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British Psychological Society

Equalities, Human Rights and Civil Justice Committee

Gender Recognition Reform (Scotland) Bill

This submission sets out the British Psychological Society's (BPS) written evidence to the Equalities, Human Rights and Civil Justice Committee's inquiry in to the Gender Recognition Reform (Scotland) Bill. The BPS is the representative body for psychology and psychologists in the UK, and is responsible for the promotion of excellence and ethical practice in the science, education, and application of the discipline.

As a society we support and enhance the development and application of psychology for the greater public good, setting high standards for research, education, training and knowledge generation, and disseminating our knowledge to increase public awareness.

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1. **An overview of the support that the BPS currently provide to trans people in Scotland.**

   The British Psychological Society is a registered charity which acts as the representative body for psychology and psychologists in the UK, and is responsible for the promotion of excellence and ethical practice in the science, education, and application of the discipline. We represent a diverse membership which includes academics, practitioner psychologists and others working in the wider psychological workforce. The Society does not directly provide psychological services or support.

   Only a small minority of psychologists have received the requisite training to practice competently in this area. The BPS holds a register of Gender Diversity Specialists and the majority of registrants work within NHS Gender Identity Clinics or have previously done so. The role of psychologists may include tasks related to assessment, the provision of psychological therapies as well as educating and advocating for clients within community settings (e.g. working with schools, preparing evidence for Gender Recognition Panels etc) (Coleman et al., 2012)

   The Society promotes equality, diversity and inclusion. The BPS subscribes to the principle that human rights are universal, that all human beings are worthy of dignity and respect, including respect on the basis of gender diversity. We actively support inclusive and respectful treatment of trans people through our Code of Ethics and Conduct (BPS, 2021), our Practice Guidelines (BPS, 2017) and our Guidelines for Psychologists Working with Gender, Sexuality and Relationship Diversity (BPS, 2019).

2. **The interim Cass review has reported an increase in the number of young people seeking appointments at Gender Identity Clinics. Does the British Psychological Society recognise the concerns raised in the Cass review in terms of what you are seeing in Scotland?**

   The Society is aware that specialist services have evolved rapidly and organically in response to need and that in recent years, gender identity services for young people have experienced a significant increase in referrals. We agree with the Cass Review's interim report that children and young people with gender incongruence or dysphoria deserve the same standards of clinical care, assessment and treatment as every other young person accessing health services.

   We have particular concerns regarding the waiting times for people to receive an initial appointment at a gender identity clinic in both children and adult services. We understand that in Scotland the waiting time can in some cases be three to four years for an appointment. We have concerns regarding the negative impact this may have both on the individual's psychological wellbeing, as well as on equitable access to gaining a GRC under the current requirements for a medical diagnosis.

   We also agree that guidance about the appropriate clinical assessment process should be underpinned by high quality data and evidence. As a Society we promote psychology as a scientific discipline and an evidence informed profession. We welcome research in this area and note that trans healthcare is a rapidly growing area of research.

   The Society welcomes evidence-based recommendations for a different service model together with significant additional funding for gender identity services. We would also like

to see significant investment in training more health professionals to be competent in this area of care.

The heated nature of the public discourse regarding trans rights may have caused some people to be wary of openly discussing these issues, particularly in public forums. However, practitioner psychologists specialising in gender identity have told us that open discussions about the nature of gender dysphoria and the multitude of factors that might affect a patient's presentation is a routine part of the job and standard practice in gender services in Scotland. The BPS is clear that we encourage respectful and open dialogue of these issues and we welcome the Cass Review.

3. **Can you explain the BPS Guidelines for Psychologists working with Gender, Sexuality and Relationship Diversity, how they are used, what monitoring is undertaken of their use, and how often they are reviewed?**

The BPS Guidelines for Psychologists working with Gender, Sexuality and Relationship Diversity (BPS, 2019) are aimed at practitioner psychologists, but may also be applied in associated psychological fields. The principles they are based on are derived from both the literature and best practice agreement of experts in the field and apply to a range of diverse identities (e.g. LGBT+). The guidelines are to be used in conjunction with other Society guidelines including the BPS Code of Ethics and Conduct (BPS, 2021) and Practice Guidelines (BPS, 2017). The aim of the guidelines is to promote ethical, respectful and inclusive practice across all areas of applied psychology. These guidelines relate to gender, sexuality and relationship diverse (GSRD) adults and young people (aged 18 years and over).

