GIRES Response to Government Consultation on Banning CT

Preliminary Question

Do you agree or disagree that the Government should intervene to end conversion therapy in principle? Why do you think this?

GIRES Response:
Yes. It is critical that the Government should intervene to end these dangerous practices (so-called 'conversion therapy' – CT) as a matter of urgency. CT does not achieve the stated aim (i.e. to change the target's sexual orientation or gender identity), but does cause lasting damage to the mental health of those who are subjected to it; for example, the risk of a trans person attempting suicide is more than twice as high if they've been subjected to CT – and more than four times as high if they were younger than 10 at the time [1–3]. This is in addition to the well-documented disparities in mental and physical health experienced by LGBTQIA people as a result of the homophobia, biphobia and transphobia to which they are routinely exposed [4]. This makes it even more important that a ban on these practices does not create barriers to LGBTQIA people seeking affirming mental health care, and does not prohibit the exploration of sexual and gender identity in therapeutic settings. We were pleased to see this important point taken into account in the proposals.

In essence, these practices need to be banned because in all forms, they violate the target's right to freedom from degrading treatment [5].

Question 1

To what extent do you support, or not support, the government's proposal for addressing physical acts of conversion therapy? Why do you think this?

GIRES Response:
We have identified issues with the definition of CT used, but these will be covered in later parts of this response. In other regards, we support the proposal to address physical acts of CT with sentencing uplifts on already criminalised acts, particularly in the use of physical and/or sexual violence, where those acts were motivated by the goals of CT. It is also appropriate that the victim's consent would not be considered a viable defence in such cases. We would urge that care be taken to ensure that acts which are neither covered by

existing prohibitions on violence, nor solely speech, are not overlooked. Acts which may or may not be criminal, but which could constitute CT, and which do not require talking, include attempts to remove someone's access to information or materials they require due to (or in order to be able freely to express) their sexual orientation or gender identity. For the case of gender identity, acting to remove a person's access to medication prescribed as part of a medical transition, or certain items of clothing, for example, whether through deception, theft or other means. For the case of sexual orientation, this might include condoms, prophylactic medications (PrEP, contraceptives). Another example preventing someone from accessing community spaces, removing contact with friends who share the characteristic being targeted for CT, or blocking access to information about community spaces, events, specialist services, etc.

Question 2
The Government considers that delivering talking therapy with the intention of changing a person's sexual orientation or changing them from being transgender or to being transgender either to someone who is under 18, or to someone who is 18 or over and who has not consented or lacks the capacity to do so should be considered a criminal offence. The consultation document describes proposals to introduce new criminal law that will capture this. How far do you agree or disagree with this?

GIRES Response:
Somewhat Agree

Question 3
How far do you agree or disagree with the penalties being proposed?

GIRES Response:
Somewhat Agree

Question 4
Do you think that these proposals miss anything? If yes, can you tell us what you think we have missed?

GIRES Response:
We have identified a number of issues with the proposals, predominantly in areas where the proposals deviate from the recommendations of the Cooper Report [6]. Firstly, several issues arise if the definition of CT given in the proposals were to be used in the legislation. Whereas the proposals refer to attempts "to change a person's sexual orientation or to change them to or from being transgender", the definitions used elsewhere typically refer to an attempt "to change *or suppress* a person's sexual orientation or *gender identity*" [6–8]. The latter definition includes attempts to change expression/manifestation of the sexual orientation or gender identity (e.g. changing whether or with whom someone has sex), as well as forms of CT that target some transgender people but do not purport to make them cisgender. Secondly, we believe that informed consent is not meaningful in the context of degrading treatment such as CT [5], and that criminalising the *provision* of CT does not negate the right of a (consenting, despite being properly informed of the proven inefficacy

and harm of CT) individual to seek CT, albeit does make them less likely to succeed in that search. Moreover, there is substantial evidence that many survivors of CT were misinformed by the perpetrator and consented on the basis of that misinformation [9]. Thirdly, the proposals seek to ban CT without recognising that both motive and mechanism of CT and the harm it does, are specifically driven by the view, sadly still prevalent in UK culture, that (some or all) LGBTQIA+ people, lives, relationships or identities, are inherently inferior to cisgender, heterosexual counterparts. By ignoring this asymmetry, the proposals run the risk of criminalising care providers affirming an LGBTQIA+ identity, so great care will need to be taken to ensure clarity. We will address each of these issues in turn, below.

