

CHAPTER 2023-90

Committee Substitute for Senate Bill No. 254

An act relating to treatments for sex reassignment; amending s. 61.517, F.S.; granting courts of this state temporary emergency jurisdiction over a child present in this state if the child has been subjected to or is threatened with being subjected to sex-reassignment prescriptions or procedures; amending s. 61.534, F.S.; providing that, for purposes of warrants to take physical custody of a child in certain child custody enforcement proceedings, serious physical harm to the child includes, but is not limited to, being subjected to sex-reassignment prescriptions or procedures; creating s. 286.31, F.S.; defining the term “governmental entity”; prohibiting certain public entities from expending state funds for the provision of sex-reassignment prescriptions or procedures; amending s. 456.001, F.S.; defining the terms “sex” and “sex-reassignment prescriptions or procedures”; creating s. 456.52, F.S.; prohibiting sex-reassignment prescriptions and procedures for patients younger than 18 years of age; providing an exception; requiring the Board of Medicine and the Board of Osteopathic Medicine to adopt certain emergency rules within a specified timeframe; requiring the boards to consider specified factors in developing such rules; requiring that such prescriptions and procedures for patients older than 18 years of age be prescribed, administered, or performed only with the voluntary and informed consent of the patient; providing criteria for what constitutes voluntary and informed consent; providing that only a physician may prescribe, administer, or perform such prescriptions and procedures; defining the term “physician”; providing applicability; providing for disciplinary action; providing criminal penalties; requiring the Board of Medicine and the Board of Osteopathic Medicine to adopt certain emergency rules; providing that such emergency rules remain in effect until they are replaced by nonemergency rules; amending s. 456.074, F.S.; requiring the department to immediately suspend the license of a health care practitioner who is arrested for committing or attempting, soliciting, or conspiring to commit specified violations related to sex-reassignment prescriptions or procedures for a patient younger than 18 years of age; creating s. 766.318, F.S.; creating a cause of action to recover damages for personal injury or death resulting from the provision of sex-reassignment prescriptions or procedures to a minor; providing that certain limitations on punitive damages do not apply to such actions; specifying the timeframe within which such actions may be commenced; providing construction and applicability; providing severability; providing a directive to the Division of Law Revision; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (1) of section 61.517, Florida Statutes, is amended to read:

61.517 Temporary emergency jurisdiction.—

(1) A court of this state has temporary emergency jurisdiction if the child is present in this state and:

(a) The child has been abandoned; or

(b) It is necessary in an emergency to protect the child because the child, or a sibling or parent of the child, is subjected to or threatened with mistreatment or abuse; or

(c) It is necessary in an emergency to protect the child because the child has been subjected to or is threatened with being subjected to sex-reassignment prescriptions or procedures, as defined in s. 456.001.

Section 2. Subsection (1) of section 61.534, Florida Statutes, is amended to read:

61.534 Warrant to take physical custody of child.—

(1) Upon the filing of a petition seeking enforcement of a child custody determination, the petitioner may file a verified application for the issuance of a warrant to take physical custody of the child if the child is likely to imminently suffer serious physical harm or removal from this state. Serious physical harm includes, but is not limited to, being subjected to sex-reassignment prescriptions or procedures as defined in s. 456.001.

Section 3. Section 286.31, Florida Statutes, is created to read:

286.31 Prohibited use of state funds.—

(1) As used in this section, the term “governmental entity” means the state or any political subdivision thereof, including the executive, legislative, and judicial branches of government; the independent establishments of the state, counties, municipalities, districts, authorities, boards, or commissions; and any agencies that are subject to chapter 286.

(2) A governmental entity, a public postsecondary educational institution as described in s. 1000.04, the state group health insurance program, a managing entity as defined in s. 394.9082, or a managed care plan providing services under part IV of chapter 409 may not expend state funds as described in s. 215.31 for sex-reassignment prescriptions or procedures as defined in s. 456.001.