The guidelines are not intended to set out protocols for the assessment or treatment of gender incongruence or dysphoria. The BPS is clear in the guidelines and elsewhere that psychologists must practice within their competency (BPS 2017, 2021). In order to assess gender dysphoria or incongruence and make referrals for hormonal treatments or surgeries, psychologists working in adult gender services must be statutorily regulated by the Health Care Professions Council and receive specific post-doctoral training. This training must be significant formal training supervised by someone with recognised expertise in the field with considerable experience in making these referrals. At present this would be a consultant psychologist or consultant medical doctor at an NHS Gender Identity Clinic. This must occur before they are able to make independent assessments and recommendations. Psychologists in this field must also be practicing within a highly specialist multidisciplinary team and undertaking ongoing specialist CPD relevant to the field.

This particular guidance is the second version, having been revised in 2019. The draft guidance was sent out for Society-wide consultation in 2019. It was also sent to the Royal College of Psychiatrists, the American Psychological Association, the British Association for Counselling and Psychotherapy, the British Association for Behavioural and Cognitive Psychotherapy, the UK Council for Psychotherapy as well as to LGBT stakeholder organisations for comment.

All our guidance documents are subject to a full review every five years to ensure they are still needed, relevant and reflect current legislation, evidence and practice. Documents also may have a light touch review after 2.5 years if there is a specific reason. In this case we committed to review the guidance following the outcome of the Tavistock V Bell court

case. This review is currently in process. We will publish an updated version of the guidance later this year.

4. **The Gender Reassignment Protocol is under review. Can you explain the purpose of the Protocol, what the review seeks to achieve, and what role the British Psychological Society has in it?**

   The Gender Reassignment Protocol for Scotland sets out those procedures which may be provided by the NHS. The British Psychological Society is not directly involved in this review nor can we comment on it. However, some of our members with relevant expertise and experience are on the oversight group.

5. **One of the Scottish Government's arguments for reforming the GRC process is that the World Health Organisation has redefined gender identity-related health, replacing diagnostic categories like "transsexualism" and "gender identity disorder of children" with "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood", respectively. It was removed from a list of 'mental and behavioural disorders' and moved into conditions relating to sexual health. What is the British Psychological Society's view of WHO's reclassification?**

   The Society supports the de-pathologisation of trans identities. The WHO's reclassification followed recommendations by a working group of international experts tasked with evaluating clinical and research evidence and human rights considerations as part of their process of revising the International Classification of Diseases (ICD) (Reed et al., 2016). The placement and name of categories relating to gender incongruence have shifted over time reflecting developing views and understanding.

   The diagnostic category of 'Gender Incongruence' in the ICD-11 is defined as "a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to be accepted as a person of the experienced gender" (WHO, 2019).

   It's placement under ICD-11's sexual health chapter recognises that, whilst not being a mental disorder, trans people may require psychological or medical assistance in relation to their gender incongruence. Furthermore, a diagnostic category was maintained as not having any ICD diagnosis at all would have proved a significant impediment for trans people seeking access to medical treatment, particularly in parts of the world which require a diagnosis for medical insurance purposes (Reed et al., 2016).

   Similarly, the terminology and placement has also changed over time in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) which changed its category from 'Gender Identity Disorder' in DSM IV-TR to 'Gender Dysphoria' in DSM 5 and placed it in its own chapter (Drescher, 2015).

   A key difference between the two diagnostic categories is that Gender Incongruence (ICD-11) refers to a persistent incongruence between a person's experienced gender and their assigned sex, whereas the category of Gender Dysphoria (DSM5) additionally requires distress to be experienced as a result of this incongruence. Many experts prefer the ICD-11 category because not all trans people experience significant distress – perhaps because they are psychologically resilient or are well supported (Richards & Barrett, 2020).