Defining CT

The definition of CT in the proposal is, in our view, inadequate, while a more typical definition would be 'practices that seek to change *or suppress* a person's sexual orientation or *gender identity*'. This more typical language enables all forms of CT to be covered by the ban, including CT perpetrated against non-binary people, intersex people, bisexuals and asexuals, which it is not clear the proposed language would, since CT against (e.g.) a bisexual person needn't seek to change their orientation, merely suppress expression of their attraction to a particular gender. The proposals note:

'The government has heard from victims that in recent years many of those who would previously attempt to change a person's LGBT identity have conceded that this is not possible. Instead, they may liken feelings of same-sex attraction or being transgender to a defect, deficiency, or addiction and may conduct conversion therapy in an attempt to remedy or control this. The government considers that in certain instances this would amount to conversion therapy and our approach will target such practices.'

However, it is not clear from the proposals how the government's proposed approach would be able target these practices, given the unusual language used in defining CT. We therefore urge the government to instead use the more standard language above; by including 'suppress,' this language prevents perpetrators from claiming they did not commit an offense because they are aware of the abundant evidence that sexual orientation and gender identity cannot be changed and therefore could not have been attempting to do so. It also means bisexual people, whose sexual orientation would be 'suppressed' rather than changed by CT, would be effectively included. Likewise, since we all have a gender identity, ambiguity about whether the gender identity a perpetrator attempts to suppress or change is a 'transgender' one, would be negated, meaning non-binary people would be effectively included. This language could also allow for the possibility that gender non-conforming cisgender people, including children, who may be subject to attempts to suppress (non-conforming) expression of their gender identity, could also be protected by the ban.

The government may wish to consider definitions of CT used by others. For example, the very recent ban in Canada defines CT as:

> "…including any practice, treatment or service that is 'designed to change a person's sexual orientation to heterosexual**,** to change a person's gender identity or gender expression to cisgender or to repress or reduce non-heterosexual attraction or sexual behaviour or non-cisgender gender expression.' This provision adds, 'for greater certainty,' that practices, treatments or services that relate 'to the exploration and development of an integrated personal identity without favouring any particular sexual orientation, gender identity or gender expression' are not

included in the definition" [Taken from; (7), including original quotations of the legislation. Original emphasis removed.]

Another example can be found in the Memorandum of Understanding (MoU) on Conversion Therapy in The UK [8], which was signed by numerous UK professional bodies and centres of expertise, including the British Psychological Society, the Royal Colleges of Psychiatry and General Practitioners, NHS England, NHS Scotland and the Association of Christian Counsellors:

> "… 'conversion therapy' is an umbrella term for a therapeutic approach, or any model or individual viewpoint that demonstrates an assumption that any sexual orientation or gender identity is inherently preferable to any other, and which attempts to bring about a change of sexual orientation or gender identity, or seeks to suppress an individual's expression of sexual orientation or gender identity on that basis." [8]

We urge the government to ensure that the ban defined CT in a way that, like the examples above, is able to capture all forms of CT, including:

- Those that aim to suppress (i.e. prevent it from being expressed), rather than change, the sexual orientation or gender identity. For example, those that aim to alter the gender expression of gender-nonconforming individuals, a bisexual person's choice of sexual partner, or an asexual person's choice about whether to have sex.
- Those that aim to alter a transgender person's expressed gender identity, but which do not change whether that person is transgender, for example, attempting to change the gender identity of a nonbinary person (for the example, someone assigned male at birth), to be a female gender identity.

Informed Consent?

The current proposals remain inadequate to effectively end CT due to the inclusion of a loophole for adults to give "informed consent". This inclusion is not necessary. Even if someone could consent to CT, criminalising provision does not criminalise seeking referral to a service. Furthermore, adequate protection of exploratory talking therapies – those that seek to explore issues related to sexual orientation and gender identity but do not actively intend to change or suppress the individual's (expression of) sexual orientation or gender identity – would mean that an individual who seeks CT could still obtain talking therapy in which to explore those issues. In the event that such exploratory therapy were to result in suppression or change of the sexual orientation or gender identity, this shouldn't be criminalised, provided at no stage was the therapy provided in a manner intended to produce that specific outcome. Therefore, the use of a precise definition of CT, in line with the recommendations of the Cooper Report [6], would negate the need for this loophole.

