Gender Recognition Reform (Scotland) Bill

CMF is an association of about 5,000 UK doctors, medical students, nurses and midwives. It is linked to about 80 similar organisations worldwide. CMF exists to unite and equip Christian doctors and nurses to live and speak for Jesus Christ.

The removal of the requirement for a medical diagnosis of gender dysphoria and supporting medical evidence.

Currently, under the Gender Recognition Act 2004, in order to legally change gender a person needs to be over 18, have been diagnosed with gender dysphoria by two medical practitioners, and have lived in their new gender identity for two years before applying to a Gender Recognition Panel (GRP) for a Gender Recognition Certificate (GRC). The recognition process is lengthy, interviews may be experienced as intrusive and the gathering of evidence in support of the application can be costly, complex, and inaccessible to some trans-identifying people. Some reform is therefore required, but we believe the proposed changes are ideologically driven, unsafe, and unworkable.

THE CHANGES ARE IDEOLOGICALLY DRIVEN NOT EVIDENCE BASED

The new proposals we believe would be harmful for individuals, their families and society generally. They rely on a self-declaration process that would make gender identity a matter of a person's subjective feelings and changing legal gender a matter of personal choice. They encourage the view that gender identity defines reality, and that biological sex is but a social construct, something 'assigned' at birth. This new ideological dogma has no evidence-base in science, but self-declaration would appear to reinforce it as if proven fact. No such reality-defining proof exists.

THE CHANGES ARE UNSAFE

The new proposals would certainly make the process simpler, but we suggest that it is not necessarily a good idea to make it simpler for someone to make a life-changing decision that, evidence suggests, they might later regret. The current law's delays are often seen as too onerous, but their purpose is to allow people time to explore their new identity before making far-reaching decisions.

Gender-dysphoria often co-exists with mental health disorders like anxiety and depression, suicidality, and sometimes autism. (See 1, 2 and 3 below). According to trans activists this is due simply to 'minority stress' resulting from society's negative attitudes towards trans people, a claim without supportive evidence. The results of another recent study suggest otherwise (4). It offers no proof that radical therapies such as puberty-blocking drugs, double mastectomies and cross-sex hormone treatment will prevent adolescents from attempting suicide. If anything, the findings of the survey underline the need for serious scientific research into the potential environmental causes of gender dysphoria and the risks—both physical and psychological—of medical transition.

It is vitally important to distinguish distress relating to one of these other conditions from dysphoria related to gender incongruence. This requires the skills of appropriately qualified healthcare

professionals. Self-declaration would deprive people of contact with these professionals at the very time when their assessment and advice could be crucial. There is a real risk that individuals who require psychological support and specialised psychiatric treatment will not receive it.

Until recent years, gender dysphoria was viewed as a mental health disorder and required specialist expertise to make a correct diagnosis (5). Many in the medical profession believe that the change from disorder to dysphoria was ideologically driven, not evidence based. Removing the need for medical diagnosis would remove a sensible 'barrier' to overly easy transition that would result in more people embarking on early medical transition with insufficient thought, more people living to regret

irreversible changes to their bodies, and/or wanting to de-transition later, and an overall increase in co-morbid mental health issues including suicidality.

In this sense, the proposed changes would positively harm those wrestling with gender confusion. The changes would shift the point of balance away from holistic assessment and treatment of co-existing mental health conditions, and towards easier identification as transgender and earlier trans-sex interventions.

THE CHANGES ARE UNWORKABLE

Given that many trans activists believe that gender identity is fluid (6), it is predictable that a significant proportion of applicants will subsequently wish to reverse their gender recognition.

1. 2 Dhejne C et al. Mental health and gender dysphoria: A review of the literature. Int Rev Psychiatry 2016; 28(1):44-57

2. Zucker KJ et al. Gender Dysphoria in Adults. Annu Rev Clin Psychol, Vol 12, 2016:217-247

3. Annelou L. C. de Vries et al. Autism Spectrum Disorders in Gender Dysphoric Children and Adolescents. Journal of Autism and Developmental Disorders, Vol 40, Issue 8, 2010: 930–936.