6. **What is the British Psychological Society's view of the Bill's approach, which effectively separates the process of legal and medical transition?**

   The BPS supports the purpose of the Bill to make the process of obtaining a gender recognition certificate less intrusive, distressing and stressful for trans people. There is psychological evidence suggesting that access to gender-concordant documents is associated with positive mental health indicators for transgender people (Scheim et al., 2020). While there are few practical benefits of obtaining a GRC, there may be significant personal sense of fulfilment in knowing that one's gender identity is recognised by the State (Richards & Barrett, 2020).

   In principle, we support the separation of the legal from the medical process. Our members who work in this area believe that some people would benefit from social aspects of transition (including legal document changes) but cannot benefit from medical transition (e.g. hormones/surgeries) due to physical health issues or do not require psychological support.

   The Society subscribes to the principles of human rights and believes that psychologists should seek to uphold human rights. The issue of medical diagnosis was subject to a Judicial Review in Northern Ireland in 2021 (JR111's Application for Judicial Review). The High Court found that the requirement under the Gender Recognition Act 2004 for an applicant to prove they are suffering from gender dysphoria was a breach the applicant's right to private and family life (Article 8 of the European Convention on Human Rights). The court found that it failed to strike a fair balance between the interests of trans people and those of the community. However, the requirement of general medical reports were found to be within the permitted range of requirements that a State can impose.

   Whilst this ruling was not binding in the Scottish context, the judgement does provide an analysis of the 2004 Act's compatibility with the ECHR in the context of recent developments in the WHO's reclassification of gender incongruence in ICD-11.

7. **Some witnesses, opposed to the Bill, have raised concerns that without medical oversight in the GRC process, there is a chance that other mental health issues may be overlooked. What is the British Psychological Society's view on that suggestion?**

   The medical pathways are not regulated by the Gender Recognition Act. Trans people require an assessment and diagnosis as well assessments for readiness/appropriateness before receiving any medical treatment. Part of this assessment should involve identifying any co-existing mental health issues (Richards & Barrett, 2020). The proposed reforms would not change the medical pathway that trans people need to go through for a medical transition under the NHS.

8. **How does the GRC process currently impact on the work that the British Psychological Society does in supporting trans people, and what do you think is likely to change as a result of the Bill?**

   As previously noted, the Society does not directly provide psychological support to trans people and so the Bill would have no impact in this regard. However, the removal of requirement for medical evidence may have a positive impact on the ability of some of our members to support trans people. Staff working in gender identity clinics are often asked

to provide reports in support of GRC applications. We have heard from our members who work in gender identity clinics that this is an administrative burden that negatively impacts on the time clinicians can spend with patients.

9. **From your experience, do trans people seeking medical treatment seek to obtain a GRC as part of their overall transition and can you give an indication of the proportion that do seek to obtain a GRC?**

   As far as we are aware, most people seeking gender affirming medical interventions do so for reasons other than to obtain a GRC, for example to enable them to live more comfortably in their experienced gender. We are not aware of any data about the proportion who seek to obtain a GRC.

10. **Do you think that fewer trans people might seek medical treatment if they are able to obtain a GRC by self-declaration, or do you think a system of self-declaration might encourage more trans people to seek medical treatment?**

    We are not aware of any evidence to suggest a statutory self-declaration process is likely to result in an increase or decrease in trans people seeking medical treatment. Our members who work in this area have told us they do not believe obtaining a GRC would encourage people to seek medical interventions.

11. **Has the British Psychological Society supported people with the medical evidence required to obtain a GRC, and if so, what can you tell the committee about the process?**

    This is not within the Society's remit. Some of our members who are practitioner psychologists working within gender identity clinics have supported people with medical evidence to obtain a GRC. They have told us that having to justify in a medical report why someone has decided not to have gender reassignment surgery can be experienced by the patient as intrusive. People may choose not to undergo surgeries for a range of personal reasons, for example some individuals may decide that the potential risks outweigh the benefits of some surgeries given information on outcomes or for physical health reasons.

    For further information regarding the process, we would refer the committee to evidence given by trans people who have lived experience of going through the process.

12. **It has been suggested that in Denmark, which has a system of self-declaration, there is now a desire to make access to the medical treatment pathways self-declared as well. Is this something the British Psychological Society is aware of, and what can you tell the Committee about international practice relating to medical treatment, where systems of self-declaration have been introduced?**

    Medical pathways occur within regulated health settings as set out in the Gender Reassignment Protocol and NHS Service Specifications which are subject to evidence based reviews.

