Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	This data accords with figures published by the Cass Review in March 2022 show a trend since 2011 in which the number of natal females is higher than the number of natal males being referred. Prior to that the split in the caseload was roughly even between natal girls and natal boys, but by 2019 the split had changed so that 76% per cent of referrals were natal females. That change in the proportion of natal girls to boys is reflected in the statistics from the Netherlands (Brik et al "*Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria*" 2018). The proposals may disproportionately impact individuals who are natal female based on this data, but NHS England has concluded that no discrimination arises. Some respondents to consultation felt that the previous EHIA could have more thoroughly addressed the potential impact on those with the protected characteristic of sex – particularly the impacts on girls who, as recent statistics showed, were now much more likely to seek treatment from gender dysphoria services than boys. The report on the independent analysis of consultation responses reads: "*NHS England was encouraged to investigate and publicise the degree to*	*disproportionately been of natal females, and the implications of these matters".* The Cass Review will deliver final advice to NHS England in 2023/24. The service specification sets out a model of care that will be holistic, multi-disciplinary and will take an integrated approach to assessing and responding to an individual's needs and will recognise the range of co-presentations that may present in this patient cohort. By ensuring detailed and individual assessments and addressing the most appropriate clinical pathway in the best interest of the child or young person, the specification will increase the likelihood of having a positive impact on those referred to the service who have the protected characteristic of sex, irrespective of whether they were registered female or male at birth. NHS England's proposed interim service specification for a new

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	which possible causations such as internalised homophobia, exposure to social media, trauma, bullying, difficulties in navigating bodily changes at puberty, experiencing sexual objectification, familial and social situations and social contagion had played a part in this trend".	configuration of providers describes the importance of building research capabilities for the purpose of continuous quality improvement initiatives. Also, in 2019 the Government Equalities Office announced that it would commission new research to explore the nature of adolescent gender identity and transitioning to better understand the issues behind the increasing trend of referrals of adolescents, particularly natal females, to NHS gender dysphoria services. Working with the new configuration of service providers and academic partners, NHSE will consider how to use the outcome of this research to inform its future approach to the commissioning of these services.
Sexual orientation: Lesbian; Gay; Bisexual; Heterosexual.	We do not hold data on the sexual orientation of individuals who are referred to or seen by the NHS commissioned service. A large UK-wide study in 2012 (Trans Mental Health Study) reported the following:	NHS England's proposed interim service specification for a new configuration of providers describes the importance of routine and consistent data collection, analysis and

<table>
<tr><th>Protected characteristic groups</th><th>Summary explanation of the main potential positive or adverse impact of your proposal</th><th>Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact</th></tr>
<tr><td></td><td>
<table>
<tr><th>Sexual Orientation</th><th>N</th><th>Percentage</th></tr>
<tr><td>Bisexual</td><td>145</td><td>27%</td></tr>
<tr><td>Queer</td><td>126</td><td>24%</td></tr>
<tr><td>Straight or heterosexual</td><td>104</td><td>20%</td></tr>
<tr><td>Pansexual</td><td>79</td><td>15%</td></tr>
<tr><td>BDSM/Kink</td><td>73</td><td>14%</td></tr>
<tr><td>Lesbian</td><td>69</td><td>13%</td></tr>
<tr><td>Not sure or questioning</td><td>64</td><td>12%</td></tr>
<tr><td>Other</td><td>59</td><td>11%</td></tr>
<tr><td>Don’t define</td><td>55</td><td>10%</td></tr>
<tr><td>Gay</td><td>51</td><td>10%</td></tr>
<tr><td>Polyamorous</td><td>46</td><td>9%</td></tr>
<tr><td>Asexual</td><td>41</td><td>8%</td></tr>
<tr><td>Total</td><td>912</td><td></td></tr>
</table>
<p>The 2021 census reported that 89.4% of the UK population (16+years) identified as straight or heterosexual, which is a marked variation to the findings of the above survey in 2021 (20%). It is unclear as to the extent to which these data can be extrapolated for the purpose of this EHIA, but it may be reasonable to surmise that there is likely to be a lower percentage of children and young people who are referred to a gender</p>
</td><td>
<p>reporting. We expect providers to report demographic data for the purpose of continuous service improvement initiatives, including to identify whether any particular groups are experiencing barriers in access to service provision.</p>
<p>The specification also sets out the requirement for the service to have evidence of engagement with children, young people and families in design and review of the service which will be an opportunity to address any inequalities and better understand and mitigate against any negative impact on young people referred to the service who have the protected characteristic of sexual orientation.</p>
<p>The standardised assessment process that is detailed in the service specification details the requirement to consider sexual orientation, psychosexual development and any sexual experiences of adolescents referred to the service will ensure that</p>
</td></tr>
</table>

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	incongruence service who identify / will identify as straight or heterosexual than for the general population. It is not possible to extrapolate these data to the gender diverse children and young people referred to the service and NHS England has concluded that there is insufficient evidence to determine if a particular group or cohort will be disproportionately impacted by the proposals. The independent report on the analysis of responses to NHS England's public consultation on a proposed interim service specification for gender incongruence services for children and young people (2023) reads that some respondents were of the view that "*the protected characteristic of sexual orientation had not been sufficiently addressed in the Equalities and Health Inequalities Impact Assessment due to their belief that gender dysphoria services have disproportionately impacted on homosexual or bisexual children and young people in the past*".	the service should increase the likelihood of having a positive impact on those referred to the service who have the protected characteristic of sexual orientation. The service specification sets out the workforce requirement of ensuring that the MDT includes practitioners with expertise in childhood and adolescent development, including sexual development which will also have a positive impact on those young people referred to the service who have the protected characteristic of sexual orientation. NHS England's proposed interim service specification also describes the importance of building research capabilities for the purpose of continuous quality improvement initiatives. Working with the new configuration of service providers and academic partners, NHSE will consider how to use the outcome of this

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
		research to inform its future approach to the commissioning of these services. The Cass Review has said that in forming further advice to NHS England it is considering further the complex interaction between sexuality and gender identity, and societal responses to both – the Review's Interim Report (2022) cited the example of "*young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as lesbian rather than transgender*".

4. Main potential positive or adverse impact for people who experience health inequalities summarized

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). Please state **N/A if your proposal will not impact on patients who experience health inequalities.**

Groups who face health inequalities[11]	**Summary explanation of the main potential positive or adverse impact of your proposal**	**Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact**
Looked after children and young people	There is an over-representation percentage wise (compared to the national percentage) of looked after children seen by services for children and young people with gender incongruence[12].	NHS England's proposed interim service specification recognises that a significant number of children and young people with very complex needs may also be *Looked After* or may not live with their birth family and may require the active involvement from children's social care and/or expert social work advice alongside support from the specialist service.
Carers of patients: unpaid, family members.	NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the proposals do not discriminate against this group; and that the proposals will have a neutral impact on reducing health inequalities in accessing	
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.	The proposed interim service specification requires patients to be registered with a GP in order to access the service (this requirement maintains the provisions of the current service specification for GIDS).	Individuals who are homeless are more likely to encounter difficulties in registering with a GP, though the Care quality Commission provides access to research that 92% of homeless people surveyed were registered with a GP.

