



Women and Equalities Committee

Oral evidence: [Transgender Equality Inquiry](#), HC 390

Tuesday 15 September 2015

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Written evidence from witnesses:

- [Gendered Intelligence](#)
- [Mermaids](#)

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Members present: Mrs Maria Miller (Chair); Ruth Cadbury; Maria Caulfield; Jo Churchill; Angela Crawley; Mims Davies; Mrs Flick Drummond; Ben Howlett; Jess Phillips; Cat Smith

Questions [48-129]

Witness[es]: **Susie Green**, Chair, Mermaids, **Anna Lee**, Vice President, Welfare and Community, Lancaster University Students' Union, **Dr Bernadette Wren**, Head of Psychology and Associate Director, Gender Identity Development Service, The Tavistock and Portman NHS Foundation Trust, and **Dr Jay Stewart**, Director, Gendered Intelligence, gave evidence.

Q48 Chair: On behalf of the Committee, can I thank our panel this morning for taking the time to come here? We really value these oral evidence sessions, but we know that they take time to prepare for and they can seem a little, perhaps, intimidating. We do not intend them to be at all. They are incredibly helpful for us in forming our views on the inquiry that we are undertaking at the moment, so can I thank you, on behalf of the whole Committee, for the time you are taking to be here today?

Could I ask you each to introduce yourselves? We then, as a Committee, have a number of questions we would like to pose to you, but if there is anything that you want to talk to us about afterwards, please drop us an email or drop us a line if there are things that you felt you wanted to say but were not able to say within the session. Perhaps I could start with Dr Stewart.

Dr Stewart: I am one of the co-founders of Gendered Intelligence. We work with young trans people up to the age of 25. Really it is about bringing young trans people together, sharing experiences and reducing isolation. We do a lot of education work and support

schools, colleges and universities as well. We also work with businesses, organisations and local authorities around trans inclusion and also gender diversity; they are our key words.

Dr Wren: My name is Bernadette Wren. I am a consultant clinical psychologist and family therapist at the Gender Identity Development Service, of which I am also the Associate Director. That is the nationally commissioned specialist service for young people. I work at the London base, but we have a base in Leeds and we have satellite clinics in different parts of the country.

Anna Lee: I am Anna Lee, Vice President, Welfare and Community of Lancaster University Students' Union and a member of the NUS National Executive Committee along with being the trans rep of the NUS National Women's Committee.

Susie Green: I am Susie Green. I am Chair of Mermaids, which is a support group for children and young people with gender dysphoria and their families. I am also parent to a daughter who was born male.

Chair: As I say, we have a number of questions we want to go through. If I could ask you to be reasonably brief in your responses and then we will be able to get through all of them.

Q49 Jo Churchill: Good morning and thank you again for coming. How would you describe current attitudes to young trans people in society, particularly with regard to the media and how they involve themselves in positive or negative portrayal?

Susie Green: The media coverage of trans youth is improving, but there does seem to be a lot of sensationalism around it. There seems to be a lot of misunderstanding. Misrepresentation in terms of the clinical pathways and treatments seems still to be endemic. We know that there are better articles starting to come out now and journalists are responding to the changes in attitude, but we still have an incredibly long way to go, I feel. It is very much still a topic as an area of interest that seems to be different. What people do not seem to understand is that there is quite a high trans population and there are lots of children and young people out there who will not be open about who they are because of the level of discrimination and prejudice that is out there.

Anna Lee: One thing that is quite terrifying as a young trans person is the fact that your very existence is a news story, which should not be the case. A trans person existing should not be something that is printed in the newspaper. There are now more and more positive stories, but still there are the constant negative stories that naturally have a detrimental effect on young trans people, seeing people they know suddenly harassed by the media.

Dr Wren: You can put it very positively or you can put in terrifyingly in relation to how things once were, so it is relative. I could say that since I became involved in the service in the late 1990s, the attitude amongst parents, in schools, in social care and so on has changed out of all recognition in terms of a readiness, or willingness, to be supportive of these young people's entitlement to live as they feel they must, but I agree that it is still front page news, which is extraordinary. We are in a transitional stage. It might be a very long transitional stage; it might be quite a short one. What people say in relation to what they do and think when you are not present is always a question. We have wonderfully supportive people we talk to in schools, but the young people in the playground might still voice views that would

not have been out of date 100 years ago. It is a very mixed picture and there are some times when we spin it really positively.

Dr Stewart: In terms of general current attitudes, we live in a world that is very much about being a girl or a boy and never the twain will meet, and trans people complicate the picture of the gender binary. We are noticing that there are many young trans people who identify as neither girl nor boy and ‘non-binary’ is an identity category or a descriptor for about a third of our young people. We are going to see more and more stories coming through where people are really challenging the gender binary, and that is a challenge to shift cultural attitudes, because we are very regulated in terms of our behaviour and social expectations of what it means to be a girl or a boy. That is a poor attitude that we need to shift across society through the media, through our education programmes and elsewhere, really. Sometimes, trans narratives in the mainstream press can work to reinforce the binary. We need to see more stories coming through where people are living and challenging this idea of what it means to be a girl and what it means to be a boy, because that is going to improve everybody’s lives, not just those of trans people themselves. That is my view.

Q50 Chair: Yes, there are much broader implications for society. Unless anybody has any other questions here, can I move the questioning on—perhaps Dr Wren might want to start with this—to how gender dysphoria is diagnosed in young people? I was interested to read in the evidence that you gave to the Committee that the majority of referrals to your services are amongst 14, 15 and 16 year-olds, whereas in another part of your evidence you gave a case study around the Dutch experience, where it appeared to me that young people were perhaps starting to receive, in that research, interventions at a slightly younger age. What is your comment around the age at which people are being referred? Is it appropriate or is it being delayed in some way?

Dr Wren: That is a huge question. We are seeing more and more younger children being referred—let us say under 10, or pre-pubertal, anyway—and the treatments and the options that are open for them is a much broader picture. We are really surprised that despite all the knowledge that is out there, the majority of our young people are still in their mid-teens.

Q51 Chair: Why are you surprised?

Dr Wren: We are surprised because we would have expected, in light of the comments we have been hearing about the views in society, that young people are more able to speak out at an earlier point if they feel that their gender identity is an issue at an earlier point. We could take this in a number of ways. One is to ask whether we are doing enough to make sure that younger children, if they need to come forward for support and early intervention, know enough so that the people who are advising them know enough about it. There is also the issue that a large proportion of our young people are not clear that they want help and support until they are in or coming out of puberty. This is the surprise to us: that many of the young people, and increasing numbers of them, have had a gender-uncontentious childhood, if you like, and it is only when they come into puberty and post-puberty that they begin to question. That now represents a substantial proportion of our group. A lot of the Dutch published research is in lifelong or longstanding gender dysphoria. They are the ones who have been followed through across four time points in the latest research that sees them as having done incredibly well. These are young people who have been identified early or have identified themselves early and have had the benefit of physical intervention, if that is what they wanted.

The important thing to say—and this question is a platform for saying it—to really support what Jay is saying, is the heterogeneity of the group of young people coming forward for referral. As you know, our numbers have doubled every year for the last five years and the range and the sort of presentation we are seeing is varying so much. We are not having what you might see as the ones who are in the highly regarded Dutch study, which is this group of now 55 young people being tracked over time, who have had lifelong GIDS, very supportive families and very few associated difficulties. That sort of profile is a very small proportion of our young people. The range, the terms of gender binary—we are having more and more young people coming forward with really quite disrupted attachment histories; more looked-after children. On a typical referral day, we are really concerned about the complexity of many of the young people coming forward. My point about that is that many of them are not identifying their gender issues as being deeply significant to them until their mid-teens.

Q52 Chair: Anna, can I just bring you in here? Would that be your experience as well, in terms of the individuals that you work with and the parts of the organisations that you work with?

Anna Lee: Many young trans people realise at a relatively young age and when they realise they absolutely know; from there on, they 100% know that they are trans. Quite often they do not know how to access medical care. They do not want to come out because of the stigma and potential bullying and harassment at school. Like me, they get to university or get to later life where they are in a position where they are more confident and comfortable to come out and start receiving medical care in this area and they regret not being able to have accessed it earlier.

Chair: There is an interesting issue here, is there not? If it was easier to access the services, then more people may access them before puberty than are currently. I suppose the reason why this is important is the level of self-harm and the harm that may come to the individuals concerned by not having access to that. Dr Wren, do you not think we should be doing more to make sure that those services are available to this younger group?

Dr Wren: Yes. I think we are just talking about the range of presentations. I do not think that we would have anything to disagree with about the young people who Anna also knows. In one sense, it is easy to access help early; young people can go through the usual agencies and get to us. It is about whether those young people themselves—or children, if we are talking about young children—are voicing their concerns. Are they suffering a level of distress? The point about diagnosis, if you are using the gender dysphoria diagnosis, DSM-5, is it involves a degree of distress. There are many children who are growing up in homes where gender is not accentuated, and gender roles, gender clothing and gender play are not accentuated. A lot of young people come to us and they do not report distress. They might report that, yes, they have always leant towards doing such-and-such games or towards such-and-such playmates, but it is not necessarily distressing for them. It is when it becomes distressing that they then earn the diagnosis, such as it is, and they come forward or their parents will bring them forward for help.

Q53 Chair: Anna, do you agree?

Anna Lee: There is a multitude of factors. One of the biggest issues here is the lack of awareness and education within schools.

Chair: We are going to come on to schools in particular later, if that is okay. Do you generally agree with what Dr Wren is saying?

Anna Lee: Yes. There is a multitude of situations. The knowledge of being able to access the healthcare once you get in is very good and efficient. For young people, it is the step of knowing and being able then to get in.