Section 4. Subsections (8) and (9) are added to section 456.001, Florida Statutes, to read:

456.001 Definitions.—As used in this chapter, the term:

(8) “Sex” means the classification of a person as either male or female based on the organization of the human body of such person for a specific reproductive role, as indicated by the person’s sex chromosomes, naturally

occurring sex hormones, and internal and external genitalia present at birth.

(9)(a) “Sex-reassignment prescriptions or procedures” means:

1. The prescription or administration of puberty blockers for the purpose of attempting to stop or delay normal puberty in order to affirm a person’s perception of his or her sex if that perception is inconsistent with the person’s sex as defined in subsection (8).

2. The prescription or administration of hormones or hormone antagonists to affirm a person’s perception of his or her sex if that perception is inconsistent with the person’s sex as defined in subsection (8).

3. Any medical procedure, including a surgical procedure, to affirm a person’s perception of his or her sex if that perception is inconsistent with the person’s sex as defined in subsection (8).

(b) The term does not include:

1. Treatment provided by a physician who, in his or her good faith clinical judgment, performs procedures upon or provides therapies to a minor born with a medically verifiable genetic disorder of sexual development, including any of the following:

a. External biological sex characteristics that are unresolvably ambiguous.

b. A disorder of sexual development in which the physician has determined through genetic or biochemical testing that the patient does not have a normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a male or female, as applicable.

2. Prescriptions or procedures to treat an infection, an injury, a disease, or a disorder that has been caused or exacerbated by the performance of any sex-reassignment prescription or procedure, regardless of whether such prescription or procedure was performed in accordance with state or federal law.

3. Prescriptions or procedures provided to a patient for the treatment of a physical disorder, physical injury, or physical illness that would, as certified by a physician licensed under chapter 458 or chapter 459, place the individual in imminent danger of death or impairment of a major bodily function without the prescription or procedure.

Section 5. Section 456.52, Florida Statutes, is created to read:

456.52 Sex-reassignment prescriptions and procedures; prohibitions; informed consent.—

(1) Sex-reassignment prescriptions and procedures are prohibited for patients younger than 18 years of age, except that:

(a) The Board of Medicine and the Board of Osteopathic Medicine shall, within 60 days after the effective date of this act, adopt emergency rules pertaining to standards of practice under which a patient younger than 18 years of age may continue to be treated with a prescription consistent with those referenced under s. 456.001(9)(a)1. or 2. if such treatment for sex reassignment was commenced before, and is still active on, the effective date of this act. In developing rules under this paragraph, the boards shall consider requirements for physicians to obtain informed consent from such patient's parent or legal guardian, consistent with the parameters of informed consent under subsections (2) and (4), for such prescription treatment, and shall consider the provision of professional counseling services for such patient by a board-certified psychiatrist licensed under chapter 458 or chapter 459 or a psychologist licensed under chapter 490 in conjunction with such prescription treatment.

(b) A patient meeting the criteria of paragraph (a) may continue to be treated by a physician with such prescriptions according to rules adopted under paragraph (a) or nonemergency rules adopted under paragraph (6)(b).

(2) If sex-reassignment prescriptions or procedures are prescribed for or administered or performed on patients 18 years of age or older, consent must be voluntary, informed, and in writing on forms adopted in rule by the Board of Medicine and the Board of Osteopathic Medicine. Consent to sex-reassignment prescriptions or procedures is voluntary and informed only if the physician who is to prescribe or administer the pharmaceutical product or perform the procedure has, at a minimum, while physically present in the same room:

(a) Informed the patient of the nature and risks of the prescription or procedure in order for the patient to make a prudent decision;

(b) Provided the informed consent form, as adopted in rule by the Board of Medicine and the Board of Osteopathic Medicine, to the patient; and

(c) Received the patient's written acknowledgment, before the prescription or procedure is prescribed, administered, or performed, that the information required to be provided under this subsection has been provided.