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[11] Please note many groups who share protected characteristics have also been identified as facing health inequalities.

[12] Interim report of the Cass Review, 2022

Groups who face health inequalities[11]	**Summary explanation of the main potential positive or adverse impact of your proposal**	**Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact**
		NHSE has issued guidance to GP practices, based on the Patient Registration Standard Operating Principles for Primary Medical Care (2015) that *“A homeless patient cannot be refused registration on the basis of where they reside because they are not in settled accommodation”.* GP practices have a responsibility to register people who are homeless, or have no fixed abode or are legitimately unable to provide documentation living within their catchment area.
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the proposals do not discriminate against this group; and that the proposals will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.	
People with addictions and/or substance misuse issues	NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the proposals do not discriminate against this group; and that the proposals will have a neutral impact on reducing health inequalities in	The service specification sets out a model of care that will be holistic, multi-disciplinary and will take an integrated approach to assessing and responding to an individual’s needs and will recognise the range of co-presentations that may present in this patient cohort. By addressing the most appropriate clinical pathway in the best interest of the child or young

Groups who face health inequalities[11]	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	accessing services or achieving outcomes for this group.	person, the specification will increase the likelihood of having a positive impact on those referred to the who might have addictions or substance misuse issues. The standardised assessment process that is detailed in the service specification will ensure that the service should identify and confirm any significant co-existing conditions or challenges, including addictions or substance misuse, which will also have a positive impact on this group.
People or families on a low income	NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the proposals do not discriminate against this group; and that the proposals will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.	
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).	NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the proposals do not discriminate against this group; and that the proposals will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.	

Groups who face health inequalities[11]	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
People living in deprived areas	NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the proposals do not discriminate against this group; and that the proposals will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.	
People living in remote, rural and island locations	NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the proposals do not discriminate against this group; and that the proposals will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.	Over the longer term, the expansion of the number of services across the country may reduce current adverse impacts such as travel costs and inconvenience of travelling long distances.
Refugees, asylum seekers or those experiencing modern slavery	NHS England is in receipt of no evidence to suggest otherwise and therefore is of the view that the proposals do not discriminate against this group; and that the proposals will have a neutral impact on reducing health inequalities in accessing services or achieving outcomes for this group.	

Groups who face health inequalities[11]	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
Other groups experiencing health inequalities (please describe)	Some respondents to the public consultation suggested that the changes to the service specification which limited referral routes – and therefore made accessing the service more difficult – would disproportionately and negatively impact children and young people who either lived with unsupportive families or who lived outside the family home. This was seen as discriminatory and requiring reflection in the assessment, as well as necessitating consideration and proposals of ways to practically address the impact.	NHS England is developing a separate service specification that will propose access routes onto the waiting list for the service, and for management of the waiting list, and a separate EHIA will consider the impacts of the proposals to those with protected characteristics and other groups including this proposed group.

6. Engagement and consultation

a. Have any key engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

Yes	No X	Do Not Know
	The proposed interim service specification was developed through an urgent process to ensure stability of service provision during the transitional phase. The substantive	

	service specification for Gender Incongruence Services for Children and Young People will be built and developed through a range of stakeholder engagement activities and public consultation once the Cass Review has delivered final advice in 2023/24. A full engagement plan will be developed.	

7. What key sources of evidence have informed your impact assessment and are there key gaps in the evidence?

Evidence Type	Key sources of available evidence	Key gaps in evidence
Published evidence	As detailed in the current Service Specification for GIDS; or detailed in this impact assessment (above). As detailed in the interim report of the Cass Review (March 2022).	Limited published evidence around risk, benefits and outcomes of GnRHa and masculinising / feminising drugs (as per NICE evidence reviews 2020)
Consultation and involvement findings	As detailed in the interim report of the Cass Review (March 2022). As detailed in the public consultation undertaken on the interim service specification and associated analysis report	
Research		
Participant or expert knowledge For example, expertise within the team or expertise drawn on external to your team		

8. Is your assessment that your proposal will support compliance with the Public Sector Equality Duty? Please add an x to the relevant box below.

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?			
The proposal may support?	X	X	X
Uncertain whether the proposal will support?			

9. Is your assessment that your proposal will support reducing health inequalities faced by patients? Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?		
The proposal may support?	X	X
Uncertain if the proposal will support?		

10. Outstanding key issues/questions that may require further consultation, research or additional evidence. Please list your top 3 in order of priority or state N/A

Key issue or question to be answered	Type of consultation, research or other evidence that would address the issue and/or answer the question

1	Future clinical model for responding to children and young people with gender incongruence / gender dysphoria.	The Cass Review will work with NHSE and other stakeholders to define the new clinical model for adoption by the new regional services from 2023/24. The phase 1 services will use an interim service specification until a new national service specification is adopted.
2	Risks, benefits and outcomes of GnRHa and masculinising / feminising drugs	Cass Review has described proposals for research activities; and following advice from the Cass Review NHS England is in the process of forming proposals for prospectively enrolling children and young people being considered for hormone treatment into a formal research programme with adequate follow up into adulthood, with a more immediate focus on the questions regarding GnRHa.
3		

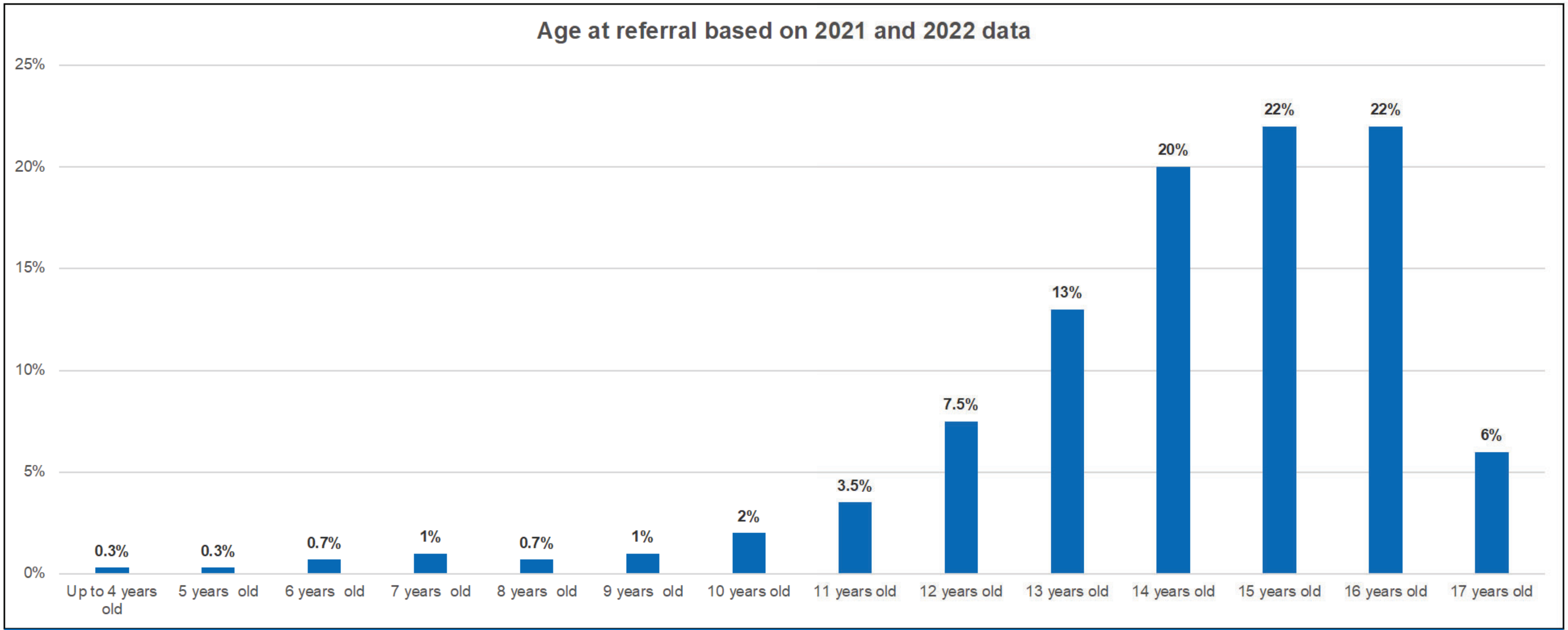
11. Summary assessment of this EHIA findings