Susie Green: I have a slightly different view. We run a parents' forum and a teens' forum on Mermaids. Parents join the forum and they can post about their experiences. We have 491 parents on our parents' forum at the moment and we are seeing posts increasing; in 2010 we were getting about 2,000 posts per annum and we are now on 7,000-plus. What we constantly seem to hear is that, yes, the majority of parents who join our parents' forums have teenagers, but they come in after a period of time when their children have been very distressed but they have not known why. They may have had depression and self-harm, but there has been an elephant in the room and it has not been discussed and their children have not confided in them. Often, young people will use a letter or an email or send them a text explaining what it is that is worrying them, because they are afraid of rejection. When they come in, they will go to their primary care—their GP—and, in at least half the cases, the GP will turn around and say, "There is nothing you can do until you are 18" or, "No, we cannot refer you to any specialist, because we do not know about it", so they will refer them to CAMHS. Half the time, CAMHS will discharge and say, "We know nothing about gender dysphoria." We have had parents who have spent two years battling the system just to get a referral to the Tavistock. We did a survey in 2014 of young people who were pubertal when they entered the system. We had 44 parents who responded with children within that age range. What we found was there is a median time of between 13 months and 15 months from when they were referred to when they accessed pubertal treatment.

Can I read out a parent's comment that was on the forum last week?

Chair: Yes.

Susie Green: "It will be a year in November since we were referred and today we are still no closer to hormone blockers for my 14, almost 15 year-old male-to-female child. The initial assessment in Leeds has been completed for a couple of months now and we are still waiting for an appointment to be assessed again for blockers. The frustration we have all felt is so deeply upsetting and the psychological impact that my daughter is going through is heart-breaking. In this last year, she has continued to develop at a rate. Her voice has broken, she has developed an Adam's apple and facial hair, and all of this could have been avoided had they not prolonged the appointments."

This is a discussion between about four or five parents who are looking to go abroad because they have not accessed timely care within the current pathway.

"Like you said, we know our children better than anyone else. I am also desperate to seek options for help and treatment. I am left with little option. I will have to raise the money to go to America as I too believe, if I do not, I will not have a child to treat."

That is on the forum now. Our forum is completely confidential and closed. It is a real shame that the commissioners for healthcare, etc. and the Tavistock cannot read those comments, but we do report regularly and we have sent a copy of our survey to

NHS England, because we do not believe that the system, as it is at the moment, with the lengthy assessments, etc., is dealing with pubertal children who are clear about what they want in a timely manner.

Chair: Susie, you have very cleverly set up our next set of questions. Thank you for that. We want to explore this access to services in a bit more detail.

Q54 Maria Caulfield: You have touched on a number of issues, but I wanted to explore how wide-ranging that experience is. In order to gain access to the Gender Identity Development Service, is the barrier at the GP level, is it that the service itself is at capacity and just cannot take referrals, or is it both?

Susie Green: It is both, I believe. I believe that GPs do not know enough about it and will often turn their back on it or say that they do not want to be involved because it is a specialism and they do not know enough. They will often refer to CAMHS. You will then have a six-month wait to be seen by a CAMHS counsellor, regardless of whether you are suffering from depression or self-harming, etc., and then you get to CAMHS and they go, “We do not know anything about gender, so we are not dealing with it either.” I had a parent who accessed the parents’ group a couple of weeks ago who said that she had phoned the Tavistock to ask whether or not she needed to be referred through CAMHS and they said categorically that she had to be and her GP could not refer her. I said to her, “That is not true. I know that the Tavistock will accept referrals from GPs.” There seems to be this miscommunication about how to get into services. Then, for the pubertal children, when they get into services, even if it is very straightforward in terms of their presentation and their need, they are still being assessed in the same way as the very complex cases, with very lengthy waits between appointments and a certain number of appointments before any sort of physical intervention is given, and the wait between blockers and cross-sex hormone seems to be an arbitrary time limit that has no flexibility.

Q55 Maria Caulfield: Are there guidelines or a standard pathway that they should be referred on or is it just really hit and miss depending on who you speak to or come across?

Dr Wren: Before I answer that, I think we just have to be really careful not to conflate treatment, in the broadest sense, with physical intervention. I work in a service where a lot of the young people—and anybody who wants it—have physical intervention. We have no record of turning people down for physical intervention, but what we offer is not just physical intervention. It is really important to say that right up front, because often that is what treatment is seen as. It is not what everybody wants and it is not what everybody wants at a certain point; people need time to think it over. The question is whether there are rules or guidelines. There are international guidelines to which we work. You will have heard in the adult thing about the association that, in a sense, puts out the guidelines to which most services are conforming. For that, there is an expectation—and this is what we work by—that now there is no age at which people are eligible for hormone suppression; that is based on the stage that the child is at pubertally. There is not an age attached to that. There used to be, but things have changed a bit over the years. Cross-sex hormones are still only available at 16 or above and surgery at 18 or above. Broadly, those are the international guidelines to which we work.

Q56 Chair: Not all countries follow that, do they?

Dr Wren: The European countries do almost exclusively, except for one or two clinicians who are stepping outside those recommendations. For example, in Hamburg there is a team who will give cross-sex hormones younger. In the United States, there are many clinicians who do not work within those guidelines.

Q57 Chair: That must be because they think it benefits their patients. Is that something that you are looking at and considering?

Dr Wren: Which bit?

Chair: In particular cross-sex hormones being available to younger individuals.

Dr Wren: Do we give it any thought? Yes, we do. It exercises us a very great deal. It is an enormous issue for our service. Clearly, as you have heard from Susie, organisations like Mermaids put it on the agenda for us all the time and are very unhappy about our sticking to the international guidelines at the moment, so we are reviewing it constantly. I would say that in the sense that it is an ongoing process. It is not like we will review it again in two years' time, although our specification is being reviewed as we speak this year by NHS England. They are reviewing it and this is one of the things that has been up for discussion, so we are in the midst, at the moment, of all these conversations about what to do. There are issues about the positive evidence in the field. There are issues about the range of young people coming forward and the difficulty of knowing which are the children who might do really well, unless we confine it to a vanishingly small number, which we possibly should, but that would be an issue. I am sure Susie would want us to have a flexible approach to this, so that not everybody who comes in the door at 13 or 14 would have fast access to cross-sex hormones. I am sure Susie would want us to do a reasonable assessment of that young child and how they are presenting, so that we are making a wise clinical decision. On the other hand, once you drop that age limit it will be harder and harder for us to say, "No". Maybe that is okay. Maybe this Committee will think that is okay. We are made anxious about that. We do not take an absolute stand of certainty that it is going to be a wrong thing and it is a wrong thing forever. It used to be that you could not get puberty suppression until you were 16. Now it is at any age, effectively. These things change over time, but we try to proceed in as wise a way as we can, looking at what the research shows, looking at what other countries are doing and debating with other centres of excellence, like the Amsterdam clinic, who have been the pioneers in this, as you probably know from your reading, who have not gone below 16, interestingly, and who are very nervous about it. We had the first European conference this year in March, in Ghent, and there was a lot of talk about that. They are bringing in ethicists, as are we at the Tavistock, to discuss this and to think ethically about the issues of consent about cross-sex hormones for young people of 14 and 15; although we do not really speak about regret, about the idea that gender identity development moves across time and how these young people might feel making critical life-changing decisions at 14; and about whether it is sound ethically in our practice to do so. These things are under review on a continual basis.

Q58 Maria Caulfield: In the evidence that we have received, there does seem to be an issue about lack of choice in where to go if you are referred to a service. Is that a problem? If I am right, it is only the Tavistock that operates this service. Is that a problem?

Dr Wren: There are other centres, but it is all part of one unified service. I would say two things in relation to that. One is that the experience in the adult world of having seven

different services all working to slightly different practices and rules has not been an entirely happy one. The second is that I understand that NHS England would still be commissioning even if you had a range of services and that the specification would be the same for all of them. I am not saying there would not be some room for difference—clearly there would be—but I do not think we would see a huge diversity in practice necessarily, unless NHS England wished for that to happen and opened it up.

Susie Green: We have had many reports from parents where they have said that they have issues around their children’s treatment and the timescales involved and the clinicians—not necessarily the diagnosis particularly, but how long they are waiting for initial blocking medication and then the wait between blocking medication and then going on to cross-sex hormones. Many of them are afraid to do anything other than complain anonymously, because they feel that, as a single provider—which is against NHS principles; you should be able to seek a second opinion. We even had one parent who asked for a second opinion and was then phoned by the director of the same service to say that she would give a second opinion, which is not appropriate. There is not a second opinion. There are no options for any family that is sourcing treatment. The only option for them, if they do not agree or they are finding that their children are being damaged by the timeframes within the treatment at the Tavistock, is to seek treatment abroad. We have current conversations going on; I have at least six families who have children who are pubertal who are looking at that option now and are actively contacting the Hamburg centres and America to access that treatment, because they know that they are not going to get it here within the NHS.

Q59 Mrs Drummond: Just for clarification, is it the pathways that are the problem? It is not the funding or the access to doctors.

Susie Green: It is the pathway.

Mrs Drummond: It is definitely the regulations and the pathways; there are enough doctors and people to see.