(3) Sex-reassignment prescriptions or procedures may not be prescribed, administered, or performed except by a physician. For the purposes of this section, the term "physician" is defined as a physician licensed under chapter 458 or chapter 459 or a physician practicing medicine or osteopathic medicine in the employment of the Federal Government.

(4) Consent required under subsection (2) does not apply to renewals of prescriptions consistent with those referenced under s. 456.001(9)(a)1. and

2. if a physician and his or her patient have met the requirements for consent for the initial prescription or renewal. However, separate consent is required for any new prescription for a pharmaceutical product not previously prescribed to the patient.

(5)(a) Violation of this section constitutes grounds for disciplinary action under this chapter and chapter 458 or chapter 459, as applicable.

(b) Any health care practitioner who willfully or actively participates in a violation of subsection (1) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Any health care practitioner who violates subsection (2), subsection (3), or subsection (4) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(6)(a) The Board of Medicine and the Board of Osteopathic Medicine shall adopt emergency rules to implement this section.

(b) Any emergency rules adopted under this section are exempt from s. 120.54(4)(c) and shall remain in effect until replaced by rules adopted under the nonemergency rulemaking procedures of the Administrative Procedure Act.

Section 6. Present paragraphs (c) through (gg) of subsection (5) of section 456.074, Florida Statutes, are redesignated as paragraphs (d) through (hh), respectively, and a new paragraph (c) is added to that subsection, to read:

456.074 Certain health care practitioners; immediate suspension of license.—

(5) The department shall issue an emergency order suspending the license of any health care practitioner who is arrested for committing or attempting, soliciting, or conspiring to commit any act that would constitute a violation of any of the following criminal offenses in this state or similar offenses in another jurisdiction:

(c) Section 456.52(5)(b), relating to prescribing, administering, or performing sex-reassignment prescriptions or procedures for a patient younger than 18 years of age.

Section 7. Section 766.318, Florida Statutes, is created to read:

766.318 Civil liability for provision of sex-reassignment prescriptions or procedures to minors.—

(1) A cause of action exists to recover damages for personal injury or death resulting from the provision of sex-reassignment prescriptions or procedures, as defined in s. 456.001, to a person younger than 18 years of age which are prohibited by s. 456.52(1).

(2) The limitations on punitive damages in s. 768.73(1) do not apply to actions brought under this section.

(3) An action brought under this section:

(a) May be commenced within 20 years after the cessation or completion of the sex-reassignment prescription or procedure.

(b) Is in addition to any other remedy authorized by law.

(4) The cause of action created by this section does not apply to:

(a) Treatment with sex-reassignment prescriptions if such treatment is consistent with s. 456.001(9)(a)1. or 2. and was commenced on or before, and is still active on, the effective date of this act.

(b) Sex-reassignment prescriptions or procedures that were ceased or completed on or before the effective date of this act.

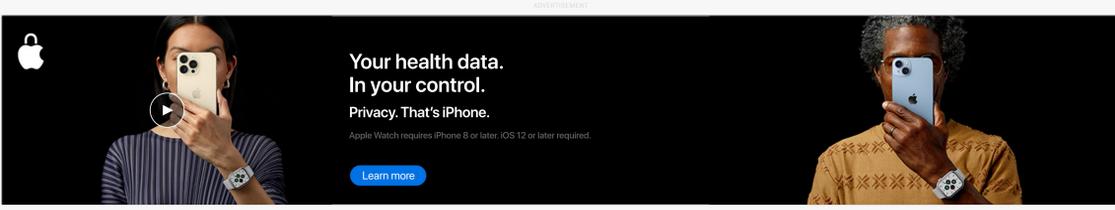
Section 8. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 9. The Division of Law Revision is directed to replace the phrase “the effective date of this act” wherever it occurs in this act with the date this act becomes a law.

Section 10. This act shall take effect upon becoming a law.

Approved by the Governor May 17, 2023.

Filed in Office Secretary of State May 17, 2023.



