

Gay Men's Network G

INTERIM SERVICE SPECIFICATION FOR SPECIALIST GENDER DYSPHORIA SERVICES FOR CHILDREN AND YOUNG PEOPLE

Response to the NHS England public consultation

Executive Summary

The Gay Men's Network is a not-for-profit grassroots organisation dedicated to fighting homophobia in all its forms and advocating for the interests of male homosexuals. We have developed this response from the perspective of these primary objectives.

We generally welcome the proposed ISS which moves to a multi-disciplinary team approach, medical leadership, and a clear acknowledgement that "watchful waiting", and not a rush to medicalisation will be the right response for the vast majority of patients. We welcome safeguarding referrals where potentially dangerous drugs like puberty blockers and cross sex hormones are obtained online. We welcome the general move back to a standardised NHS service with normal follow up, record keeping and awareness of the serious ethical issues at play.

We are, however, dismayed that the proposed ISS makes no mention of the serious and malign influence of homophobia in this area. We say lessons must be learned from the past. NHS staff should never be briefing newspapers that their service "feels like gay conversion therapy". We argue that the proposed ISS should include specific reference to this serious safeguarding and ethical concern. It is apparent that internalised and external homophobia was and is a safeguarding risk in the field of paediatric gender medicine.

The interim Cass review highlighted problems with this field of medicine so serious that the Tavistock was ordered to close. Inappropriate influence by lobby groups, poor record keeping, inadequate general and safeguarding assessment of patients, medicalisation of patients while ignoring co-morbidities were among the many issues addressed. We take the view this was a medical scandal which must never be repeated.

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Introduction

About the Gay Men's Network

The Gay Men's Network is a grass roots, not-for-profit organisation of gay men from a diverse range of backgrounds and professions, including the medical profession. We have pooled our expertise and resources to come together to respond to policy from the perspective gay men. Our primary objectives are to fight homophobia in all its forms and to advocate for the interests of gay men in the current social conversation which is often framed as a conflict between women's and trans rights.

Our approach to this response

We have approached our response to the NHS England (NHSE) consultation through the lens of our primary objective of fighting homophobia. The Homophobia experienced by young people can come in many forms; their own, growing realisation of their difference from others, homophobic bullying from peers, the cultural or religious setting in which the young person is being raised, familial disapproval and, as we will argue, the idea of gender identity which drives the field of gender medicine, is itself inherently homophobic. Indeed, this form of homophobia has been identified several times as a safeguarding risk at the Tavistock Gender Identity Development Service ('GIDS').

We have analysed the ISS from a desire to ensure that homophobia is not allowed to become a driver for young people experiencing either gender incongruence or gender dysphoria. From the perspective of advocating for homosexual males, we seek to protect young people who might otherwise grow up to be homosexual, from being set upon an irreversible, medical pathway either as a means of escaping the experiences of homophobia or because of it.

Before we turn to the specific questions in the consultation, we have some comments about the background against which the consultation is taking place. We support the decision by NHSE to substantially reform the Tavistock GIDS in response to the damning findings of the interim report from Dr Hillary Cass's review. However, any replacement for GIDS must be made aware of the very clear evidence (**Appendix 2**) that at least 70% of young people presenting with gender incongruence will, if left alone a) desist post-puberty and b) grow up to be homosexual.

Furthermore, any replacement for GIDS must be seen to be completely independent of outside influence from powerful lobby groups pushing an “affirmation only” approach to treating both gender incongruence and gender dysphoria. It must be seen to apply sound clinical practice, engage in detailed follow up of patients, play an active role in helping to understand the phenomena of gender incongruence and dysphoria and the sudden and alarming shift in patient demographic.

The history of the Tavistock GIDS (well documented in newspaper reports and legal proceedings that we have laid out chronologically in **Appendix 1**) speaks clearly to homophobia being a well-known safeguarding concern. One which was silenced by lobby group activity, the political expectations of the wider NHS and a climate of fear among clinicians should they express concerns about the service. Spurious accusations of “transphobia” were levelled against anyone daring to question the influence of groups such as Mermaids over treatment plans or raise concerns regarding homophobia as a significant factor for many patients being referred to The Service. So compelling is the body of evidence that we would go so far as to say that The Service, under the influence of these lobby groups and from within, had become institutionally homophobic which led to ideological malpractice. As a group dedicated to fighting homophobia in all its forms, we are dismayed and shocked that clinicians and non-clinical safeguarding staff were ignored when they expressed the concern that what was happening at GIDS amounted to gay conversion therapy by gender.

The proposed ISS presents an opportunity to highlight and remedy the homophobia within gender medicine and we welcome many of the measures being introduced in the ISS. The decision to move provision of The Service to specialist, paediatric units is to be commended as is the shift to a treatment paradigm based on “watchful waiting” and individually tailored care plans. The ISS clearly recognises two key aspects which had hitherto been ignored at GIDS:

- a) that gender incongruence/dysphoric presentation is transient and most often subsides with the onset of puberty.
- b) that autism spectrum conditions and other neuro-developmental or mental health diagnosis, are often key factors in feelings of gender incongruence and should be thoroughly explored and treated.

The decision to involve multi-disciplinary teams with consultant level experience in the development of individual treatment plans following a standardised assessment is a much-

needed step to ensure treatment is based on sound clinical practice and not unduly influenced by lobby groups or ideology.

We welcome the advice to GPs and local healthcare providers that patients obtaining Gonadotropin-Releasing Hormone Analogues (GnRHa) (“puberty blockers”) and masculinising/feminising hormone drugs should be treated as a safeguarding issue (indeed, please see Appendix 2). Finally, the drive to secure a robust and reliable evidence base of who is using The Service and long-term follow up of patients by assessing and recording treatment outcomes, is a vital step in grounding the treatment of gender incongruence in young people in sound evidence-based medicine rather than by ideological interference.