Susie Green: Yes. Essentially, it is the protocol. We have had parents who have gone and mapped out evidence in terms of things like the wait between blocking medication and cross-sex hormones. Often, if somebody goes on to blocking medication, they are told categorically that it is a year, with no wiggle room—nothing—until they get cross-sex hormones. Parents have gone in and said, “We have children who are self-harming and suicidal because the wait for those cross-sex hormones is too difficult. They are dealing with GCSEs. They are not presenting or growing and developing like the other children within their age ranges. They feel that it is more isolating and that they are becoming the victim of more prejudice. If they are going in stealth, it means they are not developing like their peers are.” When this was raised as an issue, the director of the Tavistock said that children were “upping the ante” with suicide and self-harm, which I find to be an incredibly worrying comment from the director of a service where there is a 48% suicide attempt risk.

Q60 Chair: Can I bring Dr Stewart in here on that point? Do you think we are getting the balance right between the protocols that are there, which are important to ensure that we give young people the right treatment at the right time, and ensuring that we are minimising the possibilities of self-harm and suicidal thoughts in those individuals themselves? That seems to be where the tension lies, as Flick said. It does not seem to be a funding issue; it seems to be about the protocols.

Dr Stewart: I want to say a couple of things also about the process for the purposes of assessing, diagnosing and treating people with gender dysphoria, which is problematic for our community. We need to be moving towards understanding trans people as an identity category rather than reducing people to this diagnosis. It is a fundamental point that is always going to be raising its ugly head, if you like. It is really important to think, “What does treatment look like? What does the person want to happen?” That is only some of the trans people that are out there in the world. If you are looking only at who is being distressed by their developing gender identity, you cannot unpack that from the prejudice that is in the world around them. These things are incredibly complex. I am an advocate of people making decisions for themselves and having autonomy over decision-making that is going to affect their lives. Working with young people in particular, families are involved in that, but we must work with the individuals who are in front of us and ask them what they would like to happen and, if they want treatment, what that treatment looks like rather than have lines in the sand.

I think we can agree there is a problem at the moment in that those people aged 15, 16, 17, 18 and 19 are really struggling at the moment with accessing the services, because they are caught between children’s services and adult services. It is a real problem that people are starting, for instance, university and are still waiting 12 months down the line for their first appointment going into adult services. If someone is 17, they will not be seen by the children’s team; it is an adult services thing. If someone is 15 or 16 and really quite ready to go on to cross-sex hormones sooner, then they will have to go through the referral process and go on hormone blockers before then getting cross-sex hormones a year later, by which point they will probably be 17 or 18 as well. We can really look at the around-16 age bracket to think about how we can really help that set of young people who are accessing treatment in the sense of physical intervention—hormone therapy—and how that can be much more humanely delivered. I think our young people are really shocked by the level of wait and the lack of support.

Q61 Chair: Dr Stewart is talking about the group of people that you represent, Anna. How would you respond to what you have just heard?

Anna Lee: I agree that there is a gap between youth services and adult services where, transferring from one to the other, the adult services have absolutely monstrous waiting times for first appointments. Particularly at a young age, every day does make a change, and it is crucial to get the time waiting to access hormone blockers and other hormone therapies as low as possible. The one-year time between the hormone blockers and then being able to have cross-sex hormones is just far too long, but by that point they absolutely know.

Q62 Chair: Dr Wren, I sensed you were shaking your head a little at what was being said earlier in the conversation. Are we talking here about a capacity problem or an issue around the protocols? As a clinician, clearly you need to make sure you are doing the best for the people in your care, but I am hearing an awful lot from the people in your care in terms of dissatisfaction. How do you respond to that?

Dr Wren: A lot of different points have been made; I do not know which ones you want me to take up. Working backwards, the link with the adult service is well known to be deeply problematic and what happens to those young people caught in the middle. We are financially penalised if we have people over the age of 18 in our service. That means if somebody comes in at 16 and a half, you are really almost up against it right from the point

they arrive for their first appointment, if you are going to do assessment and treatment and so on. We try to refer them at 17 on to adult services in the knowledge they will not be seen until well over the age of 18. It means, almost at the point where you have them coming in the door, perhaps saying, “I am still quite uncertain about what I want to do” you are talking about adult services and surgery. If they do go down that road, in order for them not to have any more of a wait, you almost have to force that conversation, to be trying to think ahead down the road. That is a problematic area.

Q63 Chair: What is the NHS doing to address that? You have just heard from Anna a deep level of dissatisfaction with the service you are currently providing. It is all well and good to say it is a problem of transition. How are you resolving it?

Dr Wren: No, I was saying there are a number of issues there. I have only met Anna today, so I am not sure about all the young people she is talking about. We have 1,000 young people on our books at the moment. The dissatisfaction, as I hear from Susie, is around the time that is taken to proceed through an assessment of young people and—I am not sure about this; I do not know who this mother is who seems to have had this unconscionable wait in Leeds—that at the moment we have hit a bottleneck. Given that the service has expanded by 50% every year for the last five years, there are times in the year when we do struggle to get everybody into the clinic in time and it is a capacity issue, inevitably, with those sorts of numbers. We do recruit more staff, we get them trained up and so on, but the endocrine clinics can sometimes be too few. We have to decide them a year in advance. There are those capacity issues.

Q64 Chair: Sorry to press you on this, but I am still unclear: is this a capacity problem or is it a protocol problem? You seem to be saying both.

Dr Wren: I am saying it is both. It is a capacity problem in the way I have tried to explain with those two things that I have just said. I would need to talk with Anna much more about the young people she is talking about. These are people getting to 19 and 20 and I do not know what their story has been or their experience has been. I cannot speak for them. Our protocol is to see people through a period of assessment. That can last between three and six sessions. We try to make that roughly monthly. If we do not, it is a capacity issue, but the protocol is that they will be seen between three and six times. That is both protocol and capacity. Then, if they want it, they move on to their first appointment with the endocrine service, where they have a whole series of tests that they have to go through if they want puberty suppression. There are some problems with capacity sometimes in the year. At other times, we do not have a waiting list in which those will be seen. Sometimes they run into problems. Sometimes we need to do more tests and sometimes there are issues that are thrown up—that would be a medical issue.

We are talking about young people in the midst of adolescence, many of them, and the issues of their desperation to get on to physical treatment. I am trying to choose my words really carefully here, because this is a debate that we have with Mermaids on a very regular basis, so our positions are well rehearsed and I feel I want to appreciate what Susie is saying today, but we also take the view that moving straight into physical intervention at speed for some of our young people is not necessarily always in their best interest. I know that Susie and Mermaids would like a fast track so that young people who are already well into puberty and feel that they know that they want to move forward into physical intervention would bypass our assessment process and move straight into physical

intervention. We feel that is not an ethical way to practise, and this is a sticking point between us and Mermaids.

Q65 Chair: How often do you talk to young people about your protocols and whether or not they meet the needs that they have?

Dr Wren: We have a stakeholders' group, but teenagers coming to your service will make you a present of their views of what they think of your service very often. Many of the older ones are unhappy to be on the blocker for a year. We are well aware of that. Many of them are. We still regard that as a time when they do not have their own endogenous hormones circulating in the body and the effects of that plateau, and that it is an experience for them that they can use to further explore the options available to them and the pathways they want to take. At the moment, we still feel that that is a valuable time and that many of the teenagers we see who will talk to us afterwards will understand the value of that. That is some feedback that we also get.

Susie Green: My experience of that is the opposite: that teens reflect an enormous amount of frustration with the fact that even though they have a diagnosis of gender dysphoria, which means that they are eligible for blockers, they are then kept in a holding pattern and, as I say, are not developing alongside their peers. Their autonomy is not respected and they have no say in whether or not they have any consultation or their view is heard as to whether or not they should progress to cross-sex hormones. I had a conversation with a teenager yesterday evening and his frustration was, "Look, I am 17 years old. I started on blockers two months ago. I have a clear diagnosis of gender dysphoria. I know who I am. I do not need to wait another 10 months before cross-sex hormones. That makes me feel exceptionally vulnerable, very isolated and very nervous, anxious and afraid." His opinion and his views are not taken into account

Anna Lee: I completely agree with Susie that the one-year period is too long and there should be a fast track available. The one-year wait is something that some people may want, but they can say that they want it; most people want to move in a timely fashion because their peers are moving forward and they are stuck in this waiting period.

Chair: So there is not enough flexibility in the system.

Q66 Ruth Cadbury: Is the pressure from young people to go through fast track when they know where they are and where they want to go coming from the fact that they are definite and they feel supported with that choice, or is there some element that they do not get to the Tavistock until they have been through this previous delay around referral from GP to CAMHS and then from CAMHS to Tavistock? Is that adding to pressure to get things quickly when the biological clock is ticking?

Susie Green: Absolutely. Every day these young people are feeling their bodies changing, as in that account from a parent with regard to their daughter who is going through this process. When they started the process, they had not had any irreversible changes of masculinisation due to their pubertal process. They are not even at the stage where they have an appointment for blocking, but they are now dealing with changes that are going to last into their adulthood, which means that their confidence and their self-esteem regarding their appearance and passing is going to be vastly compromised by the fact that they have not received timely care. The American centres are working on a triage basis. When somebody comes into the service

they are triaged on the telephone. They have to have a history of some counselling, so it is not that they will just say, “Okay, well, you look okay, so we are just going to give you this.” There has to be a history of counselling and support regarding the gender dysphoria, but if they are triaged and they have that history, then at their first appointment they will get blockers. If they are an appropriate age—say around 15 years old—they will not bother with blockers and go straight on to cross-sex hormones. Those individuals are functioning far better. We have done a survey and we have seen the dissatisfaction, the mental health effects, the distress and the suicide attempts that have come around because of the wait for treatment.

Q67 Chair: I know Dr Wren wants to come in here before Angela and Ben. Do you want to respond to that? Can you make it brief? I am sorry; we are getting terribly short of time.