The perception that such a loophole is viable suggests inadequate attention to the power dynamics at play, which were elucidated by the Government-commissioned Coventry University report; 'Although most people who have conversion therapy appear to do so voluntarily, they also describe being led into conversion therapy by people in a position of authority in their religious institutions or families.' [9]. This report identified that survivors of CT undergone as adults typically gave consent, but that this was due to a combination of

external pressure, incomplete or false information, and the negative mental health effects of being LGBTQIA+ in an unaccepting environment.

This evidence suggests, in line with legal analysis of CT as degrading treatment, that free, informed consent to undergo CT is neither possible nor relevant to the legality of the practice under international human rights law [5]. By leaving the door open for over-18s to consent to CT, the legislation as proposed would introduce an insurmountable evidentiary burden for prosecutors to meet. One solution to this problem would be to explicitly place the burden of proof regarding consent to CT on the defendant. A better alternative would be to recognise from the evidence that it is not possible for an LGBTQIA person to give truly free, informed consent to CT, since no reasonable person would conclude, if fully informed, that undergoing CT was in their best interest. It may be helpful to consider how consent is handled elsewhere in UK law.

Under current UK law, consent is not a defence in cases of Actual Bodily Harm, for example, and in a case of truly free, informed consent to ABH the nature of the harm to which the individual consents is far less ambiguous. Moreover, there is no systemic sociocultural pressure that might mislead the individual to mistake ABH for healthcare – the same cannot be said of CT. This is why attending to the role of power is important here. If someone has been repeatedly told, perhaps directly from a pulpit, or more indirectly through media (including social media), for example, that there is something fundamentally 'wrong' with being LGBTQIA, since before they even knew that they themselves were LGBTQIA+, subsequent consent to CT is a product of that coercion. Therefore, if a defence of consent is permitted, and the burden of proof as to whether valid consent was given remains with the prosecutor/complainant, the legislation will fail to protect the large majority of adults at risk of becoming victims of CT.

Another demonstration of the importance of attending to the role of sociocultural power in how consent is negotiated and understood comes from gender-affirming care, which cannot in practice be accessed in the UK on an informed consent basis. Gender-affirming care is backed by substantial evidence of both efficacy and safety [10–13]. Meanwhile, the evidence shows that CT is both ineffective and harmful, and that meaningful informed consent is impossible, or at least very improbable, in the context of CT [2,3,5,9,14]. Therefore to insist that '…the freedom for an adult to enter such an arrangement [to undergo CT] should be protected,' gives the appearance that the government is readier to assume capacity to consent where the consenting party is seeking to conform to a cisgender, heterosexual 'norm', than where such compulsory conformity is antithetical to the individual's goals – even though the former group are consenting to be harmed, and the latter are consenting to evidence-based treatments with miniscule regret rates [15–17].

The suggestion to draw on existing legislation related to coercive control in drafting the proposed legislation may indeed be useful, not least because by its nature, CT is (attempted and/or actual) coercive control. Nevertheless, we would emphasise that the requirement to be "personally connected" to the victim would exclude cases involving 'professional' CT practitioners, but also authority figures outside the family/home, such as religious leaders, university lecturers or employers, and should therefore be dropped or significantly broadened for the purposes of the proposed CT ban.

(A)symmetry and Access to Affirming Care

Legislating against attempts to render heterosexual, cisgender people LGBTQIA is both futile (an attempt to ban a practice that does not actually exist) and risks creating a legal instrument that could be abused by opponents of LGBTQIA rights to attack legitimate healthcare and support services for LGBTQIA people and those questioning their sexual orientation or gender identity. Gender transition often entails a change in the term describing ones sexual orientation, for example, a trans man may describe his sexual orientation as 'gay' after transition, but before his gender was known, his orientation would have been termed 'straight' on the false assumption that he was a woman. However, his orientation has not changed; he is still exclusively attracted to men. Nevertheless, opponents of transgender healthcare use the ambiguity introduced by this linguistic quirk to claim that transition amounts to CT, despite the greater prevalence of LGBQA+ identities in the transgender population [18]. Additionally, there is some evidence that sexual orientation can sometimes change when a person transitions, but this is an entirely unpredictable phenomenon, and tends to increase the proportion of the trans population who are LGBQA+, contrary to the goals of CT [19,20]. By treating CT as a symmetrical phenomenon, as the proposals appear to, it becomes more difficult to draw such clear distinctions between what does and does not constitute CT, and in so doing, risks criminalising care tailored to the needs of the LGBTQIA+ population, including transitional care and therapeutic interventions to address internalised stigma. As it stands, the proposed legislation may 'protect' cisgender people from the non-existent problem of being coerced to transition, better than it protects transgender people from the very real problem of coercive interventions aiming to suppress or change their gender.

