Responding to NHS consultation on 'gender dysphoria' service

The Tavistock's Gender Identity Development Service (GIDS), the only gender identity clinic for children in England and Wales, is scheduled to close by spring. It follows an independent report by Dr Hilary Cass, which found that it was not fit for purpose. Dr Cass said that *"a fundamentally different service model is needed"*.

NHS England is now seeking views on a service to temporarily replace GIDS. Long-term plans will be developed during 2023 to 2024, based on final recommendations from the Cass Review.

The proposal includes "substantive changes" in four areas (Composition of the clinical team; Clinical leadership; Collaboration with, and support for, referrers and local services; Referral sources), and an important clarification in a fifth (Social transition). Many of these are positive, although some do not go far enough.

HOW TO RESPOND

You can find the consultation documents and respond online at: **www.bit.ly/NHSconsultation**

The consultation closes on **4 December.** We have highlighted the key questions, and suggested points for you to make. Please use your own words – **this is very important**.

GUIDE TO THE ONLINE FORM

At the link above, scroll down to the 'Give us your views' box and choose 'Online Survey' to start your response.

About you (page 1)

There two compulsory questions on this page, about whether you are responding as 1) an individual or an organisation; 2) a patient, parent, clinician or service provider (you can also select 'Other'). You must answer these to continue. NB, if you are a church leader responding on behalf of your church, please say you are responding as an organisation.

Select Continue

Your views (page 2)

The questions on this page are not compulsory.

3. "To what extent do you agree with the four substantive changes to the service specification listed in the supporting documents?"

A. COMPOSITION OF THE CLINICAL TEAM

The GIDS service is provided largely by gender dysphoria specialists. The new approach will have a broader clinical team, adding experts in paediatric medicine, autism, neurodisability and mental health. The stated intention is to provide for the holistic needs of the young people referred to the service. This is a welcome improvement to the current system. However, there must be safeguards to ensure the new service is not also captured by radical gender ideology.

We suggest answering "**Partially Agree**". You could make some of these points:

- The Cass Review of the Tavistock gender clinic highlighted that under the current service young people's underlying issues are often *"overlooked"* because of an overemphasis on their discomfort with their biological sex.
- Dr Cass called for a stronger and more holistic assessment process that meets the needs of each gender-questioning child and which involves *"appropriate clinical experts"* and includes support *"for any other clinical presentations"*.
- The *"unquestioning affirmative approach"* which was criticised by Dr Cass must be replaced with one that should *"be open to exploring all developmentally appropriate options"*.
- A broader clinical team gives hope that young people who also have conditions such as depression, anxiety, PTSD or autism will be properly assessed and receive care appropriate to their real needs.
- The current affirmative approach has robbed many children and young people of proper care to address their underlying conditions and started them on a one-way path to more dangerous and irreversible 'treatments'. A more rounded, explorative approach is an opportunity to change that.
- Those operating at GIDS have been guilty of systemic failures. Children have been wrongly treated, consent procedures have been poor and there has been a lack of long-term follow up with patients. It would be wrong for these staff to be simply redeployed to the new service.
- If those operating the GIDS approach are still involved there is a risk that the new teams will be captured by the same ideology.

B. CLINICAL LEADERSHIP

The new service specification says: *"The key clinical leadership role will be through a medical consultant with significant experience in the developmental needs of children and adolescents."* This new requirement is positive.

We suggest answering "**Agree**". You could make some of these points:

- It is shocking that a service with such serious potential medical implications was ever allowed without requiring a medical doctor as the clinical lead.
- The Cass Report stated that children and young people accessing the service should find *"clinical staff with the training and expertise to meet their healthcare needs"*.
- With the high prevalence of mental health and other conditions in gender-confused young people, it is crucial that the clinical lead is an experienced medical doctor. This could help to create a safer, more thorough and less ideologically driven service.

C. COLLABORATION WITH REFERRERS AND LOCAL SERVICES

(We suggest skipping this section.)