Dr Wren: Yes, I will. Again, I really do not want to get into opposition to everything that is being said by the other speakers, but there is evidence that a wholehearted focus on medical intervention is not the answer to all the difficulties of these young people.

Chair: With respect, I do not think that is what has been said.

Susie Green: I have not said that at all. I do not think it is all about medical intervention at all.

Dr Wren: Let me just continue the point. There is an enormous focus on it and, clearly, that is a huge part of our work, so we are also very focused on it, but a recent study from Finland suggested that the sort of complex young people who are coming forward now are going into physical interventions and still having some of the difficulties they had before they went in. We are just very cautious about treating physical intervention for these young people as the royal road to perfect mental health. I think it really needs saying at this point.

Q68 Angela Crawley: My question follows on from what you have just said and is particularly to Bernadette and Jay. There is a lot of emphasis on the service provision and the ethics and the protocols, but what element takes into account the person-centred approach in considering the wishes of that individual? I have heard a lot about the bureaucracy of it, but I think there is an element of placing the assessor’s view on the individual rather than taking into account the individual’s views and I am not hearing a lot of that in what is coming across. Forgive me if there has been and I have not heard it.

Dr Wren: I am not sure what you feel is the bureaucracy element of this other than that we try to be a relatively well-run NHS service that has to collect data and do things by a protocol and a specification that is given to us. That is about as bureaucratic as you get. You are very welcome to come to visit us and see how we operate. “What does an assessment look like?” might be one of the questions you are asking there. An assessment is an attempt to get to know a young person in the context of their life. Our core aim is not to alter the trajectory of the young person’s gender identity development, but to think of the young person in the context of their family life, their peer development, their education and their prospects for independence in the future. We really try to think of the whole person, and the conversations that we have with the young people on their own, with their parents, with visits to their schools, and with the young people’s group and family days that we have are all attempts to get a picture of the young person living their life and what is working, and what is working against them being able to live a full life in which they will really prosper. Some idea that

this is a sort of bureaucratic screening process is a complete misconception and one I would really want to challenge. If you have picked up that picture, it is really a wrong one.

Q69 Angela Crawley: My point was not to imply that there was a bureaucratic process. My point was to try to decipher whether you felt that the ethics and the protocols were, perhaps, placing barriers on that individual-centred approach. You have answered that question, but I just wanted to make it clear that it was not an indication of bureaucracy.

Dr Wren: I will just come back as briefly as I can. The boundaries around what we offer are precisely the ones that I have described and that are given in international guidelines. Other than that, the frequency of appointments, the amount of contact that we might have with the network and the locality, and the fact that we might do assessments in the home town of the person if, for whatever reason, they are required, will all be individually agreed. The parameters that I have described that are based on international guidelines are the only, as it were, fixed framework.

Q70 Ben Howlett: We have been talking an awful lot—and, by the way, I have found this fascinating as a discussion—about those people who are accessing the services and accessing them successfully to continue on their pathway to whatever their aims are. However, as we know with young people, they are in a period of turmoil going through adolescence. There must be people who are thinking, “This is not for me. I have gone down a path of a year’s worth of psychometric assessments, etc. and decided that this is not something I want to go down the path of.” We have not heard any evidence as yet of what their experience is like and what their assessments are of the processes. Are they thinking “Okay, this is”—I do not want to use “a bureaucratic system”—“a system that has enough checks and balances to prevent me going down a path I do not want to access”?

Dr Wren: Absolutely. That is one of the big issues for us. On our recent figures, 17% of people who are referred never show up, and another 17% come for a bit and then do not come again. We have a small proportion of people who start on physical intervention and then back off. A typical situation might be where they go from 16 to 17, perhaps start their first sexual relationship and then have a different relationship to the body. That might be, in terms of their gender identity, a shift in how they see things. There is always a proportion of people who think twice. There are other people who are making judgments as they go. There is a dad Susie will know on the CRG at the moment whose child, now aged 17, has been with us for a couple of years and who has really been uncertain how to proceed and has now decided that possibly she does want to identify fully as female and move through. That is a family who feel, for example—and I mention them because they have spoken publicly—that they have had timely support and regular help to really think about and debate and discuss this. A lot of what they need is a lot of information about what these physical interventions would involve, and this idea that at any point, without any fear of any kind of, “Oh, are you sure that this is the right thing?” people can step off. This is not a runaway train that once they are on they cannot get off, and we have to reiterate that to them quite often.

Chair: I know that Mims wants to come in here as well. I am really conscious of the fact we have some very important issues still to cover, so could you do it briefly? I know Dr Stewart wanted to say something as well.

Q71 Mims Davies: I just wanted to pick up on almost the two sides of the coin here. As a parent myself, I can totally see Susie’s point of view. You want to fix and get things sorted

and help your child as quickly as possible. The other side is the checks and balances and the understanding of how long things can take, how invasive and how difficult they can be, and the challenges you will face, even though you are fixing things. I have the feeling there is a balance that needs to be struck here. A point for Anna: 16 seems to be a key age in this. Is there a typical or a recognised time before 16 that people come into this, if you see what I mean? As a parent, if there is a frustration that you have a 16 year-old who you feel has been involved in the process for a long time, is it because it is between eight and 16? How long is that timeline, or do we not have that view? I just wonder, Anna, if you could give us an idea of how long before 16 you had been managing that yourself and how you personally felt, and whether you feel that is similar within the community. That may be too personal for you to answer.

Anna Lee: There is a variety of ages. For some people, it is the age of five but for other people it is a lot higher; 16 is a big age purely because puberty starts to hit a bit before then and then there are the waiting times involved with accessing services, which winds up coming to about 16. If some of it was more efficient, the age might be reduced slightly.

Q72 Chair: Dr Stewart, I know you were trying to come in before.

Dr Stewart: It is hard to know what to say under pressure. There may, for example, be a 13 or 14 year-old who has accessed the services at GIDS, has come out and is transitioning in school and has family support. Organisations like ours, Gendered Intelligence, would go in and support the school. We would do assemblies and get some workshops and some discussion going across the student cohort. That young person will have quite a smooth transition and then, at the age of 16, start cross-sex hormones. That, for us, is quite a successful picture. People seem to be generally quite happy. There might be some other professional people involved, such as CAMHS, who might come together to really think about what help looks like. We should be really careful thinking about trans in this reduced way of being either gender dysphoric or not. It is really problematic for me. If you read the criteria, they continue to be incredibly binary in their thinking. They talk about “rough and tumble play”. If you do not want to play with stereotypical masculine toys, then you have reached these criteria. I do understand that the team at GIDS has a very tricky, complex and ethically fraught job to assess whether these children and families do want to have medical intervention, but really that is not the whole picture of what it means to be trans. We really need to keep that broad view as well. Only some people will access the services, because only some people want something to happen that the medical service can provide.

Chair: Susie, can you forgive me if we just move on to schools? Is that okay? Cat, I know you have some questions in that area, neatly teed up by Dr Stewart.

Q73 Cat Smith: You led into that quite nicely, in some ways. As a Committee, we have had quite a lot of evidence presented to us about the range of problems young trans people experience in schools. I am thinking of under-16 schools or maybe sixth form colleges attached to schools rather than FE or HE at this point. I wondered whether or not perhaps Jay, Anna and Susie could tell us what you feel are the key problems in terms of the issues young people are facing in schools.

Dr Stewart: Again, for me, it is about going back to the fundamental point around this gender binary in how children, young people and adults think about gender and that gender diversity, as a subject, is not being sufficiently taught in school. PSHE is a very important area for us

to develop our young people to think about what prejudice looks like and what poor behaviour looks like so they can make informed decisions and behaviours that are respectful to all people, including trans people. We need to open up opportunities for people to express their gender in rich and diverse ways rather than put people into one of two boxes. Really, we need to be thinking about teaching practice or senior leadership understanding to allow all children and young people to thrive in their schools rather than just the people who fulfil those stereotypical gender norms. Education has to be the place to tackle the prejudice that is in society against trans people. Our society is entirely, horrifically and massively transphobic. People just do not understand enough about it. When coming out as trans, you very much immediately feel that you are wrong. It is not wrong. We have to educate the people around those trans people to respond appropriately and positively to our young people coming out as trans. Schools can do a lot around education just generally, certainly in terms of what respect and good behaviour look like, and to celebrate gender diversity specifically. That would be my big point to make about education.

Q74 Chair: Are there any schools that really get it right?

Dr Stewart: There are some fantastic schools.

Q75 Chair: Could you tell us who they are? We would like to know.

Dr Stewart: A little bit like I described earlier, we often get telephone calls saying, “We have a young person who has disclosed their trans status or wants to come out and socially transition at school.” They may or may not be part of the GIDS service or accessing that. Really, a good school would be one that has great, strong leadership from the head and senior leadership team. We have some amazing SENCO teachers who just go that extra mile supporting that young person and really putting that young person at the centre of the project of what they need to do around the edges. That would be good. Staff training is always key. Teachers’ time is incredibly precious, but we need to get trans experience—

Jess Phillips: They are always on a training day, it seems to me.

Dr Stewart: Well, we struggle to get them in a room. We usually get an hour. If we get an hour with all the staff in a school, then that can bode well and then we can work a little bit more locally with a smaller team. As I said before, it is about just trying to work with the students themselves and give students an opportunity to explore trans identities. If someone is trans and coming out as trans in their school, then we need to make sure that everyone is responding positively to that and to send strong messages and really take it as an opportunity to learn about gender and gender diversity, because it is not sufficiently taught in schools. Gender is complex and it is a really important part of our identity. There are other projects that we can work with; for example, I am thinking about the STEM projects getting young women into science, technology and engineering professions, and those getting young boys and men thinking about nurturing and caring for their friends and for their future families and being brilliant fathers. There are big projects there. Trans is just a part of that, but it should be at the heart of these things. That is what we feel passionately about.