We are concerned, however, that neither the ISS or the accompanying Equality and Health Inequalities Impact Assessment adequately discuss homosexuals or have considered the influences of homophobia in relation to The Service or its users. Despite the universally recognised relationship between gender incongruence and homosexuality (it is the root of many stereotypes of homosexuals) it has been completely ignored in the development of the ISS.

Finally, we note the glaring omission from the ISS of the subject of detransition and transition regret. As we have pointed out, it has become clear that over 70% of young people experiencing either gender incongruence or dysphoria desist post puberty (**Appendix 2**). The number of young people who have already been through a process of transition and now regret their decision is growing. This group of people face complex medical needs which are currently not met in any part of the NHS. They deserve the same end-to-end, professional care as those who are experiencing gender incongruence in the first place.

We set out now, our responses to specific consultation questions below.

Consultation Questions

Question 3: To what extent do you agree with the four substantive changes to the service specification explained above?

Question 3 A: Composition of the clinical team

AGREE

The proposed ISS is as follows (emphasis added):

"The new interim service specification proposes to extend the clinical team so that it is a more integrated multi-disciplinary team that, in addition to gender dysphoria specialists, will include experts in paediatric medicine, autism, neuro-disability and mental health.

The reason for this proposal is to respond to evidence that there is a higher prevalence of other complex presentations in children and young people who have gender dysphoria, that the Phase 1 services will also address, working with local services where appropriate. The proposal also responds to the findings of the Care Quality Commission's 2021 inspection report of GIDS, which highlighted the need for a better multi-disciplinary mix of care providers for some children and young people referred to the service. Furthermore, the interim advice of the Cass Review concluded (page 69) that "a fundamentally different service model is needed which is more in line with other paediatric provision, to provide timely and appropriate care for children and young people needing support around their gender identity ... this must include support for any other clinical presentations that they may have".

We welcome the decision to extend the clinical team to include specialists in areas other than gender dysphoria to allow co-existing mental health conditions to be assessed alongside a patient's gender incongruence. Specialists should have a clear understanding of how young people's mental health, including feelings of anxiety and depression, can be affected by the manifestation of their sexual orientation and that homophobia – both external and internal – can be a major driver for referral to The Service. It is vital that clinical teams are aware of homophobia as a safeguarding risk and can assess if patients are being driven to The Service as a means of escape or through parental or other coercion/peer pressure. We would suggest that this is also integrated into the ongoing training regime that NHSE propose elsewhere in the ISS.

We agree that a multi-disciplinary team using standardised assessment and diagnostic criteria creates a robust and auditable treatment approach which can guard against the “diagnostic overshadowing” identified in the Interim Cass Report. We would urge The Service to include experience of homophobia and, where appropriate, feelings towards sexual orientation as an integral part of the assessment criteria to be developed.

We applaud the recognition that autism spectrum^{1,2} conditions were overrepresented in GIDS patients. This recognition represents a marked and welcome shift from the lack of critical inquiry demonstrated by GIDS in the face of the evidence before them. The complete lack of clinical curiosity or inquiry into the overrepresentation of autistic spectrum disorder patients among referrals to GIDS represented a fundamental failing of GIDS to protect vulnerable young people. The proposed multidisciplinary team should, therefore, include psychiatrists and psychologists or psychotherapists with specialist clinical training and experience of working with ASD patients.

Question 3 B: Clinical leadership

AGREE

The proposed ISS is as follows (emphasis added):

“The current service specification for GIDS does not describe criteria for the clinical lead for the service. The new interim service specification proposes that the clinical lead for the service will be a medical doctor.

The reason for this change is to reflect that the new integrated clinical teams will have a broader range of clinical disciplines, including medical professionals, who will be addressing a broader range of medical conditions in addition to gender dysphoria.

We agree with the decision to make the clinical lead for the service a medical doctor. Doing so would create a single, expert locus for accountability, co-ordination and decision making. Medical doctors are professionally accountable to their Regulators and professional disciplinary bodies and liable for damages where negligent practice is proved. In an area where questions as to *Gillick* competence and ideological malpractice have arisen, the opportunity of recourse to a professional regulator offers further assurances of and clear

¹ Holt V, Skagerberg E, Dunsford M. Young people with features of gender dysphoria: Demographics and associated difficulties. *Clin Child Psychol Psychiatry*. (2016) **21**(1).

² Kaltiala-Heino, R., Sumia, M., Työläjärvä, M. et al. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child Adolesc Psychiatry Ment Health* (2015) **9**.

mechanisms for accountability. It is also consistent then with the professional regulation of other NHS services.

We welcome the reference in the ISS that the clinical lead be those with significant experience in child development. Such experience will be necessary to provide effective clinical oversight of the multidisciplinary team being proposed. We would strongly urge that clinical leads be alive to and are trained as to the risks of internalised and external sources of homophobia in prompting referrals to the service.