The proposed interim service specification change is a reasonable and appropriate measure that is intended to confer benefit upon this cohort of children and young people by way of describing a safe service that will operate in a robust clinical governance framework, and that offers a more integrated approach to responding to a child or young person’s overall and individual health needs. We have detailed above the areas of the service specification that should have a positive impact on those with protected characteristics and other groups who experience health inequaltiies.

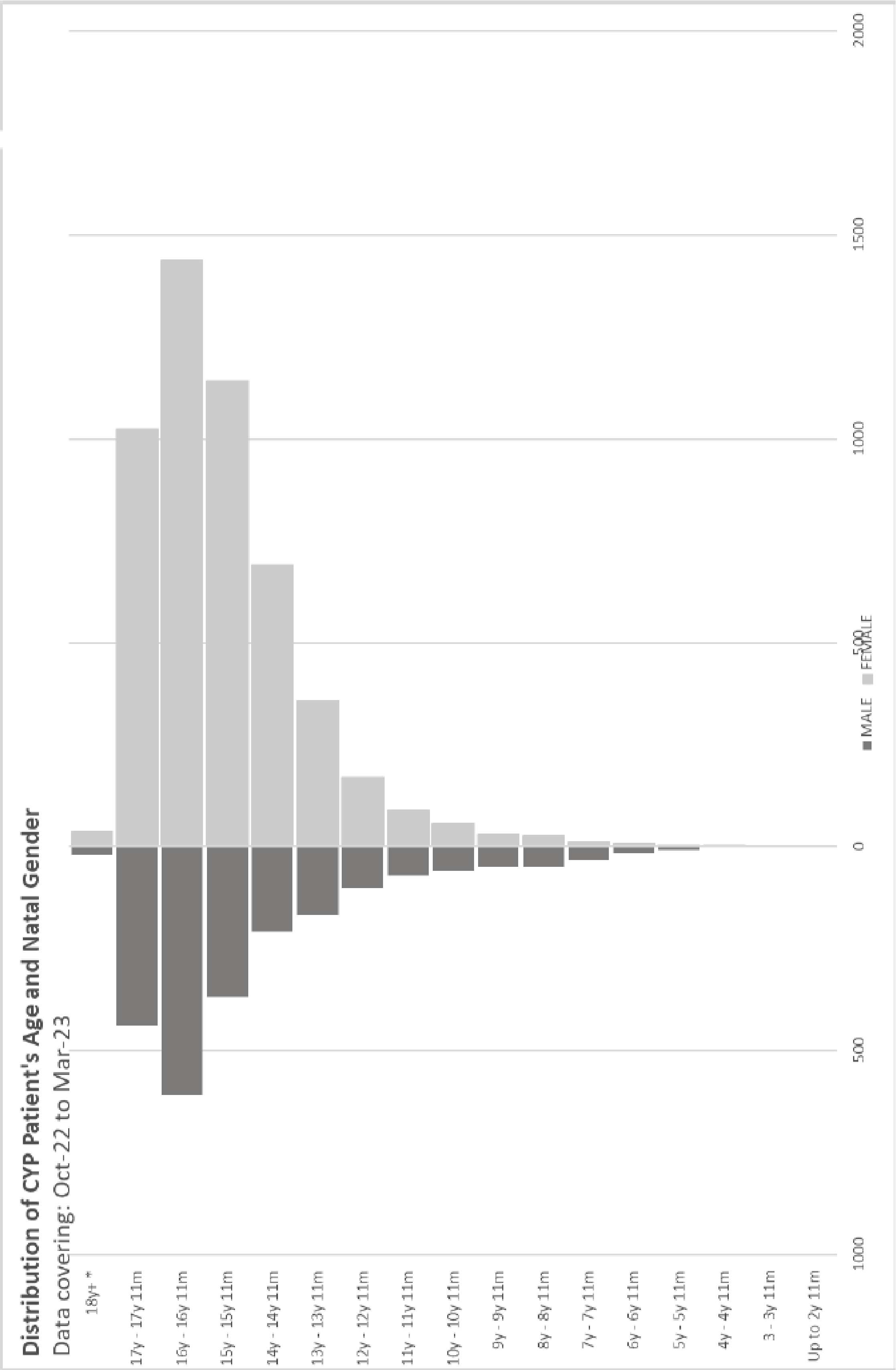
The EHIA will be reviewed for approval by the NCG.

Appendix A

Age at referral



Age at referral based on 2021 and 2022 data


Distribution of CYP Patient's Age and Natal Gender
Data covering: Oct-22 to Mar-23
18y+ *
17y - 17y 11m
16y - 16y 11m
15y - 15y 11m
14y - 14y 11m
13y - 13y 11m
12y - 12y 11m
11y - 11y 11m
10y - 10y 11m
9y - 9y 11m
8y - 8y 11m
7y - 7y 11m
6y - 6y 11m
5y - 5y 11m
4y - 4y 11m
3 - 3y 11m
Up to 2y 11m
1000
500
0
500
1000
1500
2000
■ MALE
■ FEMALE

NHS England
Interim Service Specification for Specialist Gender Dysphoria Services for Children and Young People

Public Consultation Analysis and Summary | April 2023

Rory Miller, Katie Lund, Maria Gallagher and Matthew Scott

Version: 1.7
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Date: 16/04/2023

TONIC

CONTENTS

Section 1 – Executive Summary

Background

In July 2022, following agreement by a committee of the NHS England Board, NHS England announced its plan to establish new services for children and young people experiencing gender incongruence and gender dysphoria. Part of this plan was to decommission the Gender Identity Development Service (GIDS) for children and adolescents, delivered by the Tavistock and Portman NHS Foundation Trust in London, and replace it with two 'Phase 1' services. One Phase 1 service is planned to be based in London and be led by a partnership between Great Ormond Street Hospital for Children NHS Foundation Trust, Evelina London Children's Hospital, and South London and Maudsley NHS Foundation Trust, while the second is planned to be based in the North West and led by a partnership between Alder Hey Children's NHS Foundation Trust and the Royal Manchester Children's Hospital. Both Phase 1 services will be supported by the Tavistock and Portman NHS Foundation Trust and the endocrine teams based at University College London Hospitals NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust. The Phase 1 services will be commissioned against an interim service specification which will replace the current service specification used by the Gender Identity Development Service.