4. Toomey RB et al. Pediatrics October 2018, Volume 142 / Issue 4

5. DSM-5. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th edn. Washington DC: American Psychiatric Publishing, 2013, 302.85:455

6. International Gay and Lesbian Human Rights Commission, Institutional memoir of the 2005 Institute for Trans and Intersex Activist Training, 2005:7-8.

Provisions enabling applicants to make a statutory declaration that they have lived in the acquired gender for a minimum of three months (rather than the current period of two years) and that they intend to live permanently in their acquired gender.

The proposals reduce the requirement for a minimum period for the applicant to have lived in their acquired gender from two years to three months. We suggest this could result in a tsunami of ill-considered applications. Many young people, whose dysphoria could have been alleviated by

treating co-existent mental health disorders or by giving appropriate support where family breakdown/social isolation are factors, will instead pursue transgender recognition (and possibly reassignment for which evidence of effectiveness is lacking).

We believe it is unreasonable to expect a 16-year-old to declare an intention to live permanently in their acquired gender. Development psychologists consider identity development to be a process that continues long after adolescence. Modern neuro-imaging techniques have shown that brains continue to develop into our mid-twenties. It has even been suggested that a term such as 'emerging adults' should be adopted to designate 18-25-year-olds, for whom it is normal to continue a significant exploration of their own identity (7).

The Australian expert on adolescent health Prof Susan Sawyer puts it this way: 'An expanded and more inclusive definition of adolescence is essential for developmentally appropriate framing of laws, social policies, and service systems. Rather than age 10–19 years, a definition of 10–24 years corresponds more closely to adolescent growth and popular understandings of this life phase and would facilitate extended investments across a broader range of settings.' (8)

The view that a person's subjective sense of gender identity is fully formed by the age of even 18 years rests on increasingly shaky ground. To lower the current age limit at which people can apply to the Registrar General might be a popular move among trans activists but would lack any evidence base in science and is likely to lead to an increase in the number of requests to de-transition within a few years.

Studies show adolescents and young adults to be less risk-averse, more open to novel experiences and more motivated by potential rewards than more mature adults (9). As a result, teenagers are more inclined to risky behaviours. Two neurodevelopmental factors are thought to play parts in the genesis of this risk-taking propensity. One is the sudden and dramatic release of sex hormones that bathe the brain at the beginning of puberty. The other is the relative delay in the maturation of their cognitive control. Reducing the minimum requirement for having lived in the acquired gender from two years to three months fails to take into account the growing body of evidence about the nature of neurodevelopment.

Can it be right to consider someone, considered too young legally to purchase or consume alcohol in licensed premises, too young to purchase cigarettes or tobacco, too young to place a bet or get a tattoo, mature enough to change their legal gender? Teenagers are hormonally primed to take risks, and traditionally the law has put legal barriers in their way to save them from making decisions they might later regret.

Furthermore, for consent to be valid it must be fully informed. Studies like that referred to above show that the capacity to make fully informed decisions about one's own gender identity is not reliably mature before one's mid-twenties. Lowering the minimum age for application to the Registrar General, and/or removing the two-year period as a requirement will mean that more people make an immature decision to transition, and more will live to regret their decision. For anyone, at any stage of maturity, to be able to give fully informed consent to a legal change of gender, more than time is required. They need to understand the consequences of the decision. They need to be able to make a settled and sober decision that will last a lifetime. They need to make the decision of their own free will, free of duress arising from peer-group pressure or coexistent mental health issues. It is unrealistic to expect a person whose sense of personal identity, including gender identity, is still forming, to be able to confirm that they have a settled and sober intention to live for the rest of their lives in their preferred gender. To lower the age threshold for

application we believe would be unsafe and likely to bring the whole process into disrepute because of a high rate of later requests to de-transition.