Q76 Cat Smith: Anna and Susie might be able to provide the Committee with some ideas of the more negative experiences, if you have had contact with young people or personally, around bullying in schools, inclusion in sport or access to toilets. Is there anything around there that is particularly problematic in schools?

Susie Green: Absolutely. We get a lot of it. One of the things that seems to be very contentious is the subject of toilets. We have had several families who have moved areas and have tried to get their children into a new school and the school have then discovered that the pupil is trans and have refused to engage. Regardless of whether or not it is against the Equality Act, they have offered a place, found out the child is trans and then taken the place away and said they have no capacity any more.

We have had an incident where a child turned up after transitioning over school holidays and the school refused to allow the child entry to the building and insisted on saying that the name and the gender on the birth certificate was the one that was legal and, therefore, they could not and would not respect their gender choices or their name change choices.

I have written letters just recently to a school where a 16 year-old has changed his name by deed poll and the school are refusing to change the registers, etc. because he has unsupportive parents. Even though he is legally of an age where they should respect his choices and he has legal documentation, they are still refusing to engage. We are working with the Equality Advisory Support Service regarding that one.

Changing rooms are another issue. Two weeks ago, we had a school that pulled a child to one side who has been identifying and living as male, both at home and at school, for two years. They are starting swimming lessons. The child is eight. They took the child to one side and said, "You need to wear a swimming costume" even though all of their peers know them as a boy. They are saying, "You need to wear a swimming costume, because you are born female." They pulled the child to one side and tried to coerce the child into agreeing before they went home.

There are immense issues but, at the same time, on the other hand, we are finding that more and more schools are going, "Okay, we have this child. What can we do?" We get a lot of schools contacting us and saying, "How can we best support this young person?" We will often refer them to GIREs and to Gendered Intelligence regarding training and education. Those are the schools that are fantastic and they are doing everything they can, but there are still way too many that completely fall short. In fact, we have about three ongoing cases with the Equality Advisory Support Service where they are looking at whether or not it is applicable to take that forward into legal action.

We have local authorities that say the same: "Your name and your gender in this are this, and that is the way it should be." What we need is the Government to issue guidance for the entire country. We have individual councils that have schools guidance that is excellent, but if we have the Lancashire guidance, which is fantastic, how can we expect another county to pick up that guidance? It needs to be nationwide guidance as to how you should accommodate and what things you are legally required to do and your responsibility.

Q77 Chair: It is a lack of consistency.

Susie Green: A total lack of consistency.

Q78 Ruth Cadbury: This goes back to local authorities, but local authorities run fewer and fewer schools now. If the Government took leadership, that would affect certainly all

state-funded schools. Do you have different responses between faith schools and non-faith schools and between private and state-funded schools?

Susie Green: Not particularly. Each school is different, to be honest. They are all governed by the Equality Act. Gender reassignment is a protected characteristic, so they should all adhere to the fact that that child should be supported in an environment. It is often like the victim mentality; they want to go, “You are the problem. Let us try to get rid of you” rather than accommodate and look at the wider issues. Diversity is good. Diversity should be celebrated and everybody should be seen as a unique individual. Schools should be looking to instil that in their pupils, but in some schools they say, “We do not want to be dealing with that, so let us just shuffle it off to one side” or refuse to acknowledge it.

Q79 Ben Howlett: That is a really interesting point. I just want to delve a little more into what was said earlier in relation to those excellent schools that have promoted trans issues. Do they have strong PSHE lessons and is that how it is communicated amongst their students? Would that therefore be a very strong vehicle for the communication around the issue? I am thinking back to the L, G and B days, when promotion of homosexuality was wrong through Section 28. I do not want to go down the path of resurrecting that whole issue and how we learned from the mistakes of what happened in the 1980s on this issue. I can see the comparisons here. It is going to be incredibly important, so I am just wondering if you would like to see additional PSHE or even statutory PSHE being put on the agenda.

Dr Stewart: Definitely. I would be recommending statutory PSHE across the country. You are right; it is a brilliant curriculum to support students to know lots of stuff around sexual orientation and also gender identity. We go in under PSHE days. We will do the drop-down days and go in with other third sector organisations delivering different points, so it is a great opportunity for us. In terms of good practice, you may have—it is quite common for us—brilliant teachers who are advocating and feel really strongly. They may be the drama teacher or the form tutor or the head of year seven. That is our buy-in. We need someone on the other side who feels as passionate as we do to really teach all young people around trans experience and gender diversity. Yes, there are lots of parallels with LGB young people. Do not forget some LGB people will also be expressing their gender differently. What is homophobic bullying? Homophobic bullying often comes from what you look like, how you carry yourself and how you are perceived. There is a lot of work that we can do here together, and there are some excellent tools out there.

Chair: We have run out of time and I do not want to miss the opportunity to ask a couple of other areas of questions, so do you mind if we move on? I feel that we could stay on that for a while.

Q80 Mims Davies: I have a brief question for Anna, picking up on the problems that trans students face in higher and further education and how we can perhaps address that area.

Anna Lee: It being tackled in the earlier stages through statutory PSHE is crucial, as then everyone is on a level playing field when they are coming into university. Then it is making it easier to do things like change records, and simple things, like being able to access toilets and having gender-neutral toilets, being a standardised part of the education system. One other big area is the universities not being as accommodating as they should be to trans students requiring time out during their course for mental health reasons or a variety of other

reasons, and students having to really fight for their ability to, say, take a degree in one year longer.

One other area that we have not really mentioned is sport, which is a big issue. Almost all young trans people are systematically excluded from sport through the governing bodies' guidelines. BUCS, the governing body for sport for universities and colleges, just defers straight to the national governing bodies and all of those have often unattainable requirements and requirements that just should not be necessary for young trans people.

Q81 Chair: We are talking to the Minister in that department. Do you think that there is a solution that somebody has found to that that we can point him in the direction of?

Anna Lee: Some sports get it right. Predominantly they are the sports that are not as big as things like football. Flat-track roller derby is the sport that a lot of trans people turn to, because they are allowed to play. Their policy is very strong; it makes trans people comfortable to play and includes them.

Q82 Angela Crawley: On higher education institutions, one of the examples I have seen recently is a gender-neutral bathroom in a university union. Is this something that you would recommend that could be accommodated in more places to allow for that?

Dr Stewart: Gender-neutral toilets, gender-neutral spaces and gender-neutral language need to flow through many of our institutes of education, right through to higher education. There is no reason to say "male" or "female" in many senses, so why should we? We should not say, "Good morning, girls and boys." We should say, "Good morning, children." We should have more gender-neutral toilets, the same for everyone. That will help lots of people, including trans and non-binary-identified people.

Can I say a couple of things about sport? It is a very interesting area. I am not an expert in this area, but the exceptions laid out in the Equality Act include gender-affected sports, and this is the problem, I think, in terms of what constitutes gender-affected activity. The legislation states that a gender-affected activity is a competitive activity where "the physical strength, stamina or physique of average persons of one sex would put them at a disadvantage compared to average persons of the other sex." We have been doing some work with the Football Association. It is impossible to really think about "the average sex" and, again, of having a male body and a female body. It is the requirement of the bodies themselves to be able to evidence that they have made the right decisions. To measure the strength, stamina and physique of any person is nigh on impossible, so what they do is look at testosterone levels. My understanding is that there is no evidence internationally to say that levels of testosterone correlate to these ideas of physical strength, stamina and all the rest of it. We have a real problem here and it is a big issue.

My point—and Anna might say this as well—is that the messages then become so blurry for people on the ground in terms of how we can include trans people in our sports activities. We have this big problem with gender-affected activity. Just look at the guidelines. People who only want to have a kick around and who just want to do some sport activity at university are being excluded. They are not allowed to play because there is fear, there is lack of awareness and there is lack of knowledge around being this one thing or the other. Mainly we are talking here about trans women being discriminated against in accessing women's sports, but it does work the other way around as well.

Chair: You have given us a challenge. We will go away and investigate that some more.

Dr Stewart: Yes.

Q83 Ruth Cadbury: I just wanted to know what problems young trans people face in social care—looked-after children, secure accommodation or other general contact with social services.

Susie Green: Ignorance is the main thing. Social services and social workers do not have any training on trans issues at all. We have supported a number of children who have been in local services, etc. The people who are meant to be caring for them on a day-to-day basis often have their own prejudices around trans issues and the young people often feel very unsafe. If you are lucky enough to find that they have been placed in accommodation where the people who are working with them are willing to learn, which is one of the placements, then they will invite Mermaids, Gendered Intelligence or whoever in to give training to staff so that they are sensitive to the young person's needs regarding privacy, etc. I do know of a couple of places where we have not been invited in and where the young person who is on our teens' group has no support, is very frightened of consequences and has had violence against them in that setting where staff have not interceded appropriately.

Q84 Chair: It is somewhat surprising staff would not be aware of their legal need to treat people equally.

Susie Green: Yes, you would think that they would, but then again, we still have social workers who are attempting to take children off their parents because they are allowing them to live as their preferred gender.

Q85 Ruth Cadbury: Are trans young people disproportionately represented in the social care system?

Susie Green: I would not say so.

Q86 Ruth Cadbury: Let me put it another way. You may have answered this already, but are some of the young people you come into contact with in the social care system because of their—

Susie Green: Yes, for the young people who are known to us and whom we have supported, it is categorically because of the fact that they are transgender that they are in social care—not because they have been removed by social services, but more because their family have thrown them out.

Chair: Anna, you are nodding vigorously.