NHS England explained in the supporting consultation guide that the draft interim service specification builds out from the existing specification to incorporate advice from the ongoing Independent Review of Gender Identity Services for Children and Young People (The Cass Review)[1] and to provide greater clarity in a number of areas. The draft was developed in partnership with and endorsed by the Phase 1 providers and by senior clinical leads, including the National Medical Director for Specialised Services, the National Clinical Director for Children and Young People, and the Associate National Clinical Director for Children and Young People's Mental Health.

Public consultation

In order to hear the views of patients, parents and carers, clinicians and service providers, as well as other interested parties, NHS England ran a public consultation between October 20th and December 4th 2022. The draft interim service specification was published on its website along with a consultation guide and an Equality and Health Inequalities Impact Assessment. The consultation asked seven quantitative questions and eight qualitative questions on the following:

- Four questions related to substantive changes to the service specification regarding: a) the composition of the clinical team; b) clinical leadership; c) working with referrers and local services; and d) referral sources;
- Clarification of NHS England's approaches towards social transition;
- Management of patients accessing prescriptions from unregulated sources;
- Suggestions for other changes or additions to the interim service specification; and
- The Equality and Health Inequalities Impact Assessment (EHIA).

5,183 responses were received, with an average of over 2,800 respondents per qualitative question providing views, ideas and suggestions, as summarised in this report.

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[1] https://cass.independent-review.uk/

Analysis and report

NHS England commissioned TONIC[2], a UK-based public consultation and social research specialist, to undertake an independent analysis of the consultation responses and to produce a written report of the findings. TONIC analysts conducted thematic analysis of this data by reading each response, making a record of all views, ideas and suggestions put forward, and describing the overarching themes that emerged. These themes are summarised, explained and illustrated in this report. For more information on the methodology used, please see Appendix A.

Respondent demographics

Respondents were asked in which capacity they were participating in the consultation and whether they were responding on behalf of an organisation. The three largest respondent groups were parents (28%), patients (23%), and members of the public (22%), with a further four groups, as well as those who did not provide an answer, comprising the remainder:

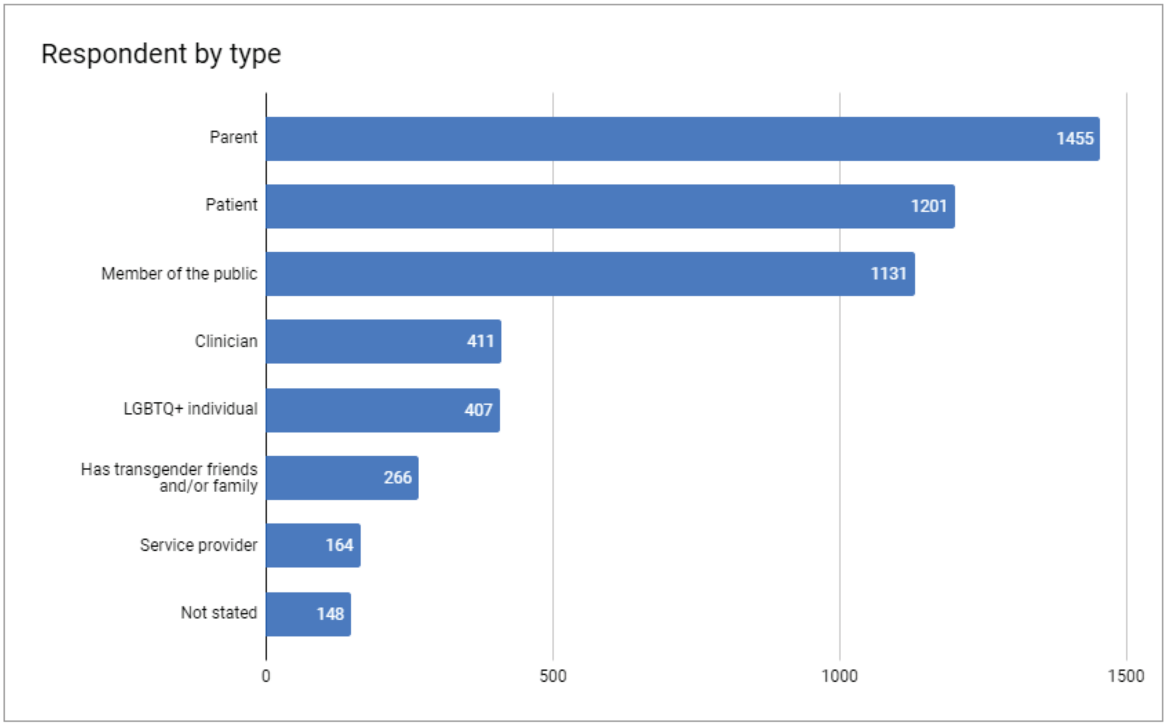

Figure 1. Consultation respondents by respondent type

Of the above, 180 respondents also stated that they were responding on behalf of an organisation, representing a total of 156 different organisations. These organisations are listed in Appendix B.

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[2] TONIC is a social research organisation. For more information see their website https://www.tonic.org.uk

Summary of quantitative responses

As a whole, respondents were slightly more likely to disagree or partially disagree with the proposals and questions in the consultation (53%) than they were to agree or partially agree with them (39%).

There were higher levels of agreement with regard to the proposals about the composition of the clinical team (53% agree and 39% disagree) and the clinical leadership of the team (49% agree and 41% disagree).

There were higher levels of disagreement with regard to the proposals about social transition (67% disagree), unregulated drugs (63%), referral sources (57%) and the EHIA (57%). Responses were more mixed with regard to proposals on working with local services, where 44% agreed and 47% disagreed.

The breakdown of the quantitative results per question is as follows:

Table 1. Quantitative question results by question

Question	Disagree	Partially disagree	Neither agree nor disagree	Partially agree	Agree
Q3A – Composition of the clinical team	28%	10%	8%	25%	28%
Q3B – Clinical lead	30%	11%	10%	18%	31%
Q3C – Local services	32%	15%	9%	15%	29%
Q3D – Referral sources	48%	9%	4%	12%	26%
Q4 – Social transition	61%	6%	3%	14%	16%
Q5 – Unregulated drugs	56%	7%	5%	5%	26%
Q7 – The EHIA	49%	8%	15%	8%	19%

There were noticeable variations among the different respondent types, with parents, clinicians and members of the public more likely to agree or partially agree with the proposals, and patients, service providers, LGBTQ+ individuals and friends and family of transgender persons more likely to disagree or partially disagree. The results by respondent type across all consultation questions are set out in the following table:

Table 2. Overall quantitative question results by respondent type

Respondent type	Disagree	Partially disagree	Neither agree nor disagree	Partially agree	Agree
Parent	27%	8%	6%	17%	42%
Patient	70%	9%	7%	7%	6%
Member of the public	34%	9%	8%	19%	31%
LGBTQ+ individual	56%	15%	11%	11%	6%
Clinician	24%	8%	8%	20%	40%
Has transgender friends or family	47%	14%	11%	12%	16%
Service provider	41%	14%	10%	16%	19%

Summary of qualitative responses

Responses to the open-ended consultation questions largely fell into two groups: Group A contained those who supported the idea of children and young people accessing gender dysphoria services and entering a pathway to transition; and Group B was made up of those supporting a more explorative approach who believed that children and young people should primarily receive comprehensive psychological support in order to explore the causes of their sense of gender dysphoria.