Moreover, this asymmetry is also present in the proposals themselves:

> "The government is determined to ensure that no person is put on a clinical pathway that is not right for them, and that young people are supported in exploring their identity without being encouraged towards one particular path."

We of course agree that young people should be supported in exploring their identity without being directed to a particular path. However, the vast majority of cases in which a young person presenting for gender identity related care "is put on a clinical pathway that is not right for them" are cases in which a young person is denied care; for example, an individual who, due to waiting lists and/or excessive hesitancy by clinicians, is unable to obtain puberty blockers, **will** undergo **irreversible** physical changes that will be traumatically incongruent with their identity [21]. In these instances, one could argue that the 'inappropriate clinical pathway' is so-called 'watchful waiting', but it might make more sense simply to recognise that inaction is not neutral in medicine, perhaps especially transgender medicine, and that the government should therefore seek to ensure instead that no person will be given gender-affirming treatment without being given adequate information and opportunities for exploration, **nor denied timely gender-affirming treatment** if and when they decide that they do not need to wait for further verbal exploration before commencing a treatment (capacity permitting) [22,23]. It may be worth noting that by prohibiting inappropriate delay or withholding of gender-affirming care, the fear of being denied care, which can motivate patients to withhold information or lie to clinicians, is ameliorated and patients will be more likely to openly raise any doubts they have about the pathway they are on. Therefore, if this is the appropriate legislative vehicle for improving regulation of

transgender medical care (which we doubt), we would ask the government to take care not to treat provision as weightier than refusal in the context of medical treatment of transgender people. It may be helpful to consider a hypothetical. A general practitioner who refuses to refer a patient to an appropriate gender identity service, without a good reason, motivated instead by, e.g. their opinion that trans people should not medically transition. We contend that this should not be permitted, and *could*, depending on the language in the legislation, be covered by a ban on CT.

Relatedly, it is important explicitly to protect LGBTQIA community support organisations and both NHS and private gender-affirming care providers, including **encouraging** individuals to accept themselves as LGBTQIA+ (c.f. the quotation, in the preceding paragraph, of the government's proposals).

We will return to some of these issues, and the omission of a plan for tackling religious practices of CT, in our response to Question 4.

There are a number of specific omissions from the proposals we'd like to highlight. Firstly, it is crucial that legislation related to CT make it absolutely, unequivocally clear that gender-affirming treatments – including medical transition, talking therapies to address internalised transphobia, and community support organisations for trans people are in no way analogous to CT. While some may seek to disguise CT as affirming care, perhaps especially targeting people who are considering a second transition (sometimes called "detransition"), these instances can be captured by specifying that CT entails a predetermined goal to suppress or change the target's gender identity or sexual orientation, which will also protect gender-affirming services.

Furthermore, the language 'to or from being transgender' would fail to protect people from CT that seek to change one's gender identity but do not seek to change one's gender modality (trans and cis are examples of gender modalities [24]). For example, a nonbinary person may be subjected to CT with the goal of creating a binary gender identity, and as long as that binary identity is not the gender they were assigned at birth, the proposed legislation would not classify this as a conversion practice. For this reason, if the government is for some reason not able to adopt the usual definition in the eventual legislation, they will need to ensure the ban explicitly includes CT that seeks to alter the gender identity or expression of an individual without necessarily seeking to change them 'to or from being transgender'.

As discussed above, CT may often entail attempts to force an individual to behave in contradiction to their sexual orientation or gender identity, without necessarily seeking to change the orientation or gender identity itself, and it is for this reason that the standard definition includes the term 'suppress'. The inclusion of 'suppress' allows acts that may form part of a conversion practice and/or a means of coercing an individual to cooperate with a conversion practice – for example, attempting to block an individual's access to gender-affirming medical treatment, STD prophylaxis, or information about LGBTQIA+ people – to be understood in their proper context, for example, as evidence of intent and/or coercion. This suppression could also include attempts to force an individual to stay 'in the closet', or, in a religious context, to commit to 'celibacy'.