Anna Lee: That very much comes on to the issue of estrangement that young people often face, whether it is going into higher education or going into care. The lack of support particularly for young trans people who are estranged is really troubling.

Susie Green: I would say about 25% of the teenagers in our teens' group—we have just over 100 young people in our teens' group—do not have any support at home. They speak to their parents and their parents refuse to acknowledge or address the gender issues. They are the ones who are most at risk in terms of talking openly about self-harm and suicide.

Q87 Jess Phillips: Just to delve into this quickly, if the child was in care and they tried to come to the Tavistock, would they have to have their parents' consent?

Dr Wren: No.

Q88 Jess Phillips: I just wonder if they are under-represented because vulnerable groups of people are always under-represented in almost every category. If you are not seeing people in care, do you think there is a reason for that?

Dr Wren: We do see people in care, but we see the people we see and who make their way to us. I cannot speak about all the people who are not being referred to us, and they are the people we ought to be worried about. Our experience has been, again, a sea-change, partly driven by the equalities legislation that enables social workers to have a degree of confidence of knowing what these children are entitled to. With each young person who is referred you then get into a conversation about the remaining responsibilities of the parent. A lot of parents do still have PR, so we are in the business of trying to get in touch with those parents to talk to them. There may be a dad who has disappeared or it may be that both parents are unwilling to raise this young person, but they still have a say, so we work quite hard to engage those parents and offer them an opportunity to understand what is being offered. I would say it is a very mixed bag. We have some exemplary cases where social care is incredibly supportive of the young people. There is good practice out there.

Q89 Jo Churchill: This is more of a statement than a question. What concerns me now, hearing that, is, when we overlay that with the medical stream and everything else, that the multifactorial nature of this is such that we have to make sure that there is, to use your expression, the ability to step off the train. It strikes me that if the young person is being rejected by the family, you have psychological impacts there. You have a lack of CAMHS support anyway; we know that we have crisis provision there. We have this issue of development coalescing with service provision, with decision-making and so on, and then the inability of the individual to know which percentage of pressure is coming to them from which direction at which time. If you like, I suppose what you are getting from me is confused.com. Where do we put the checks and balances in to make sure we are doing the right things and not the wrong things? A lot of this stems back to educating everybody. My personal opinion is that, with what we are already asking teachers to do, to give them yet another tranche that they are not equipped and informed then to teach or to educate everybody in may not be the right way. To use a stick and not a carrot is not always the best way, in my view.

Dr Wren: Could I just quickly respond to that? In many ways, we feel we are at the cutting edge of a huge social revolution—and it is a social revolution that many of us have really fought for and wanted around sex and gender and diversity and its acceptance in society—but where we are heading is really unknown to many of us. That is what we would talk about with Gendered Intelligence quite a bit, with these young people. For example—this is one group we did not mention—a much higher proportion of natal females is coming forward who have got through to puberty but who now really dislike their female body. I have to see that in the context of the attack on female bodies and the general sense that feminism has not delivered—

Jo Churchill: And the media.

Dr Wren: Absolutely. You put that in the mix as well. I do not have the answers to any of that, because we are just a service, but these are massive social issues of change. We, in our small way, are trying really to support individual children but not to get swept along in something that we simply do not understand at this point. That is the balance.

Jo Churchill: I speak as a mother of four just moved out of teenagedom—22 to 18. You are really aware that they are fighting so much on some many fronts.

Dr Wren: That is right.

Q90 Chair: Dr Stewart, I am going to give you the last word. Go for it.

Dr Stewart: There are two things that I would take from that. One is we have not really sufficiently talked about general mental distress amongst our young people and what help looks like to curtail some of these. People feel distress because they experience prejudice and discrimination, so we need to address that as well, but also they have difficulties with their body image and the way that they are perceived. We do need more work, more thinking, more support and more provision to really offer counselling therapy, regular activities and talking opportunities for our young people to talk through the detail of their own stories and their own distress. I do not think that is something that they sufficiently get from GIDS, because it is so spread out and it is assessment-based. That is a shame, because they are great, professional and very able service providers.

The second point is that I just want to be a bit careful about this idea of checks and balances and stuff like that. We might ask, “What is the harm of X? What is the harm of changing your name? What is the harm of changing your preferred pronoun? What is the harm of changing your name legally?” Most of these things in a trans person’s life—things that we can do—cause no harm to anybody around them. Once we start getting into surgical procedures and stuff like that, we are further down the line and many things have happened. I do not think this getting on the train, getting off the train—this linear approach to gender—is sufficient here. We need to be thinking, “How are you doing anyway? What are you up to? What are you into? What are your hobbies? What are your interests?” They are multiple, are they not? We are all doing our gender in different ways depending our cultural and social environment. I would just like to say that.

Chair: That sounds like a very good place to end these discussions. I cannot thank you enough for the time you have taken to come in today. Dr Wren is absolutely right when she says that this is part of a much bigger discussion around gender in the country as well. Thank you, on behalf of the Committee. It has been incredibly helpful. Thank you very much. I am sorry it has overrun.

Dr Wren: If anyone wants to come and visit the clinic, they would be more than welcome.

Chair: Thank you very much.

Examination of Witnesses

Witnesses: **Professor Michael Brookes OBE**, Professor of Forensic Psychology, Birmingham City University, and **Megan Key**, Equalities Manager, National Probation Service, gave evidence.

Q91 Chair: Thank you so much for joining us. Can I apologise for the fact that we are running late? Our previous group gave us a great deal of food for thought. I know you will as well. I know that a number of Committee members will be in and out during the session, so please forgive us for that. Could you just briefly start by introducing yourselves and then we will move on to Flick, who has our first question?

Megan Key: My name is Megan Key. I work for NOMS, the National Offender Management Service, and specifically the National Probation Service. I have been in the service since 2005. I started as a trainee probation officer. I then worked as a probation officer and a senior probation officer in inner-city Birmingham. I have also done project management work. My current role is as the Equality and Diversity Manager for the Midlands division of the National Probation Service. I was also a finalist in the Probation Champion of the Year Awards this year for my work on trans issues and I am a finalist in this week's National Diversity Awards for being a positive trans role model. I guess it is important that you understand that outside of my role as a civil servant—I am here today representing the Civil Service—I am an advocate, educator and activist in the trans community.

Professor Brookes: I am not here representing the Prison Service or NOMS, although I previously worked for the Prison Service, my last post being Director of Therapeutic Communities at Grendon Prison. I retired in 2014. Prior to that, I worked in headquarters, at the East Midlands area office and at HMP Gartree. Prior to that, I worked in a youth treatment service. I am currently Professor of Forensic Psychology at Birmingham City University. I bring some awareness and knowledge of working in the Prison Service and working in a treatment setting in which there were some transgender prisoners, but I am not representing NOMS or the Prison Service.

Chair: Before Flick asks the first question, I should point out that we had also invited Michael Quinn from Out-Side-In to be part of the panel today to represent people within the service. He is unable to be with us, but I am going to ask whether he could submit some written evidence to ensure that we capture his perspective as well.

Q92 Mrs Drummond: It has been suggested that trans people are over-represented in the criminal justice system. Do you have any evidence for that? What might be the reasons behind it?

Professor Brookes: The proportion depends on what you take as the number of trans people within the general population. I have read figures between 2,500 to 3,000 and 500,000. What I have read is that there are around 100 prisoners within the prison estate who are trans, but the Prison Service does not currently keep a record or undertake any systematic evaluation of the treatment and work with trans offenders.

Megan Key: I would agree that there is very little quantitative research around the trans population in general, let alone in the prison or probation estate, because there is a lot of discussion about how valuable that data collection is and whether all trans people want to have their data collected. There are trans people who, once they go through the transition process, no longer consider themselves to be transgender. It is a really important point about the over-representation. If we think about trans people in the general population—I am a transgender woman; it is good that I say that, really—trans people are more likely to experience mental health issues, substance abuse and suicidal tendencies, and are more likely to self-harm, than the rest of the general population. We know in the Prison Service and the Probation Service that those are some of the things that contribute to offending, so it stands to reason that there are going to be more trans people in the prison system.

Professor Brookes: It links into why people offend in the first place and the multiplicity of reasons for that. As you have been hearing through your hearings in terms of the harassment and victimisation that trans people can experience, sometimes there is a negative reaction to that, which is why some of their responses may be captured within the criminal justice system and drawn into it as a response to what they have experienced within society in terms of rejection. That is a factor to take into consideration. When working with trans people, you are working with the identity issues, you are working with their offending and you are working with the interrelationship between the two.

Q93 Mrs Drummond: I was asked to ask that question, but it seems to me that that is a question we should not be asking, because people are people; you already are a woman. Hopefully, we will get to the stage where we do not need to ask that sort of question, if you see what I mean. I know it sounds a bit complicated, but you know what I mean.

Professor Brookes: We are talking about small numbers both within the general population and within the criminal justice system. The question always is: how can wider society adjust and adapt to a minority and take into account their needs and considerations? When you have hierarchical organisations, that is always much more complex, much more difficult and much more challenging than in other settings.

Q94 Ruth Cadbury: I just wondered what we know about transgender young people in the criminal justice system.

Professor Brookes: We know very little, because the evidence and the research just is not there. With Laura Jones, who led the project really, we undertook a literature review, which was published in the *Prison Service Journal* in 2012, which highlighted the paucity of research information that is around. Much of it is based in North America and especially the United States. There have been a couple of papers written in the United States setting out the experience of trans offenders who are imprisoned. There was also one in the *Prison Service Journal* and there was an article recently in the *Journal of Forensic Practice* around the experiences of prison staff working at Whatton and their experiences of working with offenders, but it is very limited. In a sense, it is only in the past five years that the criminal justice system has begun to systematically look at and address this issue, with the coming of the Equality Act and how it takes into account the Gender Recognition Act 2004 and how we manage that and work through that. Sorry, I am slipping into my parlance of working for the Prison Service, but there we are.