Group A Views

Respondents in this group were largely opposed to the proposals outlined in the interim service specification, believing that the changes would increase delays, lengthen already long wait lists, and block access to services, resulting in significant harm to gender dysphoric children and young people.

Many of these respondents considered the interim service specification to be based on outdated and inaccurate evidence, feeling that some of the proposed changes had been motivated by political and ideological desires to prevent children and young people from entering pathways to transition. Group A respondents also believed that several aspects of the interim service specification contradicted the NHS Outcomes Framework, the Equality Act 2010, and models of best practice promoted (such as the WPATH Standards of Care[3]) and used by international organisations and other countries.

Serious concerns were raised about the suitability of GPs and other healthcare professionals to work with, diagnose and refer gender dysphoric children and young people, with many of this group of respondents stating that doctors and other NHS staff often lacked knowledge or were unsupportive, obstructive, or even explicitly transphobic. Many believed large-scale training and education for staff would be required.

Group A respondents criticised the proposal to remove routes to referral that had previously been available to non-NHS organisations such as schools, private clinics, voluntary organisations, and social services, as well as the ability for children and young people to self-refer.

There were also concerns in this group regarding what was seen as the pathologisation of transgenderism, and in particular what was viewed as the conflating of gender dysphoria and neurodiversity due to a perceived increase in and focus on mental health treatments, which many believed equated to “conversion therapy”.

Group B Views

Respondents in this group were largely in favour of the proposals outlined in the interim service specification, with many believing that an increased focus on mental health issues would address what they felt to be the underlying causes of gender dysphoria without children and young people progressing towards what they believed were harmful medical interventions such as puberty blockers and gender reassignment surgery.

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[3] World Professional Association for Transgender Health (WPATH) Standards of Care version 8: https://www.wpath.org/publications/soc

A significant proportion of this group of respondents believed that the previous child gender services had been negatively impacted by ideological influences, urging NHS England to ensure all staff were free from such beliefs and pressures, while also welcoming the reduction of connections with non-medical organisations (including schools), which they believed had contributed to poor practice, unprofessional and unscientific standards of care, and potential psychological and physical harm.

Many Group B respondents were opposed to all forms of affirmation, including social transition, with a significant proportion stating that they considered gender dysphoria to be caused by factors such as trauma, social contagion, internalised homophobia, and misplaced pressure to conform to outdated gender stereotypes. They encouraged NHS England to promote this viewpoint widely, with a focus on parents, schools, and children and young people.

Note: These viewpoints, as well as those of all respondent types, are summarised in more detail in the section that follows, and outlined in full in the main body of the report.

Section 2 – Summary of views by respondent type

The analysis of the qualitative (free text) responses revealed a strong polarisation of opinion and viewpoint, with almost all respondents falling into one of two categories: those who were almost exclusively supportive of affirming approaches to transition ('Group A') and those who, for the most part, were opposed to approaches that supported gender transition pathways for children and young people ('Group B').

In total, from the 3,314 respondents who provided at least one answer to the qualitative questions, analysis determined the position of 3,212 (97%), comprising 2,124 (64%) Group A respondents and 1,088 (33%) Group B respondents, with a further 102 (3%) either occupying a neutral position or not providing sufficient detail on which to confidently establish one.

Because of this polarisation it was decided that the clearest and most logical way to present respondents' views was in accordance with these two overarching categories (as well as with a third category for responses common to both groups and neutral responses, where applicable).

These positions are shown by respondent type in the following table:

Table 3. Positions by respondent type

Respondent type	Group A	Group B	Neutral/unknown
Patient	99%	0%	1%
LGBTQ+ individual	96%	4%	1%
Has transgender friends or family	84%	14%	2%
Service provider	76%	21%	4%
Clinician	49%	43%	8%
Parent	45%	51%	3%
Member of the public	45%	51%	4%

For those who provided sufficient information by way of their qualitative (free text) responses, therefore:

- Patients, LGBTQ+ individuals and those with transgender friends or family were overwhelmingly Group A.
- A large majority of service providers were Group A.
- Clinicians were slightly more likely to be Group A.
- Parents and members of the public were slightly more likely to be Group B.

Note: While this analysis provides insight into the positions of those who submitted answers to the qualitative questions it does not, however, reveal whether these trends can be applied to all respondents or respondent groups – i.e., whether those who answered only the quantitative questions were also Group A, Group B, both or neither in similar ratios to those identified above.

Notes on reading the consultation analysis

- In certain questions, respondents agreed or disagreed for ideologically opposed reasons. For example, in the question on social transition Group A respondents largely disagreed with NHS England's proposed approach primarily due to feeling that it was restrictive, unsupportive, harmful, and based on outdated and inaccurate evidence. Group B respondents that disagreed with it, however, did so mainly because they felt social transition in and of itself was wrong and/or that the proposed approach needed to be more restrictive.
- Similarly, many Group A respondents at least partially agreed with the two proposals to extend the multidisciplinary team and require a medical doctor as the clinical lead, while also expressing the same reservations and concerns as Group A respondents who disagreed with the proposals.
- In the qualitative responses to the question on social transition, almost all respondents chose to express their viewpoints on the idea of social transition itself, as well as NHS England's approach, both past and proposed, rather than to directly answer the consultation question on whether the wording of the interim service specification provided sufficient clarity on the issue. It is likely, therefore, that the answers to the quantitative agree/disagree question were more reflective of how respondents felt about social transition in general, and whether they agreed or disagreed with NHS England's approach, than of how they viewed the clarity of the wording of the interim service specification.
- For these reasons and others it is worth noting that the quantitative results presented in this report should be considered in the context of the accompanying qualitative response themes and explanations, and that the figures, in and of themselves, do not provide a complete picture.
- Similarly, it is important to note that the numbers of respondents presented in the tables of qualitative themes are also subject to certain contexts and conditions: namely, that in public consultations in general, respondents who disagree with and/or feel strongly about a proposal are much more likely to address the issue (either in detail or at all) than those who agree with a proposal, as are those who have a particular or personal interest. For these reasons, response themes that express disagreement and dissatisfaction almost always significantly outnumber response themes that express agreement and satisfaction, even in responses to questions where the quantitative results show that the majority of respondents answered with agreement.[4]
- It is worth noting that the number of respondents raising a theme does not necessarily correspond to the importance of the issues being put forward. Response frequencies, therefore, are included solely as a guide, not as an indication of priority.
- Where illustrative and representative, direct quotes have been included, along with the respondent type and the answer given to the corresponding quantitative question.
- Unless displayed otherwise percentage figures are rounded to the nearest whole number and therefore may not always add up to 100%.