Britain Limits Use of Puberty-Blocking Drugs to Research Only

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By Azeen Ghorayshi

June 9, 2023, 4:40 p.m. ET

The News

Britain's National Health Service announced on Friday that it would [limit the use of puberty-suppressing drugs](#) to children enrolled in clinical trials. The change comes as the agency's pediatric gender services have struggled to keep up with soaring demand.

A document explaining the N.H.S.'s reasoning [stated that](#) "there is not enough evidence to support their safety or clinical effectiveness as a routinely available treatment."

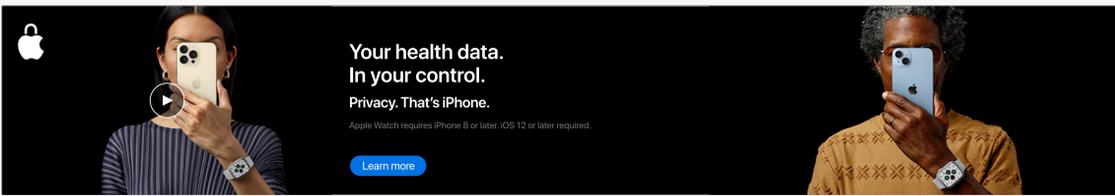
The N.H.S. had released a draft of this policy change in October, but Friday's announcement formally instituted the new approach after months of public comment. The policy will go into effect later this year.



The N.H.S. announced last year it would shut down the Tavistock Gender Identity Development Service in London after the clinic saw a sharp rise of referrals. Peter Nicholls/Reuters

Why It Matters: Other countries have limited the drugs, too

The change is part of a broader push in several countries to limit gender-related medical treatments for young people.



After conducting evidence reviews, Finland has begun limiting who can access gender-related treatments and Sweden has restricted the use of puberty blockers and hormones to clinical trials. A [Norwegian health body](#) and the [French National Academy of Medicine](#) have also urged caution.

More on Britain

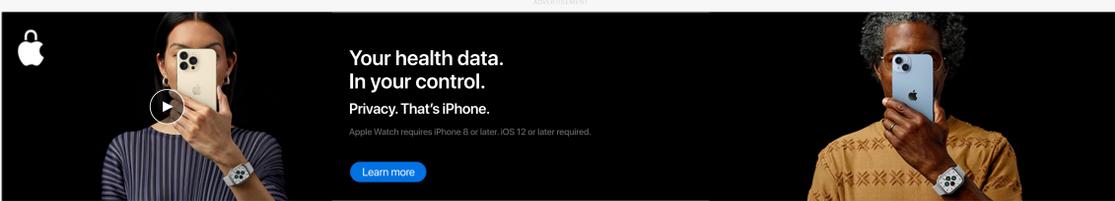
- **For-Profit Colleges:** Operating in an opaque corner of the British education system, Oxford Business College and others like it [are making millions](#), largely by recruiting immigrants.
- **Economic Woes:** [Boris Johnson's misadventures](#) still haunt Prime Minister Rishi Sunak. But it is the ghost of his predecessor, Liz Truss, that should keep him up at night, [economists say](#).
- **Sexual Harassment Case:** A British reporter had been investigating claims that a star columnist had sexually harassed women. Then her editor [decided to kill the story](#).
- **Swarming Season:** The time of the year when honeybee colonies split in half in search of new homes has begun. But an unusually high number of swarm sightings is [sending beekeepers scrambling](#).

In the United States, more than [20 Republican-led states](#) have passed laws banning the use of puberty-blocking drugs and hormones, with some making it a felony for doctors to prescribe them. Hundreds of clinicians across the country — including some who have [raised concerns](#) about which adolescents should receive gender-related treatments — have [denounced the bans](#), saying such decisions should be made by patients, their families and their doctors.

Background: Data on the effect of blockers is sparse

Last year, the N.H.S. announced that it would be shutting down the country's only youth gender clinic after an external review showed that the Tavistock Gender Identity Development Service had been unable to provide appropriate care for the rapidly increasing number of adolescents seeking gender treatments. The clinic had seen a sharp rise in referrals, from 250 young people in 2011 to 5,000 in 2021.