    The WHO's reclassification of gender incongruence did not impact on the assessment process for those wishing to undergo gender affirming medical treatments (e.g. hormones and surgery) in Scotland. People can have a "diagnosis" of ICD-11 Gender Incongruence,

and must undergo an assessment for readiness/ appropriateness for gender affirming medical treatments. Those with a confirmed diagnosis of ICD-11 Gender Incongruence do not have automatic access to gender affirming medical treatments in the NHS in Scotland. We see no reason why reform of the Gender Recognition Act would necessarily have any impact on healthcare pathways.

We would recommend that the Committee seeks evidence from countries which have already adopted a statutory declaration system of gender recognition to answer this question.

13. What is the British Psychological Society's view on other key provisions in the Bill?

A. Removing the Gender Recognition Panel from the process. Have your members been on the GRP and what can you tell the Committee regarding their experience of it?

Some of our members working in gender identity services who receive requests have noted that it is an administrative burden which reduces the amount of time they can spend working with patients. This can have an impact on waiting times.

B. Lowering the age limit from 18 to 16 to obtain a GRC.

There are mixed views among our members who are gender diversity specialists on this provision in the Bill. Some felt that it was right to lower the age limit, particularly in light of the fact that in Scotland 16 year olds are legally able to make other important life decisions. It was also noted that the age limit should be commensurate with other Gillick principle decisions. However, others felt that 18 was an appropriate age. All agreed that 16 year olds may have a clear sense of their gender identity by this age. However, some felt that some 16 year olds may benefit from support in exploring their gender identity or additional time to reflect.

C. The requirement to live in your acquired gender for three months, instead of two years.

Gender identity specialists we've heard from were generally supportive of this move, although some feel it should be longer for people under 18. Currently, to gain a GRC the two years in one's gender role is often taken from the date of a change of name (Richards & Barrett, 2020). There is a need for clarity regarding what would count as living in an acquired gender. It should be noted that there is not always a clear date when people 'officially' start living in their experienced gender. For instance, some people may be out in some contexts (e.g. with friends and colleagues) but not in other contexts (e.g. family gatherings).

D. The introduction of a three-month reflection period before a GRC is granted.

Views are mixed among our members who are gender identity specialists. Some felt the reflection period was unnecessary as people are likely to have reflected on their gender for a number of years before coming out as trans and deciding to undertake a process of legally changing their gender. Others felt that that a three month reflection period was a good idea. However, the passing of time may not in and of itself encourage or facilitate

reflection. It may be advisable to signpost people wishing to apply for a GRC to services that can help them to engage in reflection should they wish to do so.

References

British Psychological Society (2017). Practice Guidelines. BPS.

British Psychological Society (2019). Guidelines for Psychologists working with Gender, Sexuality and Relationship Diversity. BPS.

British Psychological Society (2021). Code of Ethics and Conduct. BPS.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., De Cuypere, G., Feldman, J., … & Zucker, K. (2012). Standards of Care for the health of transsexual, transgender, and gender-nonconforming people, version 7. International Journal of Transgenderism, 13(4), 165–232

Drescher, J. (2015). Queer diagnoses revisited: The past and future of homosexuality and gender diagnoses in DSM and ICD. International Review of Psychiatry, 27(5), 386-395.

Reed, G. M., Drescher, J., Krueger, R. B., Atalla, E., Cochran, S. D., First, M. B., ... & Saxena, S. (2016). Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. World Psychiatry, 15(3), 205-221.

Richards, C., & Barrett, J. (2020). Trans and non-binary gender healthcare for psychiatrists, psychologists, and other health professionals. Cambridge University Press.

Scheim, A. I., Perez-Brumer, A. G., & Bauer, G. R. (2020). Gender-concordant identity documents and mental health among transgender adults in the USA: a cross-sectional study. The Lancet Public Health, 5(4), e196-e203.

World Health Organisation. (2019). HA60 Gender Incongruence of adolescence or adulthood. In International Statistical Classification of Diseases and Related Health Problems 11. WHO.