Q95 Jess Phillips: I am delighted that you are all Brummies. I am too a Brummie who has worked in an offender service. I was interested to ask Mr Quinn, who is not here, about the experiences of trans people and whether they feel they are being treated fairly at court. I suppose that is one issue that we will certainly be interested in hearing about either today or from him later. Specifically to Megan, there are issues around writing pre-sentence reports and supporting people to get the right convictions and sentencing at court. Things like Corston went on the way to doing an awful lot to make sure that sentencing got fairer in cases of female offenders, but I am not sure whether that has been the case with—

Megan Key: Whether it has gone that far for trans people. It is a really good question. Pre-sentence report writers do have an obligation to consider the whole person and not just the offence. At the moment, we have basic training for all probation staff of a talk from the NPS—because it is the National Probation Service that writes the report—about equality. Trans identity comes into that, but I would welcome more in-depth training within the Probation Service that consider trans people's needs. I am the national lead on trans issues in the Probation Service and I am one of seven equality managers across the country and Wales. My colleagues routinely will speak to me in the report-writing process about how to best consider trans people's needs, but I do think that there is an opportunity to do more there.

Q96 Jess Phillips: When you are writing a pre-sentence report, for example, if the pathways to offending, such as substance misuse, that you highlight—is it your experience that magistrates are more likely to put into community orders or—

Megan Key: So, it is about sentencing outcomes.

Jess Phillips: Sentencing outcomes, yes.

Megan Key: We do not have any research on sentencing outcomes. If I give you some context, the National Probation Service has only been in existence for just over 12 months as a result of the Transforming Rehabilitation agenda set in place by the Government. Prior to that, there were 35 separate probation trusts, so we did not have a cohesive way of drawing data together. As I said, one of the things that the new National Probation Service is going to focus on is extrapolating better data about trans people. I do not have an answer for you at the moment.

Q97 Jess Phillips: You are not sure whether judges are wary of putting people who would be considered by them to be ambiguous into one gendered setting or another in prison.

Megan Key: There are specific prison policies regarding the placement of trans prisoners in the prison estate, and NOMS is currently reviewing those. There is an opportunity to be more flexible about where we place prisoners. At the moment, the guidance says that you need to have a gender recognition certificate to be placed in the estate that matches your acquired gender. We are looking at a more flexible approach that recognises individual trans people's needs. Does that help you?

Jess Phillips: Yes.

Q98 Chair: Can I just ask a quick question on that? If the Prison Service is not measuring the number of people within its service who are trans and if there are the problems that you

have identified, how can the Prison Service be content that it is complying with its duties in the Equality Act?

Professor Brookes: I am not here to speak on behalf of the Prison Service, but it is an evolving issue. Prison Service Instruction 7 of 2011 began to set out a framework of working it through and if the Prison Service does not adhere to that, then complaints have been upheld by the Prisons and Probation Ombudsman in terms of not following the right guidance. They are learning. As Megan was saying, it is about how we deal with this issue in an estate that was very split between male and female, and had very set and regimented policies to deal with security and with treatment issues. How do we take into account a small group of people who are getting increasing recognition for who they are? How do we manage and how do we look after them, bearing in mind all the other responsibilities that are placed upon prison governors in terms of security and control? How do we best manage that?

Q99 Chair: It might be worth us talking to the Prisons and Probation Ombudsman about the cases that they have looked at.

Professor Brookes: Yes. Certainly there is one in terms of a briefing paper that was produced in 2003 looking at sexual abuse, and there is one in terms of a transgender issue that they investigated.

Megan Key: It is important to say that the Probation Service and the Prison Service are updating their policies on managing trans people. We know that knowledge and expertise about trans people in the community in general has moved on in the last few years. The National Probation Service is shortly due to start collecting data on trans people who choose to disclose that to us at their first point of contact with the Probation Service. That will be usually after sentence at court. That is a step forward.

Professor Brookes: Previously it has been very reactive on a case-by-case basis in which a prisoner has had contact with the health service to pursue a discussion and possibly surgery to move them from their gender at birth to the gender they feel most comfortable with. It is then: how do you manage that individual? There is a unit within Albany of 35, but—you have mentioned training—even there, the IMB has recommended that staff need greater training. It is very much on a case-by-case basis for a small number of offenders rather than having a consistent approach. It is encouraging to hear that, in a sense, the Prison Service is starting to be a bit more proactive and asking the questions rather than just waiting for the prisoner to come and say, “This is where I am” and having those discussions with the health services. There is a debate also about where treatment and advice is provided. Is it through NOMS, with a focus on reducing offender behaviour, or is it through the health service and the commissioning of services to prison establishments? How best are those needs met?

Q100 Angela Crawley: To follow up on Jess’s point, in Scotland, one of the approaches that was taken, particularly to female offenders, was a custody-in-the-community approach, because the research showed that someone who stays within a family setting is less likely to reoffend and they have support networks there. Is that something that you would recommend to the justice system of England and perhaps elsewhere?

Megan Key: I am not familiar with the Scottish practice. Is this more about sentencing people to community orders as opposed to custody?

Jess Phillips: Alternatives to custody.

Megan Key: Definitely, yes. Working in the National Probation Service and previously the Probation Trust for the last 10 years, where possible, it is our wish to recommend sentences that are community-based, definitely. That is what we are there to do. We try to reserve recommending custody to the most dangerous people.

Q101 Cat Smith: Thank you, Megan. You have already answered some of the questions that I had. With the new instruction coming out soon, I was wondering whether or not you could point at anything that you would think would be a good thing to be included in that.

Megan Key: That is a good point. I cannot comment specifically too much on the new instruction itself, because it is still in draft form. It is still in the midst of internal consultation and then it has to go for external consultation. Personally speaking, it is an opportunity for NOMS to get it right about where we place prisoners according to their gender status. As I mentioned earlier, somebody having a gender recognition certificate at the moment draws a very firm line in the sand and we are looking at how we could be more flexible in our approach. In the current policies, there are already very clear guidelines for prison staff around allowing people to live in their real life role in prison—about access to clothing, some types of makeup and things like that. The policy is already there and we have very clear expectations of our staff that they must adhere to that policy. If not, as we have already mentioned, there is a complaints procedure and we can hold people to account.

Q102 Cat Smith: Is there any difference between young people's experience of the criminal justice system and adult prisons in terms of all this?

Megan Key: Unfortunately, I cannot really comment on under-18 offenders, because that is not my area of expertise. I do not have any knowledge of people under 18 in the criminal justice system, I am afraid.

Q103 Ben Howlett: If you have said this and I have missed it, I do apologise, but a lot of what you have been talking about relates to binary trans people, not non-binary trans people. I can imagine that is going to be an awful lot more difficult within prisons and the Probation Service than in the binary community itself. Are there areas that you have identified as a problem or areas you think need to be improved in the non-binary area?

Megan Key: The concept of non-binary has become more prevalent over the last few years. As I said, I am active in the trans community outside of work as well. More research needs to be done. I could not specifically comment on what challenges I may foresee there being, but I would totally welcome more research into the area of not just non-binary offenders but trans offenders as well.

Q104 Cat Smith: I would be quite interested in your view on that, Professor Brookes.

Professor Brookes: The issue for the Prison Service is where you locate somebody. Is it in the male estate or is it in the female estate? In a sense, you have to come down on one side or the other, unless the Prison Service or NOMS is being more flexible in thinking about where is the most appropriate location for the individual in terms of how they perceive themselves. You only have a binary choice. There is not a midway point. Predominantly you would go with the gender of birth, unless there are good reasons not to. The only way of being in an

establishment in terms of your gender of choice is if you have a gender recognition certificate.

Q105 Chair: Forgive me for my lack of knowledge of our prison system. What work has been done to ensure that that binary choice is the only way to run a prison service?

Professor Brookes: I do not think any work has been done; it has just been the assumed way of operating over the past 200 or so years.

Q106 Chair: I presume it is the same in every country in the world.

Megan Key: What I would say is that we operate in a binary society, do we not, and so—

Q107 Chair: The NHS does not offer a female service and a male service. We access it as people.

Megan Key: They do have single-sex wards. Is that equivalent to single-sex prisons?

Q108 Chair: Okay, so there has not really been any work done on that.

Professor Brookes: No. I think they think it is a new issue.

Q109 Jess Phillips: Thinking now about how—I am going to use the right political term—Transforming Rehabilitation has and is currently changing the way that services look and what specialisms are provided, there were lots of awards won by brilliant probation trusts for doing brilliant things and partnership working together around some of these issues. I just wondered if you are seeing any change, either for the positive or for the negative, out of the new process.

Megan Key: Definitely. It is clear that the Transforming Rehabilitation process has created two different types of probation services. There are the private CRCs—the 21 community rehabilitation companies—working alongside one National Probation Service. Throughout the country, there are various partnerships in place. It is a new service—it is just over 12 months old—so there is more work to be done, but the fact that we have started looking at new policies and we are working with different local partners across the country is a positive outcome.

Q110 Jess Phillips: Was there something about it in the contract for the CRCs, though? Was there anything specifically around trans support in the contract?

Megan Key: CRCs, because they are delivering public sector services, still have to adhere to the public sector equality duty in fulfilling those services, so there are still those added protections. Gender reassignment is one of the protected characteristics in the Equality Act, so they are committed to delivering that. If not, they can be held accountable.