Puberty blockers, which work by suppressing estrogen and testosterone, were first tested on children with gender dysphoria in the Netherlands in the 1990s. The Dutch researchers published their [first study](#) on 70 children in 2011, finding that the adolescents reported a decrease in depression and anxiety after taking the drugs.



But a British study of Tavistock patients [published in 2021](#) showed that blockers had no effect on children's scores on psychological tests. The study found that 43 out of the 44 participants later chose to start testosterone or estrogen treatments. One interpretation of the data is that all were good candidates for hormone therapy. But the numbers raised concerns at the N.H.S. about whether the drugs served their intended purpose of giving adolescents time to think.

"The most difficult question is whether puberty blockers do indeed provide valuable time for children and young people to consider their options, or whether they effectively 'lock in' children and young people to a treatment pathway," Dr. Hilary Cass, the pediatrician overseeing the independent review of the N.H.S. gender service, [wrote last year](#).

What's Next: Britain will start a trial of children taking blockers

The N.H.S. is organizing a clinical trial for all children receiving puberty blockers from the health service, which it expects will begin enrollment in 2024.

Although the Tavistock clinic has been closed, regional centers are opening across Britain to expand gender-related services for young people. The N.H.S. said that the new system for treating minors with gender-related issues will establish standardized assessments and incorporate much more mental health support.

"The main objective is to alleviate distress associated with gender incongruence and promote the individual's global functioning and well-being," the N.H.S. guidance said.

Azeen Ghorayshi covers the intersection of sex, gender and science for The Times.

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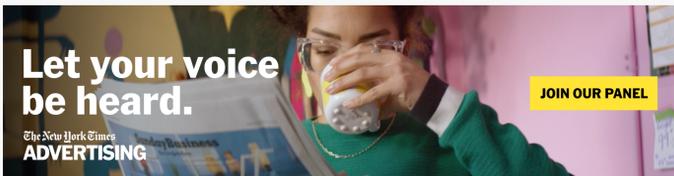
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Consultation report for the interim service specification for specialist gender incongruence services for children and young people

9 June 2023

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1. Background

In September 2020, NHS England commissioned an independent and wide-ranging expert review of gender identity services for children and young people. The Independent Review, which is ongoing, is being led by Dr Hilary Cass, past president of the Royal College of Paediatrics and Child Health. It was established in response to a complex and diverse range of issues including:

1. **A significant and sharp rise in referrals**

In 2021/22 there were over 5,000 referrals into the Gender Identity Development Service (GIDS) run by the Tavistock and Portman NHS Foundation Trust. This compares to just under 250 referrals in 2011/12.

2. **Marked changes in the types of patients being referred which are not well understood**

There has been a dramatic change in the case-mix of referrals from predominantly natal males to predominantly natal females presenting with gender incongruence in early teen years. Additionally, a significant number of children are also presenting with neurodiversity and other mental health needs and risky behaviours which requires careful consideration and needs to be better understood.

3. **Scarce and inconclusive international evidence to support clinical decision making**

This has led to a lack of clinical consensus and polarised opinion on what the best model of care for children and young people experiencing gender incongruence and dysphoria should be; and a lack of evidence to support families in making informed decisions about interventions that may have life-long consequences.

4. **Long waiting times for initial assessment and significant external scrutiny and challenge surrounding the clinical approach and operational capacity at GIDS**

This has all contributed to the service provided by the Tavistock and Portman NHS Foundation Trust being unable to meet the scale of rising demand and provide the level of appropriate care.

Next steps

In February 2022, the Independent Review published an [interim report](#) in which she set out initial findings and advice from her Review. She emphasised the need to move away from the current model of a sole provider and to establish regional services that work to a new clinical model that can better meet the holistic needs of a vulnerable group of children

and young people. She began to describe the need for these new services to work as networked centres that connected with other local services including children and young people's mental health services and primary care to support all a patient's clinical needs.