Question 3 C: Collaboration with referrers and local services

AGREE

The proposed ISS is as follows (emphasis added):

"The current service specification for GIDS describes a tiered approach for progression through the clinical pathway: the first tier involves meetings between the GIDS team and local professionals involved in the care of the child or young person and the second tier involves the child or young person accessing local services for mental health needs with GIDS offering advice to local services. There are numerous references in the current GIDS service specification to joint working between GIDS and local services including through consultation and liaison. However, GIDS has struggled to provide this support to local services in a consistent way given the constraints on the service. The new interim service specification proposes to retain this tiered approach to progression through the pathway and describes a more structured approach for collaboration with local services in the interests of the child and young person; a referral to The Service will require a consultation meeting between the Phase 1 service and the relevant local secondary healthcare team and/or the GP. Where the outcome of the initial professional consultation between the Service and the referrer is that the patient does not meet the access criteria for The Service, the child or young person will not be added to the waiting list - but the family and professional network will have been assisted to develop their formulation of the child or young person's needs and a local care plan and will be advised of other resources for support that are appropriate for individual needs. The proposed interim service specification also proposes that not all children and young people who meet the access criteria will need to be seen directly by The Service. A key intervention that will be delivered by The Service is the provision of consultation and active support to local professionals, including support in formulation of needs and risks and individualised care planning. The level and type of consultation offered to the

professional network will be determined according to the individual needs of each case and through a process of clinical prioritisation."

We welcome this measure which it is hoped will relieve pressure on the GIDS waiting lists. Long waiting times were often used to criticise GIDS and left patients without assessment or treatment for significant periods. We support increased collaboration between The Service and local professionals to properly assess young people and that the ISS explicitly states that not all children may reach the criteria for access to The Service. In particular, we commend the specific mention of "watchful waiting" as a valid treatment pathway. It is clear from the research that has been done that up to 80% of young people presenting with gender incongruence will desist after puberty. The majority of those will grow up to be gay or lesbian. It is important that this fact is recognised, and those young people are supported, given the time and opportunity to grow rather than placed on an irreversible medical pathway.

We support the revised model whereby The Service provides specialist support to local professionals in developing individual care plans for patients and the focus on awareness of co-existing mental health and other conditions. These care plans must include therapeutic interventions to address any co-existing conditions and, in particular, assess their contribution to the patient's sense of gender incongruence. The ISS also highlights working with local networks to ensure safeguarding and the involvement of child services where concerns are raised. We hope that service providers recognise homophobia as a safeguarding risk since this has so unequivocally been demonstrated as a key motivator for many young people and some families who engage with The Service in the first place. The ISS recognises "*co-existing mental health, neurodevelopmental and/or family or social complexities*" as sources of distress for young people presenting with gender incongruence. We would urge The Service to include homophobia as an additional source of distress these young people may experience on the basis that the evidence for this is overwhelming (**Appendix 1**).

Question 3 D: Referral Sources

AGREE

The proposed IIS is as follows (emphasis added)

"The current service specification for GIDS states that referrals can be made by staff in health and social services, schools, colleges of further education and by voluntary

organisations. The new interim service specification proposes that referrals may be made by GPs and NHS professionals. The reason for the proposal is to ensure that children and young people are already engaged with the local health system before a referral is considered by a local health professional into the highly specialist gender dysphoria service, including for the reason that a proposed core feature of the new pathway is a consultation meeting between the specialist service and local health professionals before a referral can be considered for acceptance. The proposal would impact on fewer than 5% of referrals at current referral patterns, in that around 65% of referrals into GIDS are currently made by GPs and around 30% are made by NHS professionals. This proposal relates only to the interim service specification for the Phase 1 services. The interim report of the Cass Review begins to describe a future clinical pathway approach that operates within a managed clinical network, including other statutory agencies, and this pathway will be worked up by NHS England in the coming months through engagement with the Cass Review and other stakeholders."

We support the proposed change. While only affecting 5% of referrals, it is an important signal that non-medical groups are no longer part of the referral process, and that only medical or other statutory bodies will be involved. Indeed, the interim Cass Review noted that it was unusual for a specialist service such as GIDS to accept referrals from non-medical sources. We know from previous evidence that the GIDS service had been unduly influenced by external lobby groups and that clinicians were, in some cases, overly concerned with placating these groups. The involvement of these groups has presented a serious lapse in safeguarding. It is vital that services for vulnerable young people be rooted in sound, clinical practice and not subject to the political or ideological positions of lobby groups.

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

AGREE

The proposed ISS is as follows (emphasis added)

"The current GIDS service specification acknowledges that social transition in pre-pubertal children is a controversial issue, that divergent views are held by health

professionals, and that the current evidence base is insufficient to predict the long-term outcomes of complete gender-role transition during early childhood.

The interim Cass Report has advised that although there are differing views on the benefits versus the harms of early social transition, it is important to acknowledge that it should not be viewed as a neutral act. Dr Cass has recommended that social transition be viewed as an 'active intervention' because it may have significant effects on the child or young person in terms of their psychological functioning.

In line with this advice, the interim service specification sets out more clearly that the clinical approach in regard to pre-pubertal children will reflect evidence that in most cases gender incongruence does not persist into adolescence; and that for adolescents the provision of approaches for social transition should only be considered where the approach is necessary for the alleviation of, or prevention of, clinically significant distress or significant impairment in social functioning and the young person is able to fully comprehend the implications of affirming a social transition."

We welcome the acknowledgement in the ISS that gender incongruence in most pre-pubertal children does not continue into adolescence and the marked shift from "affirmation" to "careful observation" as the clinical focus. Furthermore, the ISS recognises that, as expressed in the interim Cass Review, social transition is not a "neutral act" and that social transition carries with it the risk that the child will experience further difficulties reversing the behaviour if their gender incongruence resolves in adolescence.

We would further point out that social transition, like most ideas of gender, relies upon societal stereotypes of male and female behaviour. It is important to recognise that homophobia from parents or guardians and social media can also play a significant and detrimental role in inappropriate social transitioning. We would recommend that, in addition to the deeper consideration of social transition in the ISS, it go further and make specific reference to familial and social/peer pressure as a safeguarding concern, with respect to social transition and the temporary nature of most gender incongruence.