Any expectation of 'permanence' in the way a 16-year-old feels about their identity is clearly misplaced. This was given legal force in the High Court ruling in *Bell v Tavistock and Portman NHS Trust* [Neutral Citation Number: [2020] EWHC 3274 (Admin)] where the judges, commenting on gender reassignment cases in those over 16 years of age where puberty blockers may lead to subsequent surgical operations, said: 'Given the long-term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, we recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment.' The judges were recognising that 16-year-olds could not be expected to provide fully informed consent to such life-changing treatment, and that wise clinicians would invite the scrutiny of the court in such cases.

In general, we believe that there is merit in the requirement that the applicant make a statutory declaration that they intend to live in their acquired gender for the rest of their lives. It helps guard against ill-considered or frivolous abuse. However, significant voices within the trans community do not recognise gender identity as fixed but believe it to be fluid. This is clearly at odds with a declaration of intent to live in an acquired identity until death. Therefore, we do not think it can be made a criminal offence if at some later point the applicant has a change of mind or identity, for such is the likelihood when gender identity is regarded as fluid.

The question demonstrates the impossibility of drafting a law in response to an ideological imperative that ignores objective biological facts and makes identity rest on subjective feelings.

7. Arnett JJ., Emerging adulthood. A theory of development from the late teens through the twenties. Am Psychol. 2000. 55(5): 469-80.

8. Susan Sawyer S. et al. The age of adolescence. The Lancet – Child and Adolescent Health, 2018, 2(3), pp223–228.

9. Gardner M and Steinberg L. 2005. Peer Influence on Risk Taking, Risk Preference, and Risky Decision Making in Adolescence and Adulthood: An Experimental Study. Developmental Psychology, Vol. 41, No. 4, 625–635

Whether applications should be made to the Registrar General for Scotland instead of the Gender Recognition Panel, a UK Tribunal.

Gender Recognition Panels were not appointed to discriminate or prevent individuals changing their legal status with respect to gender. Their role, as tribunals, is to ensure that these individuals make well informed and careful decisions, mindful of the momentous nature of the decision. In general, they support and assist people, and are generally minded to agree to applications where they meet legal requirements.

There is a case for suggesting that such panels should comprise Scottish individuals with personal experience of transitioning, and even of de-transitioning, alongside a variety of professionals, to bring a greater breadth of knowledge and experience to the task.

It is our conviction that a supportive panel of this kind will always make better decisions than a single individual. We suggest that the magnitude and implications of these decisions are too great for them to rest with a single person, even one as capable as the Registrar General. Our contention is that no individual can bring to these decisions a sufficient breadth of knowledge and experience to make the decisions 'safe.' We propose that the GCPs be retained.

It might help further if the GRPs were taken out of the Courts and Tribunals Service and designated as Gender Support and Information Panels, simple committees within the NHS. This might serve to change the nature of the experience for applicants, away from the sense that they were being scrutinised or 'tried', in favour of a sense of being informed and supported.

Proposals that applications are to be determined by the Registrar General after a further period of reflection of at least three months.

The Scottish government's proposed Bill would reduce the requirement of 'living in your acquired gender' from 2 years to 3 months, with an additional reflection period of 3 months, thus overall reducing the current requirement to 6 months. Whilst an overall six-month period of living and reflecting on life as a transgender person is better than no requirement at all, we believe this proposal to be unworkable.

Nowhere in the Scottish government's consultation documents is a rationale provided for the three-month requirement. Why not three weeks or three days? If the reasons for doing away with the current two-year requirement are to protect applicants from prejudice or abuse, and to avoid problems created when an individual's personal documents are inconsistent or do not match the gender they present as, then why accommodate any delay?

Self-declaration removes the requirement for medical reports and the proposals do not indicate if or how the three-month requirement will be attested. If the requirement is intended to avoid 'frivolous' applications, there must be some means of confirming that the requirement has been met. In the present climate, such scrutiny is likely to be characterised as discriminatory.