In July 2022, the Independent Review sent further advice on the core components of this model. You can [read the advice in full here](#).

In summary, she said:

- 'Regional centres should be led by experienced providers of tertiary paediatric care to ensure a focus on child health and development, with strong links to mental health services. These will generally be specialist children's hospitals.
- 'They should have established academic and education functions to ensure that ongoing research and training is embedded within the service delivery model'.
- 'The services should have an appropriate multi-professional workforce to enable them to provide an integrated model of care that manages the holistic needs of this population'.
- 'Staff should maintain a broad clinical perspective to embed the care of children and young people with gender uncertainty within a broader child and adolescent health context'.

Establishing Phase 1 service providers

Following the further advice the Independent Review provided in July 2022, NHS England set out plans for how it would start building a more resilient service by expanding provision and enhancing the focus on quality in terms of clinical effectiveness, safety, and patient experience. These plans were welcomed and supported by the Tavistock and Portman NHS Foundation Trust.

The first phase in these plans is to establish two new nationally networked services which, consistent with advice from the Independent Review, will be led by specialist children's hospitals.

These Phase 1 service providers will take over clinical responsibility for seeing children and young people on the national waiting list as well as providing continuity of care for the GIDS open caseload at the point of transfer. The Tavistock GIDS service itself will be decommissioned as part of a managed transition of the service to the new Phase 1 service providers.

One service – The Southern Hub – is being formed through a partnership between Great Ormond Street Hospital, Evelina London Children’s Hospital (part of Guy’s and St Thomas’ NHS Foundation Trust) and South London and Maudsley NHS Foundation Trust.

The other service – The Northern Hub – is being formed through a partnership between Alder Hey Children’s NHS Foundation Trust and the Royal Manchester Children’s Hospital (part of Manchester University NHS Foundation Trust).

These new services will be commissioned against a new, interim service specification. The draft specification- which is the subject of this consultation- was developed by a clinically led Specification Working Group chaired by the NHS National Medical Director for Specialised Services and comprised of senior clinicians with expertise in gender incongruence, mental health and neurodiversity in children and young people, safeguarding and paediatric medicine.

NHS National Medical Director for Specialised Services
and senior clinicians with expertise in
– gender incongruence
– mental health
– neurodiversity
– safeguarding
– paediatrics

2. How we consulted

The public consultation on this draft interim service specification ran on the NHS England consultation website for 45 days from 20 October to 4 December 2022. It received 5,183 responses in total. NHS England thanks all those individuals and organisations who submitted responses to consultation.

NHS England commissioned [TONIC](#) - an independent organisation specialising in public consultation, social research and evaluation - to conduct analysis on all responses and report back on these findings. Their detailed analysis of the responses can be found on the [consultation page](#).

During the consultation period, NHS England actively engaged with individuals, organisations and services who were most likely to be directly affected by the proposed changes, including patient groups, Royal Colleges, professional bodies, as well as some of the current patients and parents of patients within the GIDS. These groups were invited to virtual meetings and discussion groups throughout the course of the consultation period with the aims of:

1. increasing awareness about the constitution,
2. clarifying our proposals,
3. listening to the early thoughts and feedback and
4. encouraging a formal, written response.

3. How has feedback at consultation been considered?

The Specification Working Group considered the report of the independent analysis of consultation responses.

The consultation asked the following questions:

- To what extent do you agree with the four substantive changes to the service specification?
 - Composition of the clinical team
 - Clinical leadership
 - Collaboration with referrers and local services
 - Referral sources
- To what extent do you agree that the interim service specification provides sufficient clarity about approaches towards social transition?
- To what extent do you agree with the approach to the management of patients accessing prescriptions from un-regulated sources?
- 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?
- 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?

The following sections outline how our consideration of consultation feedback has informed the final version of the interim service specification.

Composition of the clinical team

The current service specification for the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust describes a service that is delivered through a specialist multidisciplinary team with contributions from specialist social workers, family therapists, psychiatrists, psychologists, psychotherapists, paediatric and adolescent endocrinologists and clinical nurse practitioners. The new interim service specification proposed 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, neurodisability and mental health.