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

AGREE

The proposed IIS is as follows (emphasis added):

"Children, young people and their families are strongly discouraged from sourcing GnRHa and masculinising / feminising hormone drugs from unregulated sources or from on-line providers that are not regulated by UK regulatory bodies. In such cases The Service will make the child or young person and their family aware of the risks, contraindications and any irreversible or partly reversible effects of the drugs and will advise the GP to initiate local safeguarding protocols.

"Should a child or young person access GnRHa from unregulated sources or unregulated providers The Service will not assume responsibility for prescribing recommendations, nor will it enter into shared cared arrangements in these circumstances.

"Where a child or young person has obtained masculinising / feminising hormones from an unregulated source (such as the internet) The Service will not accept clinical responsibility for management of the endocrine intervention.

"Where a child or young person has been prescribed masculinising / feminising hormones by an unregulated provider outside of the eligibility and readiness criteria described in the current NHS clinical commissioning policy The Service will not accept clinical responsibility for management of the endocrine intervention."

We fully support the recommendation in the ISS that The Service will not accept clinical responsibility for patients who have obtained masculinising or feminising hormones from un-regulated sources. The NHS should not be a party to young people taking drugs provided to them by unregulated, on-line sources or ideologically driven lobby groups. We also welcome the increased clarity in the ISS in its advice to GPs to engage local safeguarding services where there is evidence that a patient has accessed these drugs from un-regulated sources. Where such medicines are obtained and safeguarding referrals under the proposed ISS are made, we would recommend those referrals fully capture any third-party activity by lobby groups or practitioners facilitating or encouraging this process. This step would ensure a policy that deals with causes as well as symptoms.

Question 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?

We believe the ISS ought to explicitly acknowledge that a significant proportion young people who present as gender incongruent or with gender dysphoria grow up to be homosexual. Also, that the largest cohort of adolescents referred to GIDS were homosexual. From the statements of both Mrs Sonia Appleby and Dr David Bell, we know that homophobia from within the GIDS services *and* from patient's families, as well as within the patient themselves, was a driving force in propelling many patients to and through The Service. As a group who advocate for homosexual males, we are dismayed and confused as to why the ISS fails to cite homophobia as a safeguarding risk for young people presenting with gender incongruence.

We suggest that specific mention of homophobia as a safeguarding risk be made in the following sections:

- **7.1 Service aims**

- We suggest an additional bullet point highlighting "Safeguarding against internalised and external homophobia as a reason for seeking referral to The Service"

- **8.1 Future Service Model**

- We suggest adding a bullet point indicating that The Service will take appropriate action with regards to safeguarding concerns, particularly in the case of overrepresented groups within the patient cohort such as homosexuals. We would further suggest that the research programmes to be developed to better understand gender incongruence and clinical outcomes of treatment make specific reference to the sexuality of patients as a data point to be recorded, in appropriate circumstances.

- **8.2 Current Pathways**

- *Support to Local Professional Networks*

- We suggest adding text to the bullet point *"... identifying co-existing mental health, neuro-developmental or other conditions"* such that it reads *"...Identify co-existing mental health, neuro-developmental or other conditions or safeguarding risks acting as drivers for referrals/service use such as internalised or external source homophobia"*
- *Screening, triage and professional consultation & advice*
 - We suggest augmenting the text *"Identify additional mental health needs/neurodevelopmental needs/safeguarding risks that require local professional care planning and support"* such that the screening process includes assessment of the patient's experiences of homophobia, both internalised and external.
- *Standardised Assessment*
 - We suggest that the bullet point *"With adolescents – psychosexual development and any sexual experiences"* be modified to include sexual orientation.
 - We suggest adding a bullet point to this list which deals with the initial MDT assessment to the effect of *"The presence of internalised or external sources of homophobia where it appears they are driving referral to or use of The Service."*
- *Psychoeducation*
 - The recommended psycho-education resources in the ISS should be clear that not conforming to sex stereotypes is not a pathology. Practitioners should be alive to the fact that many young people who present as gender non-conforming will grow up to be homosexual adults.
- *Direct work with pre-pubertal children, and their families*
 - We suggest that therapeutic approaches for younger and pre-pubertal children also take into consideration the potential for homophobia or "avoiding having a homosexual child" when assessing familial/social circumstances and recommend the appropriate safeguarding measures

where it is felt homophobia could be a contributing factor for referral to The Service.

- *Direct work with adolescents, and their families*
 - We suggest this section include direct reference to sexuality/sexual orientation as a source of distress for young people and their families. Furthermore, we suggest that The Service should treat with extreme caution, the use of or recommendation of social transition. Many homosexual people do not conform to sex stereotypes and were singled out and targeted as children for gender non-conforming behaviours. Clinicians need to be clear that not conforming to sex stereotypes is not a pathology and should not itself be a driver for referral to The Service, either by the patient themselves or by their family and certainly not by unqualified lobby groups.

Where a young person is mature enough to safely express a settled position about their sexual orientation, it should be recorded in the SPC charts and general data collection considered in section 7.2 of the proposed ISS. Robust data is necessary to understand the demographics of Service users in order to protect those young people who would otherwise grow up to be homosexual from unnecessary medicalisation and physical interventions.

In 2012, Dr Az Hakeem published his work on specialist psychotherapeutic intervention with adults experiencing gender dysphoria³. He describes a group therapy model bringing together patients experiencing gender dysphoria and those who have desisted or de-transitioned. Hakeem found that, through the group therapeutic process, most patients resolved their gender dysphoria, did not go on to pursue physical interventions and were able, subsequently, to address any co-existing mental health difficulties that may have been contributing to their gender dysphoria. Such group therapeutic approaches could be applied to children and adolescents and should be part of any reformed treatment model.

