanding of the experience of detransitioners and the sudden change in the demographic of patients presenting with problems related to gender identity to best facilitate harm reduction in these highly complex cases. We believe that ill-defined legislation would only compound these problems.

We agree with the EHRC and Dr Cass that much more work needs to be done and reliable data collected before any responsible Government could or should tackle legislation in this area. A failure to take the time to develop this understand and take sound, evidence-based decisions will lead to ever more physically and mentally scared young people, many of them gay or lesbian, who have been failed by a system meant to support them.

Yours faithfully,

Hassan Mamdani, Director, for and on behalf of the Gay Men's Network

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