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[4] In illustration of this point, the average number of words submitted in responses to the question on approaches to social transition were: 135 for those who disagreed; 97 for those who partly disagreed; 69 for those who neither agreed nor disagreed; 56 for those who partially agreed; and only 17 for those who agreed.

Campaign responses

A number of submissions were identified as 'campaign responses' – that is, a set of consultation responses prepared by an organisation or individual and then either copied and pasted in full or reworded and edited slightly, but clearly based on the original's content, structure, and viewpoint. Five such responses were identified, with the approximate numbers of respondents who submitted these as follows:

Table 4. Campaign responses

Response organisation	Verbatim	Mostly equivalent
Stonewall, Mermaids, Gender Intelligence and Trans Learning Partnership	120	120
Transgender Trend	25	5
Christian Concern	30	0
Katy Montgomerie	30	15
Gay Men's Network	6	0

Notes:

- *The totals above are approximate averages across all questions as not all respondents used campaign responses for each question (i.e., some respondents submitted a combination of exactly copied campaign responses, slightly reworded or edited campaign responses, and responses constituting their own words).*
- *These responses were not considered duplicate submissions as there was no basis to consider that the campaign responses did not accurately represent the views and ideas of the individual respondents who submitted them.*
- *The five campaign responses are included in full in Appendix C.*

Summary of views by respondent type

Parents

Overall, parents were more likely to agree or partially agree (59%) with the proposed changes to the interim service specification than to disagree or partially disagree (35%), with the breakdown per question being as follows:

Table 5. Views by respondent type

Parents	Disagree	Partially disagree	Neither agree nor disagree	Partially agree	Agree
Q3A – Clinical team	17%	8%	4%	24%	47%
Q3B – Clinical lead	18%	9%	6%	23%	45%
Q3C – Local services	17%	11%	6%	18%	48%
Q3D – Referral sources	27%	8%	3%	14%	47%
Q4 – Social transition	45%	7%	3%	18%	27%
Q5 – Unregulated drugs	36%	5%	4%	9%	46%
Q7 – The EHIA	28%	7%	18%	12%	35%

The themes most commonly raised by parents were:

- Concerns that the proposed changes would lead to longer delays in accessing the service and increase wait times, often considered as gatekeeping.
- Concerns that an increased focus on psychological factors and mental health issues would exclude neurodiverse children and young people from receiving treatment, as well as concerns that this focus may lead to a greater pathologisation of gender dysphoria.
- Dissatisfaction with the proposed approach to unregulated drugs, with approximately a third of parents who submitted comments stating that the families of gender dysphoric children and young people had most likely been forced to take such actions due to unworkably long wait lists, lack of access to services, and what they saw as the NHS's failure to provide the most beneficial support and treatment for gender dysphoric/transgender children and young people, also feeling that the NHS should focus its efforts on increasing resources and improving the service before threatening safeguarding and denying access and care.
- The belief that all staff in the new service should receive specialised training in gender dysphoria and that the key roles should be filled by experts experienced in the field.

Note: While the majority of parents agreed or partially agreed with the proposed changes to the interim service specification, the most commonly-raised themes were expressions of dissatisfaction and concern. As mentioned above in 'Notes on reading the consultation analysis' this is most likely to be due to the issue of points of concern being much more frequently raised and elaborated on than points of agreement.

Patients

Overall, patients were far more likely to disagree (70%) or partially disagree (9%) than they were to agree (6%) or partially agree (7%), with significantly stronger disagreement in response to the questions regarding referral sources, social transition, and unregulated drugs, as follows:

Table 6. Patients' responses by question

Patients	Disagree	Partially disagree	Neither agree nor disagree	Partially agree	Agree
Q3A – Clinical team	55%	11%	10%	16%	9%
Q3B – Clinical lead	54%	11%	13%	13%	8%
Q3C – Local services	59%	16%	9%	9%	8%
Q3D – Referral sources	80%	7%	4%	2%	6%
Q4 – Social transition	87%	4%	2%	2%	4%
Q5 – Unregulated drugs	84%	6%	3%	3%	4%
Q7 – The EHIA	73%	8%	11%	3%	6%

The themes most commonly raised by patients were the same as those raised by parents, with the addition of:

- Concerns – often stated to be based on prior experience – that GPs and other healthcare staff could be unsympathetic, unknowledgeable about trans healthcare issues, and were sometimes explicitly transphobic. This was seen as not only potentially damaging to a patient's well-being but as a barrier to referral and treatment, with many questioning what alternative avenues a child or young person would have available to them in the event of encountering obstructive or unsupportive clinicians – e.g., what the appeals and complaints process would be, and how they would obtain a second opinion or see a different healthcare professional.
- Many patients felt that several aspects of NHS England's proposed changes to the service specification were based on inaccurate and outdated evidence that was clearly contradicted by more recent, more accurate and more plentiful evidence referenced by organisations such as the World Professional Association for Transgender Health.
- Objections to the implication that social transition should be subject to clinical or medical intervention or approval.
- Objections to the idea that for an individual to qualify for the protected characteristic of gender reassignment a diagnosis from a medical professional would be required.

Members of the public

Overall, members of the public were slightly more likely to return answers that disagreed (34%) than agreed (31%), but slightly more likely to at least partially agree (48%) than to at least partially disagree (43%). In addition, responses from members of the public were more varied across the range of questions than from other respondent groups, with answers to the first four questions (the substantive changes) being mostly in agreement and answers to the last three questions (social transition, unregulated drugs, and the EHIA) being mostly in disagreement, as follows:

Table 7. Members of the public's responses by question

Members of the public	Disagree	Partially disagree	Neither agree nor disagree	Partially agree	Agree
Q3A – Clinical team	22%	9%	7%	34%	29%
Q3B – Clinical lead	22%	10%	8%	15%	45%
Q3C – Local services	23%	12%	12%	17%	35%
Q3D – Referral sources	35%	11%	4%	22%	29%
Q4 – Social transition	48%	6%	3%	25%	17%
Q5 – Unregulated drugs	47%	8%	7%	5%	34%
Q7 – The EHIA	43%	8%	17%	8%	24%

In addition to several of the themes noted above, the themes most commonly expressed by members of the public were:

- General expressions of support for an increased focus on mental health, as well as support for the extension of the multidisciplinary clinical team, feeling that this would result in a decrease in hormonal, surgical, and other forms of medical intervention.
- Belief that the primary referral source for a child or young person should be someone who knows them very well and has a significant amount of interaction with them (not necessarily, and probably unlikely, to be their GP).
- Negative sentiments towards puberty blockers, with views ranging from considering them experimental and saying they should not be prescribed to any children or young people, to views that called for them to be outlawed and for those prescribing, providing, buying or selling them to face legal repercussions.