In addition to his work on group therapeutic approaches to treating gender dysphoria, Hakeem, along with colleagues, devised a questionnaire, the Gender Preoccupation and Stability Questionnaire⁴ (GPSQ). The GPSQ which can be used both as a diagnostic tool for gender dysphoria but also track progress through any treatment – physical, social or

³ Hakeem, A. (2012). Psychotherapy for gender identity disorders. *Advances in Psychiatric Treatment*, (2012) 18(1)

⁴ Hakeem, A., Črnčec, R., Asghari-Fard, M., Harte, F., Eapen V. (2016) Development and validation of a measure for assessing gender dysphoria in adults: The Gender Preoccupation and Stability Questionnaire, *International Journal of Transgenderism*, 17:3-4

psychological – in terms of the stability of the patient’s sense of their gender and how troubled the person is by their gender. While the GPSQ was devised for adults, a version adapted for children, GPSQ2⁵, has also been developed. We believe that the ISS should support the use of these tools as a means of gathering clinical data on patients moving through treatment for gender incongruence or dysphoria.

We note with some concern the proposal in the ISS for a research programme into the outcomes of treating gender incongruence/dysphoria with GnRHa hormone analogues and other masculinising/feminising drugs. We feel that this proposal should be subject to public consultation as to how such an exercise could possibly be ethical. It is our view that it cannot be (for further details about the harms of puberty blockers, see **Appendix 2**).

We are further concerned about the inclusion of “*voluntary community services*” in the list of independent service components in Section 8.5 of the ISS. If The Service is to avoid a repeat of the scandal that unfolded at the Tavistock GIDS and Dr Cass’s judgment that it was “not safe”, the involvement of any volunteer community service must be closely regulated. We recommend that the ISS explicitly limit the role of such groups to make clear they have no role in or influence over best clinical practice for children and young people. This needs a strict and narrow definition as to what is meant and what, if any, services should even have a role to play.

We note the proposed ISS makes no provision for detransitioners. While we appreciate the objective of the proposed ISS is to allocate children and young people to appropriate clinical pathways reducing the number of detransitioners, it would be over-ambitious to imagine that this group will never be represented in the under 18 age range. Detransitioners presently face serious and significant challenges in accessing appropriate therapeutic and endocrine care and many are now speaking publicly on the subject. Given that fact, we consider the complete absence of detransitioners from the proposed ISS to be an omission which ought to be remedied by dedicated guidance on how the clinical needs of this cohort can be best met.

Question 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?

⁵Hakeem, A., Bowman, S.J., Demant, D., McAloon, J., Wootton, B (2022). Assessing Gender Dysphoria: Development and Validation of the Gender Preoccupation and Stability Questionnaire – 2nd edition. *Journal of Homosexuality*.

PARTIALLY DISAGREE

We are surprised by the Equality and Health Inequalities Impact Assessment, in particular, the way it deals with homosexuals. In relation to the protected characteristic of sexual orientation we note the summary explanation of the main potential positive or adverse impacts of your proposal where you state “*NHSE does not hold relevant data.*” This cannot be right.

All the available evidence, some of which we have set out at **Appendix 1**, suggests that homosexuals are one key group seriously impacted by a failure of safeguarding due to malpractice at the Tavistock GIDS. We therefore consider the Equality and Health Inequalities Impact Assessment to be wholly inadequate in two respects:

- First, the fact that sexual orientation data is not available suggests that homophobia has not been taken seriously up to this point. We have recommended recording this data so a reliable understanding of its influence on referrals can be obtained. Beyond this, we would suggest that the apparent overrepresentation of homosexuals in the patient cohort is itself a sign that homophobia is a concern.
- Second, we agree that the proposed ISS will do much to mitigate the concern that homophobia, both internalised and external, has been a significant problem at GIDS. However, the equality assessment makes no mention of historic homophobia at The Service, how the reformed Service intends to address homophobia as a safeguarding risk or how it will be managed in the future. Indeed, the proposed ISS does not mention the word “homophobia” at all. We consider this to be a serious omission given the evidence. Homophobia has long been a concern in gender medicine and this fact ought to be reflected in both the proposed ISS and the Equality and Health Inequalities Impact Assessment if it is so be avoided in the future.

While we welcome much of the approach of the proposed ISS, in the context of this question we do emphasise and remind NHSE of its public sector equality duty under section 149 of the Equality Act 2010. Particularly as it relates to discrimination and harassment pertaining to sexual orientation. In addition, we note NHSE’s various responses to its equality duties as follows (taken from NHSE’s latest response/policy):

The public sector Equality Duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need

to: Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.

We trust that NHSE will have due regard to its own policies. The lack of safeguarding and the risk of homophobia we have referenced throughout this response, supported by the evidence in **Appendix 1**, does also give rise to a significant risk to the NHS of civil claims and Regulatory sanctions. We note you acknowledge in the impact assessment (and in the proposed ISS) prior intervention by the CQC at GIDS and its report and findings published in 2021 in terms of implementing recommendations. Here are two extracts from the CQC's report in relation to GIDS which are instructive:

"Staff did not always work well with other agencies to safeguard young people. Most records did not include plans, agreed with other agencies, on sharing information and protecting young people."

and

"Staff did not always feel able to raise concerns without fear of retribution. Some staff, particularly those in non-clinical roles, said there was a fear of blame within the service. This meant they were reluctant to raise concerns. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. The Speak Up Guardian presented an annual report to the trust board. In their report in May 2019, the Speak Up Guardian stated that staff at GIDS had raised concerns and that many of these staff felt worried about speaking in open groups."