CMF is of the view that a three-month period of reflection, after a three-month period of living in an acquired gender, is an insufficient length of time to demonstrate a seriously thought through commitment. Our preference would be that the current two-year period should remain in place.

Whether the minimum age for applicants for obtaining a GRC should be reduced from 18 to 16.

For young persons with gender dysphoria, studies show that the large majority desist as they enter and progress through adolescence (10). It is therefore inevitable that, by lowering the minimum age for applicants, some adolescents will be 'captured' who would otherwise have desisted. As a result, more young people will start cross-sex hormone treatment.

As stated in answer to a previous question, adolescents and young adults are generally less averse to risk than more mature adults and have different cognitive control (11). Two neurodevelopmental mechanisms are thought to play a role in this - the significant secretion of sex hormones at the

beginning of puberty (which also affects the brain) and the delayed maturation of cognitive control. Also, brain volume peaks during early adolescence, affecting neural networks that impact on emotional, physical and mental ability. Those changes occur more rapidly in areas of the brain that are responsible for pleasure seeking, reward processing, and emotional response. Changes in those areas of the brain responsible for decision-making, organization, impulse control and future-planning occur more slowly. As a result of this differential development, many adolescents act impulsively and are uncritical in their thinking.

Neurodevelopment continues long after adolescence, such that even 18-25-year-olds are still exploring aspects of their identity. To expect 16-17-year-olds to have the capacity to make life-shaping decisions with potentially irreversible consequences is not supported by the growing body of knowledge about neurodevelopment. This is already recognised in Scotland where under 18-year-olds cannot vote, buy cigarettes, buy a lottery ticket, get a tattoo, place a bet or buy alcohol from licensed premises. We strongly suggest that obtaining a GRC should not be an exception, and that to make it an exception would reflect an ideological position that turns a 'blind eye' to neuroscience.

We are concerned that in five- or ten-years' time the health services in Scotland be faced with many thousands of sterile young adults whose mental health was not improved by gender transitioning and who wish to de-transition and have fertility treatment to enable them to become parents. Not to mention a slew of expensive court cases brought by those who claim they were catapulted along the road to transition and reassignment, without careful assessment of their mental health and without the maturity necessary to provide fully informed consent.

10. Zucker KJ. 'Measurement of psychosexual differentiation', Arch Sex Behav, 2005, 34(4):375-388.

11. van Duijvenvoorde AC et al. What motivates adolescents? Neural responses to rewards and their influence on adolescents' risk taking, learning, and cognitive control, Neurosci Biobehav Rev. 2016, 70: 135-147.

Barbalat G et al., Risk-taking in adolescence: A neuroeconomics approach, Encephale, 2010, 36(2):147-54.

If you have any comments on the provisions for confirmatory GRCs for applicants who have overseas gender recognition.

CMF considers GRCs should be provided for an overseas applicant who has a diagnosis of gender dysphoria, certified by two registered medical practitioners (or one medical practitioner and one registered psychologist), is at least 18 years old, has lived for a minimum period of two years in their acquired gender, and has the settled intention to live in their acquired gender for the rest of their lives.

If you have any comments on the offences of knowingly making a false application or including false information.

The Bill makes liable to prosecution someone who 'knowingly' provides information for a Gender Recognition Certificate application at an immature age which then proves mistaken at a more mature age. In effect, the Bill would criminalise a young person for making a mistaken application to change their gender at an age when they clearly lack capacity to consent. This is completely wrong.

By choosing to lower the minimum age requirement, and to remove the opportunity to discuss with a Gender Recognition Panel, the Bill forces individuals to make far-reaching decisions all by themselves, with the threat of imprisonment if they make a mistaken decision because of immaturity. This is ethically unacceptable and gives reason to question the wisdom and judgement of those drafting the legislation.