Q111 Jess Phillips: I suppose there is no more of a postcode lottery than there used to be. It was just different trusts before with different schemes, presumably. 21 different companies could do 21 different things and if you were trans and you were sentenced in Carlisle, you would potentially get a completely different service from if it was in Croydon.

Megan Key: In the CRCs, yes.

Jess Phillips: I suppose that was always the case with the trusts anyway in lots of cases.

Megan Key: Yes.

Q112 Chair: I know there was one particular question that we had around the case management system in the Probation Service. Does it record data on trans people?

Megan Key: As I said, the National Probation Service is shortly due to start collecting data on trans people—those who choose to disclose it.

Q113 Chair: So it does not do it yet, but it will.

Megan Key: Yes. We have altered our computer management systems, nDelius and OASys, to recognise that change and there will be mechanisms to record it confidentially.

Q114 Chair: Another very detailed question is: when it comes to the programmes that are being offered, have you encountered any problems with regard to getting placements for trans people, like work placements or such?

Megan Key: It is important to say that we do not offer trans-specific accredited programmes. As we talked about the binary system, the programmes offered are binary. As my colleague has said, the number of trans people who come through the system is very small. The opportunity for us is to understand better how trans people experience accredited programmes—what makes a successful outcome, what makes a successful sentence and how trans people complete those sentences—and that is where I would be looking to do more research.

Professor Brookes: The place where they do come together is in therapeutic communities, otherwise you have this delineation between health and counselling and perhaps some work by individual offender managers or prison psychologists with trans people and their offending, or else, within NOMS, a focus upon accredited offender behaviour programmes. Within therapeutic communities, you can look at the whole person and you can look at this interrelationship between somebody's identity, as you do with their background and life circumstances and childhood histories, and their offending. That is a much richer therapeutic context in which to explore these issues. There are a number of therapeutic communities throughout the country. Grendon is one but there are also therapeutic communities at Dovegate, at Warren Hill and at Gartree, and there is a female therapeutic community at Send. Those are the best places, really, in which to work through the complexity of the interrelationship between somebody's identity and their offending.

Q115 Jess Phillips: You have partially answered some of my questions around whether there is proper availability of specifically that being the presenting issue—that somebody's identity is the challenge—because there are lots of specific other things that lead with other pathways. Going back to the whole—I know it is binary and we have got down to the fact that it is men and women. Is there a potential issue with women-only spaces offering services under the CRC? I used to work for a Women's Aid. It ran a female offenders service; it was a women-only service housed in very much a traditional women-only service, although we would not have cared—but lots would. Is there an issue about that going

forward? That is a really common model now that the CRCs are contracting out work to much more traditional women-only spaces because they do not know what to do with them.

Megan Key: I work for the National Probation Service, so I could not really speak for how the different CRCs will operate, but they do have to operate within the law.

Q116 Jess Phillips: It would be the same issue for the NPS. If you had a high-risk prisoner, or a high-risk person coming out of prison, we would have worked with those people through the NPS as well as the CRCs.

Megan Key: Yes. The challenge is around what the partnership obligations are. If somebody has a gender recognition certificate, they are afforded the same rights as somebody with their birth gender as their acquired gender. There are some complex challenges around trans women—we talk about trans women mainly, because 95% of the offending population is of people assigned male at birth. The challenge is really around trans women accessing services. I agree with you that there is a real challenge if somebody does not have legal recognition in their acquired gender. Currently you need a GRC for that.

Q117 Jess Phillips: Even if you did have legal recognition, there is a move in feminist organisations, especially accommodation organisations, where there is a fear over that being a challenge. I do not agree with that, but that does exist.

Megan Key: Yes.

Professor Brookes: Those are the challenges that are faced within the criminal justice system. Some of those issues you raised were the ones around some of the initial reluctance within the Prison Service of locating trans male to female in the women's estate, certainly if they have committed a sexual offence against a woman. We know the history of women offenders and their views, but those are challenges. In a sense, as a society we have to move to say, "If we recognise them as women we cannot be exclusive in terms of providing that service". That is an issue this Committee might want to explore.

Q118 Jess Phillips: You would have a risk access pathway problem with anyone originally female, born male, whether they had committed a sexual offence, ever being allowed to stay in any gender-specific service. In my experience, that would be a no-no, in accommodation terms, regardless.

Professor Brookes: That is a challenge.

Jess Phillips: Yes, that is a challenge.

Megan Key: I should make it clear, though, that we would not exclude male to female transsexual people from the female estate because they have committed a sex offence. I just want to make that point. That is not the way we work.

Q119 Chair: Can I just turn our thoughts back to prisoners in prison, and particularly trans individuals in prison, and the difficulties that they may face, particularly around bullying and sexual assault? To what extent have you looked at that? How effective is the Prison Service at dealing with it?

Professor Brookes: Again, this information has not been systematically collected. Again, you have individual cases of trans people reporting these issues. Given the environment that the prison is, given that the general tenor of prisoners is to try to keep a lower profile and not to bring yourself to the fore of people's attention, by moving from dressing as a male in a male prison to dressing as a female, you are automatically attracting attention and highlighting issues and making it more likely that you could be victimised. It is about the Prison Service being conscious of that, being proactive in recognising those difficulties and incorporating it proactively within their anti-bullying and violence reduction policy, as well as assertion skills for the individual concerned about how you can live as a female within a male establishment and be yourself, as it is for a lot of prisoners who are quite vulnerable.

Q120 Chair: It is quite interesting. When we reviewed the evidence that was given to us, there appeared to be a level of cynicism around perhaps some who are in transition and whether that is something that is a true reflection of where they are as individuals or whether the motivation lies elsewhere. I was quite astonished at that quite acute level of cynicism.

Professor Brookes: That reflects what is in society. Prisons just mirror what is within society. What is reported in the press could be a discontented member of the prison staff reporting that and developing those issues.

Megan Key: I would agree. I read one piece of research that said that 45% of people in general society would not like it if one of their family members was transgender. There is stereotyping and ignorance, which mirrors general society. I am aware anecdotally that there is scepticism by some people, but we do have very clear rules and a policy about how to treat trans people, which we have talked about. PSI 7/2011 is being reviewed and updated to better react to trans people's needs. Our expectations are that staff work with trans people and support them if they are bullied or harassed in the prison setting.

Professor Brookes: The flip side to that coin is it is quite a brave decision to come forward, especially, as I say, that the norm is you keep yourself quiet and you do your time with as minimum fuss as possible, irritating as few people as possible, in order to progress safely through your sentence. To do something that is deliberately out of the norm takes a great deal of courage.

Q121 Chair: So there is no evidence that this is being used as a ploy, for want of a better word.

Megan Key: It is a really good point. As the lead on trans issues in the Probation Service, I have heard these views and I have tried to find research either way that confirms or dispels them and I do not have that research. It is something that I would be keen for us to commission in future.

Q122 Chair: Just another very detailed point in terms of trans people on remand and the problems that they face, particularly if they do not have gender recognition certificates or ID to identify themselves in terms of their gender. Is that, and how that can be resolved, something that is being looked at? It seems to be a particular problem for that group of people.

Megan Key: That will be looked at as part of the review of the policy on managing trans prisoners, yes. I cannot comment on the outcome, because it has not been finalised yet, but it is something that we are looking at.

Professor Brookes: The difficulty with those on remand is they are in a transient state, so you do not know how long they are going to be there and what the outcome is going to be in terms of whether they are convicted or whether they are not convicted. Therefore, it is difficult to engage them in any long-term policy, although you would want to keep and maintain whatever assistance and support they were receiving from healthcare professionals prior to being remanded. Continuity is important.

Q123 Chair: But that is something that is going to form part of your policy review.

Megan Key: That is right, yes. I have seen drafts of the document, because I am one of the people involved in the internal consultation, and that is referred to, but because it is not published or finalised, it would not be for me to comment on it.

Q124 Chair: When is that going to be finalised?

Megan Key: I am expecting it in October or November.

Chair: So relatively soon.

Megan Key: Yes.

Q125 Chair: Wonderful. Thank you very much for your contributions today. Do colleagues have anything else that they want to raise at this time? There is probably one other area that it might be useful to just ask your views on, in terms of prisoners and policies for searching prisoners, particularly those trans prisoners who may or may not have found themselves in the right sort of prison.

Megan Key: I cannot comment on it at the moment. I have not seen that in the latest draft.

Q126 Chair: That would form part of your policy review—

Megan Key: Yes, of course.

Q127 Chair: But at the moment how is that dealt with? What are the procedures and policies at the moment?

Professor Brookes: It is as set out in 7/2011. There are clearly set out procedures for both full searching and pat searching.

Q128 Chair: Which are?

Professor Brookes: I cannot remember precisely what they are, but I know that they are listed down there.

Q129 Chair: So there are policies and procedures in place. Some of the concerns around that were how involved the prisoner was in the decision-making process as to how they are dealt with when it comes to searches. Is the prisoner involved in that decision or is it something that is made by the prison staff?

Professor Brookes: My feeling is—but do not quote me on this—that it would follow the procedure for the gender in which that person is recognised. If it is a trans male to female, they would follow the searching procedures for females.

Megan Key: I do have the policy behind me, if you want me to refer to it.

Chair: Maybe it would be possible to give it to us as a piece of evidence.

Megan Key: Of course, yes.

Chair: Brilliant. Thank you very much. I really appreciate the time that you have taken today to come in. I know that preparing for these sessions takes time out of your weeks, so huge thanks from the entire Committee. We believe that the treatment of prisoners and those who are in the criminal justice system is a hugely important part of our work, so thank you very much for the time you have taken and for the quality of the evidence that you have given to us. Thank you.