Accordingly, for the reasons we have given, we do not think that the impact assessment of risks in relation to sexual orientation are adequate. Over and above NHSE's public sector equality duty we remind you of your statutory duty to provide safe care and to safeguard users from improper treatment and abuse as per Regulations 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Section 13 also stipulates that care or treatment for service users must not be provided in a way that includes discrimination against a service user on grounds of any protected characteristic per the Equality Act 2010. Such duties should as clear legal requirements, be embedded into the assessment of risk, as well as the proposed ISS more generally.

Appendix 1

Chronological Schedule of incidents at the Tavistock tending to suggest institutional homophobia

- a. November 3rd, 2018 - Dr David Bell circulates an internal report raising serious safeguarding concerns saying *"staff had "very serious ethical concerns" that children were making life-changing decisions with "inadequate" examination and consent. Some openly homophobic parents pushed their children to transition because they were gay, the report said. In other cases, youngsters seized on transition as a "solution" after abuse or bereavement. Their histories were not properly explored by clinicians struggling with "huge and unmanageable caseloads" and afraid of being accused of transphobia if they questioned the "rehearsed" surface presentation. The report said Gids had tried to "placate" lobby groups such as the Mermaids charity, which campaigns for children to be given sex-change treatment.*⁶⁷"
- b. February 17th, 2019 - doctors at the Tavistock say that *"England's only NHS gender clinic for children is exposing young patients to "long-term damage" because of its "inability to stand up to the pressure" from "highly politicised" campaigners and families demanding fast-track gender transition"*⁸
- c. February 24th, 2019 - governor and consultant psychotherapist Marcus Evens resigns in protest from the Tavistock GIDS service saying it had *"created a "climate of fear" and was trying to "dismiss or undermine" concerns raised by its own clinicians"*⁹
- d. April 8th, 2019 - GIDS staff report homophobia as a serious safeguarding issue, *"So many potentially gay children were being sent down the pathway to change gender, two of the clinicians said there was a dark joke among staff that "there would be no gay people left". "It feels like conversion therapy for gay children" one male clinician said. "I frequently had cases where people started identifying*

⁶ <https://www.thetimes.co.uk/article/governor-quits-blinkered-tavistock-trans-clinic-rrm38sv0g>

⁷ <https://www.theguardian.com/society/2018/nov/03/tavistock-centre-gender-identity-clinic-accused-fast-tracking-young-adults>

⁸ <https://www.thetimes.co.uk/article/tavistock-trans-clinic-fears-damage-to-children-as-activists-harass-staff-xf5sxxg3pp>

⁹ <https://www.thetimes.co.uk/article/governor-quits-blinkered-tavistock-trans-clinic-rrm38sv0g>

as trans after months of horrendous bullying for being gay,” he told The Times. “Young lesbians considered at the bottom of the heap suddenly found they were really popular when they said they were trans. Another female clinician said: “We heard a lot of homophobia which we felt nobody was challenging. A lot of the girls would come in and say, ‘I’m not a lesbian. I fell in love with my best girlfriend but then I went online and realised I’m not a lesbian, I’m a boy. Phew.’¹⁰

- e. October 12th, 2019 - mental health nurse Sue Evans “reported her alarm at the speed of assessment and feared that treatment plans were being influenced by groups such as Mermaids, a transgender advocacy charity... Ms Evans said: “When you work in the area of gender dysphoria you begin to see that many of these children have other areas of concern or difficulty, such as depression, autism, trauma, childhood abuse, internalised homophobia, relationship difficulties, social isolation and so on..¹¹”

- f. September 17th, 2020 - safeguarding lead Sonia Appleby wins a whistle-blowers case against GIDS based on her concerns over homophobia and the influence of lobby groups and unregulated doctors being side-lined, suppressed and ignored¹². Among her “protected disclosures” (and other evidence in that case) are the following matters:
 - i. First protected disclosure, 30th October 2017 – “a number of GIDS staff have brought some concerns to my attention of late. Predictably, there are challenges regarding Mermaids, rogue medics and the political expectations of the national service. Perhaps more worrying are the manifestations of a number of splits within the team (not unusual) but I have been reported is quite potent: (a) team members feel they are coerced into not reporting safeguarding issues, and to do so is “trans phobic¹³”

¹⁰ <https://www.thetimes.co.uk/article/it-feels-like-conversion-therapy-for-gay-children-say-clinicians-pvsckdvq2>

¹¹ <https://www.thetimes.co.uk/article/therapist-raised-alert-at-troubling-practices-at-tavistock-clinic-nfhsbb76n>

¹² https://assets.publishing.service.gov.uk/media/6149eb48d3bf7f05ac396f79/Ms_S_Appleby_vs_Tavistock_and_Portman_NHS_Foundation_Trust.pdf

¹³ Paragraph 30 – Mrs S Appleby v The Tavistock and Portman NHS Foundation Trust 2204772/2019