The current proposals thus risk framing some types of CT and adjacent acts of coercive control as 'protected speech', in which event the legislation would, while imposing

sentencing uplifts for physical and sexual crimes forming part of CT, also entrench legal protection for the most abundant forms of the very practice it ostensibly seeks to end. Therefore, to ensure that legislation effectively addresses CT in religious contexts – which represents over half of all instances – it will be necessary to make clear that since the right to freedom from degrading treatment (which all forms of CT are) is absolute, and freedom of religion is not, religious freedom would not in and of itself a defence against charges of CT. As detailed in the Cooper Report [6], addressing a congregation (and not, e.g. naming an individual) is generally insufficiently targeted to constitute CT, even if the goals of CT are endorsed. However, if a target or group of targets of CT are taken aside for (or explicitly addressed with) any kind of interaction, be it prayer, counselling, or conversation, and that interaction meets the definition of CT (i.e. has a predetermined goal to suppress or change targets' sexual orientation or gender identity), that interaction should be included as a prohibited act of CT under the legislation. Furthermore, we have already described issues with permitting perpetrators of CT to claim the victim gave informed consent. In religious contexts, extreme threats can be levelled against someone to motivate them to consent to CT; whether abstract, such as eternal damnation, material, such as excommunication, or a mixture of both, these threats need to be recognised as coercion, especially if a loophole for 'informed consent' remains in the eventual legislation.

Question 5
The Government considers that Ofcom's Broadcasting Code already provides measures against the broadcast and promotion of conversion therapy. How far do you agree or disagree with this? Why do you think this?

GIRES Response:
Strongly disagree.

We disagree. Whilst Ofcom may in principle have the authority to sanction broadcast of CT or of promotion of CT, *were it to have sufficient grounds* to do so, *independent* of the character of the broadcast as (promoting) CT. However, the code does not contain any explicit reference to CT, so (broadcast equivalents of, or promotion of) many of the 'talking' forms of CT the proposals seek to ban would be likely to slip through the gaps between rules. Moreover, it is important that the definition of CT in legislation be written so that prohibiting CT already prohibits broadcast of CT, because otherwise victims will not have legal recourse against a broadcaster of CT. Furthermore, Ofcom generally will not consider complaints about BBC material without one first exhausting the BBC complaint process, which seems rather unreasonable ***if*** the complaint is about something as serious and potentially traumatising as broadcasting (promotion/) of CT. Ofcom also do not have the ability to actually stop broadcasts that break their rules: Ofcom have sanctioned Loveworld Limited five times in the last two years, each time for misinformation about the coronavirus pandemic. Even assuming Ofcom would take CT equally seriously as misinformation about the pandemic, this makes it clear that Ofcom alone will not be able to quash CT (/-promoting) broadcasts with the urgency required. Finally, Ofcom do not cover social media at all, so even if they were sufficient to prevent television and radio broadcasts of CT(/-promotion), to be effective at banning CT, the proposed legislation would still need to include specific prohibition of the use of social media to perform CT. This could be approached similarly to online harassment. This aspect has become especially important

with the increasing ubiquity of internet-based communication such as video-calling and social media during the coronavirus pandemic. Furthermore, in the next question we detail an example of a broadcast which may constitute and/or endorse or promote CT, which was not investigated by Ofcom despite numerous complaints [25].

Question 6
Do you know of any examples of broadcasting that you consider to be endorsing or promoting conversion therapy? If yes, can you tell us what these examples are?

GIRES Response:
Yes.

Among numerous possible examples, the clearest is perhaps the BBC Documentary "Transgender Kids: Who Knows Best", which featured child and adolescent psychologist Dr Kenneth Zucker, whose treatment approach with transgender patients has been called 'conversion therapy' by former patients and colleagues – Dr Zucker himself even admits that he would work to "reduce their child's desire to be of the other gender" if parents expressed that wish [26,27]. The documentary, which ignores the existence of nonbinary and/or intersex people, argues that transgender children could probably be 'cured' – euphemistically phrased as 'learn to accept their sexed body' – by enforcing rigid gender stereotypes, particularly around play, for example by stopping the child from playing with friends who were not of the same (assigned) sex, or with toys usually associated with the "other" sex from that the child was assigned at birth (i.e. assigned-male children, most likely including feminine cisgender boys, and transgender girls, were not permitted to play with female friends or stereotypically 'feminine' toys). That he used such methods is a significant part of why Dr Zucker has been accused of practicing CT. The ineffective and harmful nature of CT methods was known at the time of the documentary, but this evidence was glossed over. In the interests of clarity, GIRES do not have an opinion on whether Dr Zucker ever practiced CT. We do believe, however, that the documentary describes methods that would constitute CT, and encourages viewers, likely including many parents, to wrongly believe that these methods could be used to convert a trans child to be cisgender.