Rather than purely focused on gender specialists, it will now include them, but add specialists in pediatrics, autism, neurodiversity, and mental health

The majority of respondents (53%) agreed or partially agreed with this proposal, while 38% disagreed or partially disagreed. A large portion of the objections to this proposal suggested that it would further increase waiting times.

The purpose of the proposed change is to improve the timely provision of appropriate integrated support for children and young people with co-presentations, while addressing concerns expressed by the Care Quality Commission in 2021 that **the current service does not always include the full range of clinical specialists to meet the individual needs of patients. NHS England has therefore retained this change to the final version of the interim service specification.**

Clinical leadership

Will be headed by pediatric medical doctor, and not an experienced expert in gender dysphoria

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

A narrow majority (49%) of respondents agreed or partially agreed with this proposal, while 41% disagreed or partially disagreed. Most comments on this proposal highlighted the need to ensure that **the clinical lead should be an experienced expert in gender dysphoria. Many respondents also said that this proposed change pathologises gender dysphoria.**

NHS England views this change as being consistent with the recommendations of the Independent Review, particularly in the context of these services being hosted by tertiary paediatric units (specialist children's hospitals), in that **it brings this service in line with other multi-disciplinary models of care across paediatric medicine. However, NHS England acknowledges that an alternative view has been expressed during the public consultation, namely that it is not only medical doctors who are suitably qualified to oversee integrated clinical teams with a broad range of clinical disciplines. Therefore, while NHS England will retain this change in the interim service specification at present, we will keep this position under review and the experience and learning from the Phase 1 providers will inform whether there is a need to retain the requirement for a medical professional to lead the service in the longer-term substantive service specification that will be developed once the Independent Review has delivered its final advice to NHS England later in 2023/24.**

Collaboration with referrers and local services

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.

The new interim service specification proposed 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. It described that a referral to The Service will require a consultation meeting between the Phase 1 provider and the relevant local secondary healthcare team and / or the GP. The interim service specification proposed that 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 be 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.

There were significantly mixed views on this proposal, but a narrow majority (47%) of respondents disagreed or partially disagreed with the proposed changes. Many respondents viewed this change as "gatekeeping" and expressed concerns around increasing waiting times for the service. As a result of the feedback received, NHS England has decided to form a separate service specification that will describe the process for making referrals onto the national waiting list that will be held by NHS Arden & GEM Commissioning Support Unit (until the new regional services are established), including the relationship with referrers and local professionals at the point of referral. NHS England will begin the engagement process on this draft service specification and its associated Equality and Health Inequalities Impact Assessment later this summer (2023).

Referral sources

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 proposed that referrals may be made by GPs and NHS professionals only. The reason for the proposal was 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 the referral is made to the specialist service. Around 65% of referrals into GIDS are currently made by GPs and around 30% are made by NHS professionals.

The majority of respondents (57%) disagreed or partially disagreed with this proposed change. Several respondents felt that insufficient information had been included in the interim service specification to be able to make an informed decision, and to understand exactly how the new referral procedure would work.

As a result of this feedback, NHS England has decided to form a separate service specification that will describe in greater detail the process for making referrals onto the national waiting list that will be held by NHS Arden & GEM Commissioning Support Unit (until the new regional services are established), including referral sources. NHS England will begin the engagement process on this draft service specification and its associated Equality and Health Inequalities Impact Assessment later this summer (2023).

Clarity on approaches towards social transition

The new interim service specification proposed greater clarity on the clinical approach to social transition. It stated that the clinical approach 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.

The majority of respondents (67%) did not agree that the draft interim service specification provided sufficient clarity about approaches towards social transition and / or disagreed with the proposed position. Various issues were raised including the reference to the previous version of WPTAH's standards of care which were updated shortly before the consultation launch, the need for a definition of social transition and describing exactly what the role of the NHS service should be in decision-making around social transition.