- ii. Second protected disclosure, 13th November 2017, “(i) Dr W is still prescribing despite being apparently suspended by the GMC (ii) the culture within the service has created a dynamic, which makes it hard for staff to raise safeguarding concerns and this is compounded by staff being referred to as being transphobic (iii) the model of service delivery is not properly take into account that some children are referred within the context of significant familial adversity (iv) a worry that some young children are being actively encouraged to be transgender without effective scrutiny of their circumstances (v) some staff have raised concerns the service, which now has a referral rate of nearly 2000 referrals annually is bound to be seeing some children, who falsely protect [sic] presenting as being transgender as a less oppressive option than acknowledging they are gay. There is apparently no acceptable mechanism for discussing these phenomena within the team¹⁴”
- iii. In a meeting in March 2018 Mrs Appleby “remarked that if they were not careful a Jimmy Savile type situation could arise, adding, when he looked upset, that she did not mean there was child abuse, but rather, an institution turning a blind eye to what was in front of them.¹⁵”
- iv. May 15th, 2018 - Mrs Appleby “was approached by another worried GIDS staff member. The claimant reported their concerns to Dr Senior, listing patients’ limited understanding, the premature use of blockers, failure to address the fact that some children lived in homophobic environments, that some staff felt themselves unsafe in the group and were afraid to report these issues within the Trust, high caseloads, staff with anxiety symptoms, and concerns that the GIDS manager had no helpful model for the complexities of the work, nor understood the culture of discontent among the staff group.¹⁶”
- v. Mrs Appleby went on to outline how her serious concerns were silenced, ignored and resulted in pseudo disciplinary action taken

¹⁴ Paragraph 31 – Mrs S Appleby v The Tavistock and Portman NHS Foundation Trust 2204772/2019

¹⁵ Paragraph 42 – Mrs S Appleby v The Tavistock and Portman NHS Foundation Trust 2204772/2019

¹⁶ Paragraph 45 – Mrs S Appleby v The Tavistock and Portman NHS Foundation Trust 2204772/2019

against her involving a note being placed on her permanent file.

- g. December 1st, 2020 - Divisional court hands down judgment in *Bell v Tavistock* [2020] EWHC 3274 (Admin) expressing grave concern for record keeping, unexplained rise in female patients, prevalence of autism in patient cohort and obtaining of Gillick consent¹⁷.
- h. December 5th, 2020 - Dr David Bell faces disciplinary action for raising concerns following his report which *"included testimonies from ten clinicians, who warned that children with complex histories were being referred for puberty blockers and cross-sex hormones after a few sessions and without proper investigation of their cases. Children were being prescribed the experimental drugs under pressure from transgender rights groups"*¹⁸.
- i. January 20th, 2021 - The Care Quality Commission publishes a damning report on the GIDS rating the service as inadequate, citing safeguarding risks as one of many deficiencies.¹⁹
- j. June 20th, 2021 - a report that a gay psychologist who worked at GIDS speaking about his fears that the clinic was running *"conversion therapy for gay kids"*²⁰. This article records that Dr Matt Bristow *"said he was one of several gay members of staff at the clinic who felt concerned that patients' homosexuality – and the possibility that gay children were saying they wanted to change sex because they were being bullied – was ignored."*
- k. September 17th, 2021 - Appeal in *Bell v Tavistock* handed down with Lord Burnett CJ warning doctors that the obtaining of Gillick consent crucial and medical negligence actions likely to follow were this is not so secured²¹.
- l. November 23rd, 2021 - Dr Bell comments that "Girls who do not like pink ribbons or playing with dolls are being treated as transgender at the NHS Tavistock clinic.... With "proper" treatment, he believed many of the children would go on to be gay or lesbian and instead wants gender-focused treatment

¹⁷ <https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf>

¹⁸ <https://www.thetimes.co.uk/article/david-bell-tavistock-gender-clinic-whistleblower-faces-the-sack-rtkl09907>

¹⁹ <https://api.cqc.org.uk/public/v1/reports/7ecf93b7-2b14-45ea-a317-53b6f4804c24?20210120085141>

²⁰ <https://www.thetimes.co.uk/article/tavistock-gender-clinic-converting-gay-children-tz8cs77p3>

²¹ <https://www.judiciary.uk/judgments/bell-and-another-v-the-tavistock-and-portman-nhs-foundation-trust-and-others/>

to be scrapped with these issues looked at as part of general mental health support.²²

- m. February 2022, interim Cass reviews reports *"We have heard that some young people [...] are advised not to admit to previous abuse or trauma, or uncertainty about their sexual orientation...We have heard from young lesbians who felt pressured to identify as transgender male."*²³
- n. July 29th, 2022, it is reported that the *"Tavistock child gender clinic forced to close over safety fears"*²⁴ following the interim Cass report.
- o. July 30th, 2022, government minister Kemi Badenoch MP refers to events at GIDS in the following terms *"The Tavistock scandal shows the dangers of civil service groupthink"*²⁵
- p. August 11th, 2022, it is reported that 1000 families will join a medical negligence group litigation action against the Tavistock GIDS service, it is reported that *"This includes allegations it recklessly prescribed puberty blockers with harmful side effects and adopted an "unquestioning, affirmative approach" to children identifying as transgender"*²⁶.

²² <https://www.thetimes.co.uk/article/tavistock-clinic-treats-girls-who-dont-like-dolls-as-transgender-ffdz7kc00>

²³ <https://sex-matters.org/posts/updates/the-cass-reviews-interim-report-is-out/>

²⁴ <https://www.thetimes.co.uk/article/tavistock-child-gender-clinic-forced-to-close-over-safety-fears-2gfj325lt>

²⁵ <https://www.thetimes.co.uk/article/the-tavistock-scandal-shows-the-dangers-of-civil-service-groupthink-5bj2z26c7>

²⁶ <https://www.thetimes.co.uk/article/tavistock-gender-clinic-to-be-sued-by-1-000-families-lbsw6k8zd>

Appendix 2

What are “puberty blockers”?

“Puberty blockers’ is a marketing-friendly term for powerful drugs known medically as gonadotropin-releasing hormone agonists (GnRHa).