LGBTQ+ individuals

Overall, LGBTQ+ individuals were far more likely to at least partially disagree (71%) than they were to at least partially agree (17%) – particularly in response to the final four questions, as follows:

Table 8. LGBTQ+ individual's responses by question

LGBTQ+ individuals	Disagree	Partially disagree	Neither agree nor disagree	Partially agree	Agree
Q3A – Clinical team	24%	18%	19%	29%	10%
Q3B – Clinical lead	27%	21%	21%	21%	10%
Q3C – Local services	30%	31%	15%	16%	8%
Q3D – Referral sources	72%	13%	5%	5%	5%
Q4 – Social transition	89%	3%	3%	2%	2%
Q5 – Unregulated drugs	80%	10%	4%	3%	4%
Q7 – The EHIA	71%	10%	13%	3%	4%

The themes most commonly raised by LGBTQ+ individuals were the same as those most commonly raised by parents and patients, with the addition of the following:

- Belief that the increased focus on mental health amounted to ‘conversion therapy’.
- Belief that the clinical lead of the multidisciplinary team should be a transgender person.

Clinicians

Overall, those who identified as clinicians were almost twice as likely to agree or partially agree with the consultation questions and interim service specification proposals (59%) than they were to disagree or partially disagree (32%), with a broadly similar ratio seen across five of the seven questions. With regard to the question on the clarity of the approach to social transition, however, they were only slightly less likely to disagree or partially disagree (47.4%) than they were to agree or partially agree (48.9%), while clinicians’ responses as to whether the Equality and Health Inequalities Impact Assessment had reflected the potential impact on health inequalities were far less decisive than their answers to the preceding questions, with almost a quarter (24.4%) stating that they neither agreed nor disagreed:

Table 9. Clinicians' responses by question

Clinicians	Disagree	Partially disagree	Neither agree nor disagree	Partially agree	Agree
Q3A – Clinical team	13%	9%	6%	29%	43%
Q3B – Clinical lead	18%	9%	6%	20%	47%
Q3C – Local services	18%	11%	6%	22%	43%
Q3D – Referral sources	23%	9%	5%	21%	42%
Q4 – Social transition	40%	7%	4%	21%	28%
Q5 – Unregulated drugs	30%	7%	6%	11%	46%
Q7 – The EHIA	27%	5%	24.4%	14%	29%

The themes most commonly raised by clinicians are already described above within the summaries of other response groups, as follows:

- Objection to the idea that a diagnosis from a medical professional was required in order to qualify for the protected characteristic of gender reassignment (34%).
- Support for an increased focus on psychological intervention (27%).
- Concerns that an increased focus on mental health issues does not pathologise transgenderism (24%).
- Support for the extended holistic multidisciplinary team (23%).
- Expression that the clinical lead should be an experienced expert in gender dysphoria and transgender issues (23%).
- The belief that parents and children use unregulated drugs because NHS England provision is insufficient, wait times are impractically long, and it represents the best and safest option available to them (20%).

Those with transgender friends or family

Overall, those with transgender friends or family were much more likely to answer with disagree or partially disagree (61%) than they were to answer with agree or partially agree (28%). They were also slightly more likely to agree with the first two questions (composition of the multidisciplinary team and clinical leadership) while strongly disagreeing with the final four questions, in similar proportions to LGBTQ+ individuals and, to a lesser extent, patients.

Table 10. Those with transgender friends or family's responses by question

Has transgender friends or family	Disagree	Partially disagree	Neither agree nor disagree	Partially agree	Agree
Q3A – Clinical team	24%	14%	13%	28%	20%
Q3B – Clinical lead	27%	15%	18%	19%	22%
Q3C – Local services	32%	25%	12%	12%	19%

Q3D – Referral sources	57%	13%	5%	8%	16%
Q4 – Social transition	69%	9%	5%	6%	11%
Q5 – Unregulated drugs	59%	16%	6%	3%	16%
Q7 – The EHIA	60%	9%	15%	8%	8%

The themes most commonly raised by those with transgender friends or family were more or less in alignment with those raised by LGBTQ+ individuals (and therefore patients), with the exception that those with transgender friends or family were less than half as likely as LGBTQ+ individuals to recommend that the clinical lead should be a transgender person (but more than three times more likely than patients – 11%, 25% and 3% respectively).

Service Providers

Overall, service providers were more likely to disagree or partially disagree (55%) than to agree or partially agree (35%), while also displaying a similar trend to other Group A groups by mostly agreeing with the first two questions and strongly disagreeing with the final four questions, as follows:

Table 11. Service provider's responses by question

Service providers	**Disagree**	**Partially disagree**	**Neither agree nor disagree**	**Partially agree**	**Agree**
Q3A – Clinical team	16%	17%	11%	33%	24%
Q3B – Clinical lead	21%	20%	14%	23%	23%
Q3C – Local services	24%	22%	13%	22%	18%
Q3D – Referral sources	54%	8%	6%	13%	19%
Q4 – Social transition	66%	5%	5%	11%	13%
Q5 – Unregulated drugs	54%	12%	6%	3%	25%
Q7 – The EHIA	52%	11%	17%	8%	12%

The themes most commonly raised by service providers were more or less equivalent, and in similar proportions, to those raised by patients. They were, however, around twice as likely as patients to express that the changes to the interim service specification were in violation of the Memorandum of Understanding on conversion therapy.

Summary of views from Group A respondents

Overall, respondents who were identified as Group A were much more likely to disagree (54%) or partially disagree (18%) with the consultation questions than they were to agree (4%) or partially agree (12%), returning significantly stronger levels of disagreement in response to the questions on referral sources, social transition, unregulated drugs, and the EHIA.

Table 12. Group A respondents' responses by question

Group A respondents	Disagree	Partially disagree	Neither agree nor disagree	Partially agree	Agree
Q3A – Clinical team	23%	21%	16%	33%	8%
Q3B – Clinical lead	25%	23%	20%	23%	8%
Q3C – Local services	30%	31%	14%	18%	7%
Q3D – Referral sources	71%	16%	5%	5%	3%
Q4 – Social transition	88%	6%	3%	2%	0.7%
Q5 – Unregulated drugs	77%	13%	5%	3%	2%
Q7 – The EHIA	67%	13%	15%	3%	2%

With regard to the first question (composition of the clinical team), while a significant number of Group A respondents either agreed (8%) or partially agreed (33%) with the proposal to extend the multidisciplinary clinical team, many also expressed caveats, concerns and stipulations in their qualitative answers, illustrating that their agreement was largely dependent on the manner in which the proposal was carried out and the results it provided for patients. In total, over 90% of the 755 Group A respondents who either agreed or partially agreed with the proposed change fit into this category, with the most commonly mentioned caveats and stipulations being:

- Concern that the extension of the clinical team could lead to delays in accessing treatment and increasing what they considered to be already lengthy waiting lists and times;
- Belief that in order to provide a beneficial service all or most staff would require specific and specialised training in gender dysphoria;
- Concern that the increased focus on mental health could exclude neurodiverse children and young people from receiving gender affirming treatment, and/or that this increased focus may pathologise gender dysphoria.

Similar concerns, caveats and stipulations were put forward by the 496 Group A respondents who said that they agreed (8%) or partially agreed (23%) with the proposal to make the clinical lead for the service a medical doctor, with 71% stating that the clinical lead would have to be an expert in gender dysphoria and 51% saying that the change to a medical doctor should not infer that gender diversity is inherently a medical issue, thereby pathologising the experience of patients.