Evidence

Several respondents suggested that NHS England had relied on out-of-date evidence to form the conclusion that in most cases gender incongruence or gender variance that presents in pre-pubertal children does not persist in adolescence. At the time of drafting the interim service specification, this conclusion was shared by various bodies in their

published guidelines, including the Endocrine Society’s Clinical Practice Guidelines and the World Professional Association for Transgender Health (WPATH) standards of care (Version 7) which said that “*in most children, gender dysphoria will disappear before or early in puberty*”. NHS England’s position was therefore consistent at the time with various professional societies. Since the interim service specification was drafted, some bodies including WPATH have refined their position on this issue. The WPATH standards of care were updated to version 8 in September 2022. While WPATH agrees that gender incongruence will be transient and will not persist into adolescence for some children, it no longer quantifies whether this will occur in the majority or minority of such children.

NHS England has re-framed this section of the final version of the interim service specification to reflect the advice set out in the consultation response received from the Independent Review. The Review’s submission agreed that pre-pubertal children have different needs to older adolescents, and advised NHS England that the detail of the approaches for the different pathways will need to develop as the new services evolve and an evidence base is built.

On the issue of building the evidence base, some respondents suggested that clinical recommendations for the support of pre-pubescent children in particular may need to be developed independently for natal boys and for natal girls, as the presentation of gender incongruence is different and different factors are predictive for the persistence of gender incongruence. Of the evidence that does exist, evidence relating to children and young people who present with a non-binary presentation is lacking. Respondents advised NHS England that young people, their parents and health professionals involved in their care should be informed about the nature and limitations of the evidence base.

What is meant by ‘social transition’?

Many respondents objected to what they perceived to be attempts to prevent a child or young person’s approach to social transition and questioned how this could be achieved in practice. In response to these views, we have amended the final version of the interim service specification to clarify that the reference to ‘social transition’ is intended to refer to an active form of support offered by NHS clinicians to children, young people and their families who have decided that the child or young person will fully present in public with a gender identity different to that of their natal sex in all forms and aspects of their daily lives – rather than less profound forms of gender diverse expressions, behaviours or interests such as engaging in activities or presentations socially defined and typically associated with another gender presentation. We have also added clarification that while the ability to express individuality – and to change and adapt that expression over time - can be important to a child or young person’s development of the self and to their overall

wellbeing, it is important to view social transition as an active intervention when it forms part of a managed individual care plan because it may have significant effects on the child or young person in terms of their social and psychological functioning. While there are different views on the benefits versus the harms of early social transition, it is important to acknowledge that it is not a neutral act - and that better information is needed about outcomes. Decisions will be individual, and the agency to make the decision will ultimately rest with the young person, along with their family.

Management of patients accessing prescriptions from un-regulated sources

The draft interim service specification clarified the position in regard to children and young people who source prescriptions or drugs from unregulated sources or unregulated providers. It stated that children, young people and their families are strongly discouraged from sourcing GnRHa and masculinising / feminising hormones from unregulated sources or from on-line providers that are not regulated by UK regulatory bodies. It was proposed that in such cases The Service would make the child or young person and their family aware of the risks, contraindications and any irreversible or partly reversible effects and would advise the GP to initiate local safeguarding protocols.

The majority of respondents (63%) disagreed or partially disagreed with these proposed changes. Many respondents argued that people use unregulated drugs because waiting times are so long, and that the proposed changes run contrary to the NHS' overarching duty of care to patients and are potentially coercive and punitive.

NHS England has retained its position on the risks and dangers of sourcing GnRHa and hormones from unregulated sources, but in response to feedback we have amended the final version of the interim service specification to;

1. set out criteria that will be applied by the Service (jointly with the endocrine team) to consider whether it is clinically appropriate to assume clinical responsibility under NHS protocols for children and young people in this situation; and
2. refined the proposed approach for initiation of safeguarding protocols, using language proposed by the Royal College of General Practitioners in its response to public consultation.