What do they do?

They block the production of sex hormones (androgens and oestrogens) by disrupting the natural signalling processes between the brain (the hypothalamus and pituitary gland) and the gonads.

What are they used for?

GnRHa are used to treat advanced prostate cancer, breast cancer, endometriosis, central precocious puberty (where a child shows signs of puberty before the age of 8 (female) or 9 (male), and to chemically castrate sex offenders.

Since the late 90s, GnRHa have also been experimented with to ‘pause puberty’ in minors experiencing psychological distress with their sex (gender dysphoria). GnRHa have never been licensed for the treatment of gender dysphoria anywhere in the world.

In the UK, the use of these drugs as ‘puberty blockers’ by the NHS does not come with regulatory approval as the appropriate safety studies are not available.

Do they reduce gender dysphoria?

In 2021 the UK National Institute for Health & Care Excellence (NICE) published a systemic evidence [review](#), concluding that ‘puberty blockers’ lead to little or no change in gender dysphoria.

The Health Research Authority has [raised concerns](#) that GnRHa may paradoxically result in the persistence of gender dysphoria – locking the patient in rather than helping them ‘buy time’ – which could be related to GnRHa halting critical brain development.

The Tavistock’s 2011 [Early Intervention Study](#) also indicates that GnRHa are not a temporary ‘pause button’ but rather the entry point to a lifelong medical pathway as 98% progressed to cross-sex hormones.

On the contrary, allowing natural puberty to occur helps to reduce or resolve gender dysphoria for the overwhelming majority of young people who may well grow up to simply be LGB (see page 6).

Dr Polly Carmichael, director of GIDS at The Tavistock, [commented](#) in 2015: "There were quite simplistic arguments that if you have the blocker all the problems disappear. In our experience all the problems do not go away."

Are they safe and / or reversible?

"The current evidence base does not support informed decision making and safe practice in children" – Carl Heneghan, Director Centre for Evidence-based Medicine (CEBM), [British Medical Journal](#) (2019).

International medical opinion, including the NHS, increasingly acknowledges the irreversible nature of the effects of 'puberty blockers' (physical and / or psychological), and urges caution over the many risks, medical unknowns and lack of evidence for their use.

Even in 2012 Professor Russell Viner, hormone specialist at The Tavistock, [stated](#) "We are dealing with the unknown," while Dr Polly Carmichael, Director of the Tavistock, stated in [2015](#) "The blocker is said to be completely reversible, which is disingenuous because nothing's completely reversible."

Changing medical opinion worldwide

In recent years, many national health authorities have revised their guidance on the use of GnRH analogues:

- UK, 2020: The NHS revises its online guidance, removing the text "The effects of treatment with GnRH analogues are considered to be fully reversible," and replacing it with "Little is known about the long-term side effects of puberty blockers in children..." and "It is not known what the psychological effects may be."
- Finland, 2020: The Finish Health Authority (Palko / COHERE) issues new guidelines stating psychotherapy should be first-line treatment, not 'puberty blockers'.
- Sweden, 2021: The Karolinska Institutet (Sweden), long considered the 'gold standard' in transgender healthcare, ends the use of 'puberty blockers' outside of research settings.

- US, 2021: Dr Marci Bowers, leading transgender surgeon and board member of The World Professional Association for Transgender Health (WPATH) states: "I'm not a fan of blockade at Tanner Stage 2* anymore, I really am not... Maybe we zigged a little too far left in some cases."
- Canada, 2021: Health Canada issues a warning that Lupron can lead to 'pseudotumor cerebri' in paediatric patients (pressure building inside the skull, resulting in headaches, blurred vision or vision loss).
- Sweden, 2022: Sweden's National Board of Health & Welfare issues a national policy update mirroring the Karolinska Institutet.
- France, 2022: France's National Academy of Medicine urges "the greatest caution" when administering GnRHa for gender dysphoria.
- US, 2022: the FDA adds a warning to the labelling of GnRHa. The warning applies specifically to their use in disrupting puberty and informs users of the risk of brain swelling and vision loss.
- New Zealand, 2022: The Ministry of Health withdraws its advice that "Puberty blockers are a safe and fully reversible medicine."

Potential Risks / effects

Among the potential risks or adverse effects associated with GnRHa drugs are:

- Short term: headaches, hot flushes, weight gain, tiredness, low mood and anxiety, reduction in bone density, bone fractures, blurred vision, vision loss.
- The Karolinska Institutet (Sweden) has also reported liver damage, unexplained weight gains, mental health problems, spinal fractures, osteopenia, and failure to grow.
- Increase in behavioural and emotional problems in girls, including an increase in wanting to "deliberately try to hurt or kill self."
- Loss of fertility / sterilisation as gametes won't develop.
- Loss of sexual function and capacity to orgasm: young people given GnRHa at Tanner Stage 2 who go onto cross-sex hormones will remain 'orgasmically naïve' which may impact their ability to enjoy intimate relationships.

- Level of puberty resumption after GnRHa use is stopped: unknown.
- Effects on brain development: unknown. Concerns raised about negative impact on IQ, long-term spatial awareness, reaction time and missing out on a window for critical cognitive development.

Alternative treatment options

- Psychotherapy / psychoanalysis / group therapy / parent-counselling:
 - Sweden, Finland and France emphasised the need for psychotherapy when ending / restricting their use of 'puberty blockers' or urging caution
- Natural puberty: WPATH [recognise](#) that the overwhelming majority of young people experiencing gender dysphoria will desist as they go through natural puberty:
 - 77% - 94% in a boys-only study, with most likely to be gay
 - 73% - 88% in a mixed-sex study