We note that despite numerous complaints, Ofcom did not investigate nor take action against the BBC in relation to this broadcast [25].

Question 7
The Government considers that the existing codes set out by the Advertising Standards Authority and the Committee of Advertising Practice already prohibits the advertisement of conversion therapy. How far do you agree or disagree with this?

GIRES Response:
Strongly Disagree.

Question 8
Do you know of any examples of advertisements that you consider to be endorsing or promoting conversion therapy? If yes, can you tell us what these examples are?

GIRES Response:
PNTS

We disagree. Not only do the codes not contain any explicit references to CT (see answer to Q5 for why this is needed), but ASA/CAP do not have sufficient authority to enforce such prohibition adequately. Moreover, targeted online advertising could enable perpetrators to present their advertisements only to audiences who would be unlikely to recognise CT as harmful, which is also necessarily the 'market' to which CT might be sold.

We do not have specific examples available - perhaps in part because we are not in the demographic such (overt) advertising would target.

Question 9
The consultation document describes proposals to introduce conversion therapy protection orders to tackle a gap in provision for victims of the practice. To what extent do you agree or disagree that there is a gap in the provision for victims of conversion therapy?

GIRES Response:
Strongly Agree

Question 10
To what extent do you agree or disagree with our proposals for addressing this gap we have identified? Why do you think this?

GIRES Response:

Somewhat Agree
We agree that there is a gap. Protection orders can be used to prevent someone from being removed from the country for purposes of FGM or forced marriage. Similar protection against being taken abroad for CT will be needed.
We note that the government has not proposed new offences for aiding and abetting CT. To ensure that protection orders are effective in preventing people being taken abroad to be subjected to CT outside UK jurisdiction, such offences will be needed, likewise in line with FGM and forced marriage, for persons who aid or abet in removing someone from the UK to subject them to CT.

Question 11
Charity trustees are the people who are responsible for governing a charity and directing how it is managed and run. The consultation document describes proposals whereby anyone found guilty of carrying out conversion therapy will have the case against them for being disqualified from serving as a trustee at any charity strengthened. To what extent do you agree or disagree with this approach? Why do you think this?

GIRES Response:
Strongly Agree

We agree. Charity Trustees occupy a position of significant public trust and this proposal would reduce the ability of CT proponents to abuse the trustee role to inflict or promote CT, or to use charitable status as a cover for an organisation whose true goals are to inflict or promote CT.

Question 12
To what extent do you agree or disagree that the following organisations are providing adequate action against people who might already be carrying out conversion therapy?
Why do you think this?

GIRES Response:
Police: Strongly disagree
Crown Prosecution Service: Strongly disagree
OTHER statutory service: Strongly disagree

We disagree. Even considering the absence of a specific legislative ban, there is much more these organsiations could do to address CT. First and foremost, there is a need for staff in these organisations to be sufficiently informed on LGBTQIA+ issues, including but not limited to CT, to enable them to recognise when CT is occurring. This also means recognising that CT is harmful and coercive, regardless of the mode of delivery, and even if the CT is entirely 'talking CT', and the CT itself is the only deviation from an otherwise supportive and loving environment.

Question 13

To what extent do you agree or disagree that the following organisations are providing adequate support for victims of conversion therapy?
Why do you think this?

GIRES Response:
Police: Strongly disagree
Crown Prosecution Service: Strongly disagree
OTHER statutory service: Strongly disagree

As above, the problem remains that without formal frameworks, professionals are left to rely on their own judgement, and given the relatively recent, and far from universal, recognition in UK culture that CT is a form of abuse and does lasting harm, may mistake CT for mere 'disagreement', for example. A very substantial amount of training will need to be rolled out to staff in these services to ensure that they're able to deliver the protection the proposed legislation seeks to offer people at risk of CT.

Question 14
Do you think that these services can do more to support victims of conversion therapy? If yes, what more do you think they could do?

GIRES Response:

CT that occurs in the home may leave victims with a choice between continued CT abuse and becoming unhoused. Therefore emergency housing provision, in line with that provided in cases of (other forms of) domestic abuse, will be needed.

CT should be incorporated under the national safeguarding requirements framework.

Reporting routes that do not require police contact, since many LGBTQIA+ people are unwilling to report crimes to police.

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