If you have any comments on the removal of powers to introduce a fee.

CMF does not believe that a significant financial barrier to application should be in place, in the form of a fee. If there is to be any charge at all, then let it be a nominal sum to offset administration costs.

If the Bill's intended policy outcomes could be delivered through other means such as using existing legislation or in another way?

CMF believes that it is important for those questioning their gender identity to have ready access to non-directive information and advice in a supportive and unhurried environment. We suggest that the current system of Gender Recognition Panels as part of the Courts and Tribunals Service could cause applicants to feel as if they are going to 'trial' over their identity.

We would favour a process that did not remove the opportunity to reflect with others on the implications of a decision to transition (as the Bill proposes) but would keep it as a requirement. However, we would suggest bringing it into a 'caring' context, rather than remaining in the 'justice' context. Perhaps NHS Gender Identity Support and Information Panels could replace GRPs?

Any other comments on the Bill.

In 2006, the Scottish Government published Delivering a Healthy Future: An Action Framework for Children and Young People's Health. This was geared to improving the quality, sustainability, and access to health care services for young people in Scotland, prioritising mental health. It was welcomed to the extent that the WHO recommended other nations follow suit (12).

For the Scottish Government now to put its weight behind an ideology that lacks a sound basis in science would hardly provide an example worthy to be followed. A recent (2019) Scottish Government report reveals that the mental wellbeing of Scotland's youth, particularly girls, is deteriorating. It is quite possible that these figures reflect the sudden surge in the number of adolescents being referred to GIDCs with gender dysphoria. The coexistence of psychopathology and gender dysphoria needs urgent research. Mood disorders, anxiety and depression, autism, and

stresses associated with family breakdown or dysfunction all need to be assessed, rather than assuming that gender dysphoria with 'minority stress' is necessarily the root issue.

Anecdotal stories of re-assignment regret, with or without requests to de-transition, are beginning to pile up. It is essential that the Scottish Government call a moratorium on the current rush towards early social transitioning, puberty blockade and cross-sex hormone treatment of children. Failure to do so now could mean that in five- or ten-years' time the health services in Scotland are faced with many thousands of sterile young adults whose mental health was not improved by gender transitioning and who wish to de-transition and have fertility treatment to enable them to become parents. Not to mention a slew of expensive court cases brought by those who claim they were catapulted along the road to transition and reassignment, without careful assessment of their mental health and without the maturity necessary to provide fully informed consent.

We would ask that consideration be given to noting a person's biological sex on their medical record, alongside but separate from their gender identity. We believe it to be in the best interests of the trans person that clinicians who look after them have this information to hand. If a trans man presents to a doctor in A&E with lower abdominal pain, and his medical record does not reveal that he was born biologically female, the doctor will not consider certain possible causes of his pain. The patient may find himself being referred to a gastroenterologist when a gynaecologist is what he needs.

The same biological female, now officially categorised as male, will no longer receive reminders to attend for regular cervical screening and must remember to book in himself. Should he forget, he might be at greater risk of cervical cancer going unrecognised. Likewise, a natal male, newly designated as a trans woman, may be distressed to receive an inappropriate invitation to attend for a smear test, lacking the anatomy.

Biological differences between females and males have an impact on many aspects of medical interpretation. For example, reference ranges for common blood tests differ between the sexes. Retaining natal sex as a category on patient notes, alongside gender identity, would prevent doctors from being misled and avoid added stress for trans patients caused by repeatedly having to explain their situations.

Research results will be impacted by obscuring trans patients within medical records. The particular health needs of trans patients will be impossible to identify. Separation of sex from gender identity is necessary for generating accurate research data (13).

12. W.H.O. Global accelerated action for the health of adolescents (AA-HA!). Geneva: WHO; 2017

13. Clayton, T., and Tannenbaum, C., 2016. Reporting sex, gender or both in clinical research? JAMA, 316 (18), 1863–1864