D. REFERRAL SOURCES

Under the current system referrals to GIDS can be made by non-medical sources, including schools and voluntary groups. The new service would only allow referrals to be made by GPs and NHS professionals. This is a sensible change, but the consultation says *"this proposal relates only to the interim service specification"*. Therefore we suggest answering with "**Partially Agree**". You could make the points below:

- The current referral practice has been described by Dr Cass as *"unusual for a specialist service"*. The proposed change in referral practices is welcome, but this should be permanently implemented as part of the long-term plans for the services.
- There should be a requirement that the referrer is genuinely familiar with the patient and their history on the basis of repeated contact with them over a lengthy period, rather than, for example, a single appointment.

4. "To what extent do you agree that the interim service specification provides sufficient clarity about approaches towards social transition?"

Social transition involves changing things like name, pronouns and clothing to those of the opposite sex. The current GIDS service specification admits this is controversial and that there is *"insufficient"* evidence to predict its long-term outcomes. The proposal says that the new approach regarding pre-pubertal children *"will reflect evidence that in most cases gender incongruence does not persist into adolescence"*. It warns that the clinical approach must be *"mindful of the risks of an inappropriate gender transition"* and emphasises a *"watchful approach"*. However, it also refers to *"a carefully observed process of exploration of social transition"* in certain circumstances. This change is an improvement, but does not reject social transition for young children.

For adolescents, the new specification says: *"Not all adolescents will want or benefit from social transition"*. But it adds that support for social transition may be considered in cases where gender dysphoria has been diagnosed, other needs are being addressed, there is informed consent and it is necessary, for example to alleviate clinically significant distress. Again, this places important reservations around social transition, but is not an outright rejection.

We suggest answering "**Partially Agree**". You could make some of the points below:

- The Cass Report warned that it is very important to see social transition not as *"a neutral act"* but as *"an active intervention"* which may have a significant effect on a young person's psychological functioning.
- A stronger, evidence-based approach would include findings that childhood social transition makes gender confusion much more likely to persist and is associated with *"more intense"* gender dysphoria.[1]
- Since social transition makes it far less likely that a child's gender confusion will resolve naturally, the service should strongly encourage social detransition for those referred to it who are already living as if they were the opposite sex.

5. "To what extent do you agree with the approach to the management of patients accessing prescriptions from un-regulated sources?"

(We suggest skipping this section.)

6. "Are there any other changes or additions to the interim service specification that should be considered in order to support Phase 1 services to effectively deliver this service?"

A fundamental problem with the intended approach is that it remains a *"specialist service for children and young people with gender dysphoria"*. Referral to this service immediately sends the message to a child that they have a gender problem, when their underlying issue may have nothing to do with gender, e.g. autism. Providing these services as part of fully rounded children and young people's mental health services would be far better than them being a specialist 'gender dysphoria' service.

Another major issue with the draft service specification is that puberty blockers will still be used *"in the context of a formal research protocol"*. Although this limits the provision compared to the previous system, these dangerous drugs should not be given to children at all.

You could make some of the following points:

- Referral to a gender dysphoria service risks closing off other possible diagnoses and becoming a self-fulfilling prophecy once the child receives it.
- The Cass Review said that we do not need a national gender service. We do not need regional ones either. Properly resourced children and young people's mental health services would be able to do this work in a truly holistic way.
- There should not be any trials of puberty blockers. Evidence shows that almost all who take them go on to more damaging cross-sex hormone treatment.[2] Without blockers, gender confusion resolves at or around puberty in the overwhelming majority of cases.[3] We should not be experimenting on children.

7. "To what extent do you agree that the Equality and Health Inequalities Impact Assessment reflects the potential impact on health inequalities which might arise as a result of the proposed changes?"

(We suggest skipping this section.)

Select Continue

Almost done... (page 3)

Enter an email address if you would like to get a copy of your response.

Select Submit Response

References | **1.** Steensma, T D, McGuire, J K, Kreukels, B P C, et al, 'Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study', *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(6), June 2013 | **2.** Carmichael, P, Butler, G, Masic, U, et al, 'Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK', *PLoS ONE*, 16 (2), February 2021 | **3.** 'Do children grow out of gender dysphoria?', *Transgender Trend*, see https://www.transgendertrend.com/children-change-minds/ as at 17 November 2022