Due to the above observations, therefore, it is important to note that although a significant number of Group A respondents did express agreement or partial agreement with some proposals, their agreement was often "in principle" and caveated with a view to a particular outcome, hope, or requirement.

Other views from Group A respondents

Across a range of questions a number of recurring themes and most commonly expressed viewpoints were raised by Group A respondents, as summarised below and explored in detail in the report that follows:

- As noted above, large numbers of Group A respondents felt that the proposed changes to the service specification would significantly increase the time required for a patient to either be seen for an initial appointment, receive a referral into the service, and/or begin treatment (including the prescription of puberty blockers). Many respondents mentioned what they saw as already lengthy waiting times, with some quoting numbers that stretched several years into the future, while many also felt that changes were being made in order to add further layers of what they called “gatekeeping“ so as to obstruct and prevent children and young people from transitioning – particularly because of the time sensitive issue of puberty and what was seen as “being forced to go through it in the wrong body“. This in turn was viewed as likely leading to strongly negative outcomes for the individuals concerned, including self-harm, detrimental mental health, depression, and an increased likelihood of suicide.
- Also as noted above, many Group A respondents highlighted that they felt NHS England had failed to properly cite and reference the evidence source or sources on which certain changes and directives were based – particularly with regard to the claim that “in most cases gender incongruence does not persist into adolescence“ – with some mentioning that they felt NHS England’s evidence was based on one outdated and inaccurate paper, while a large number provided a variety of links and citations to more recent studies, papers and evidence which they believed contradicted this claim and demonstrated the opposite.
- Many cited authorities and organisations such as the World Health Organisation (WHO), the World Professional Association for Transgender Health (WPATH), and the Australian Professional Association for Transgender Health (AUSPATH) which they felt had made recommendations outlining “best current international practice” that were both superior and oppositional to the approach detailed in NHS England’s interim service specification – particularly with regard to social transition.
- Regarding social transition, Group A respondents believed that it was beyond NHS England’s power or remit to dictate if, when and how children and young people decided to social transition, with many stating that children and young people should be free to express themselves; that there were many positive benefits to social transition; that it was harmless and fully reversible; and that to suppress or deny the desire to social transition could lead to potentially severe negative health consequences. Group A respondents also felt that social transition is not a medical issue and therefore does not necessitate a clinical intervention or require clinical approval, and that NHS England’s approach resembled conversion therapy and violated the Memorandum of Understanding.
- Overall, the question on social transition – though ostensibly referring to the clarity of the wording of the interim service specification – generated the highest level of opposition from Group A respondents, with 88% disagreeing and a further 6% partially disagreeing, while only 0.7% agreed (these respondents agreed that it was clear, but disagreed with the proposed approach). Other themes and issues raised in response to this question are explored in the report that follows.
- Many Group A respondents – especially patients and LGBTQ+ individuals – also expressed concerns that many GPs and doctors were either unknowledgeable of transgender issues, unsupportive of their patients, or explicitly transphobic and practising “gatekeeping“ due to their inherent personal biases. Many suggested that NHS England staff would need to be educated and trained to be able to provide more supportive and affirming care, as well as regularly monitored to ensure quality and compliance, while at the same time questioning

whether it was realistic to expect the provision of the necessary resources and funding. It was also suggested that the interim service specification should have included an outline of a complaints and appeals procedure, as well as a clear pathway for a patient's course of action should they require a second opinion or change of healthcare professional.

- Regarding the substantive change to referral sources – that is, removing the avenue to referrals which were previously made by non-NHS professionals – as well as believing that it would increase wait times, deny access, and serve as a form of gatekeeping, many Group A respondents expressed concerns that the interim service specification appeared to state that no new referrals would be seen and that it didn't appear to include any indication of a pathway to care for those who failed to meet the requirements for entering the service. Some pointed out that it would be likely that there was a valid and good reason why 5% of children and young people had been referred from outside the NHS – for example, they may have a poor relationship with their GP; have unsupportive parents and/or family or carers; have a living situation that precluded them from accessing local health services; or be part of a demographic group which tends to have historically lower rates of engagement with GPs and the NHS (i.e., they may be among the most vulnerable and unsupported). It was therefore felt that referrals should continue to be accepted from schools, from teachers, from social and youth workers, and from other non-governmental organisations – from adults who knew the children well and who may be able to serve them more beneficially in certain circumstances than GPs and other NHS professionals.
- Regarding the approach to unregulated drugs, Group A respondents were strongly opposed to the proposed changes to the service specification, with many believing that NHS England's stance would cause considerable harm to children and young people, as well as to their families. In particular, the proposal to require a GP to initiate local safeguarding procedures in the event that a patient was found to have sourced unregulated drugs was met with vocal disapproval and disagreement, with some feeling that this could lead to children being separated from loving families and placed into care, or that such stringent measures would drive the market for unregulated drugs underground and lead to prospective patients feeling unsafe to seek any kind of treatment from NHS England.
- Similarly, Group A respondents believed that NHS England's statements that it would neither "enter into shared care arrangements" nor "accept clinical responsibility for management of the endocrine intervention" with a child or young person who had sourced unregulated drugs was both a violation of its duty to care and likely to lead to increased harm to patients due to denial of services such as blood tests, monitoring of hormone levels, and regular health check-ups and exams. Some drew comparisons with other non-transgender individuals who used unregulated or privately sourced hormone replacement drugs, as well as those who used illegal and illicit drugs, and noted that these people still received care, therefore the standard applied seemed neither consistent nor in accordance with a credo of "do no harm". A significant number of Group A respondents – as well as some Group B respondents – stated that they felt the proposed approach to unregulated drugs was "coercive, threatening, and punitive".
- Group A respondents felt strongly that certain groups had failed to be fully reflected and represented in the Equality and Health Inequalities Impact Assessment – chief among them: black, Asian and minority ethnic (BAME); children and young people from unsupportive families; those with disabilities (primarily referring to neurodivergence/autism); and

especially "gender reassignment", with more than 900 respondents objecting to the content of the EHIA on the grounds that "a diagnosis of gender dysphoria is not required for the characteristic of gender reassignment for the purposes of equalities law", with many mentioning that this section of the EHIA failed to comply with the Equality Act 2010 and may be subject to legal challenge.

- Group A respondents also expressed dissatisfaction that transgender groups and individuals didn't appear to have been consulted or listened to during the construction of the interim service specification.

Summary of views from Group B respondents

Overall, respondents who were identified as Group B were much more likely to agree (48%) or partially agree (31%) with the consultation questions than they were to disagree (8%) or partially disagree (4%), returning fairly similar levels of agreement and disagreement across almost all questions, excepting a few areas of variation:

Table 13. Group B respondents' responses by question

Group B respondents	Disagree	Partially disagree	Neither agree nor disagree	Partially agree	Agree
Q3A – Clinical team	6%	3%	1%	43%	46%
Q3B – Clinical lead	6%	2%	2%	25%	65%
Q3C – Local services	3%	3%	11%	27%	56%
Q3D – Referral sources	3%	6%	3%	39%	50%
Q4 – Social transition	20%	9%	3%	46%	21%
Q5 – Unregulated drugs	12%	3%	8%	15%	62%
Q7 – The EHIA	7%	5%	29%	22%	37%

Regarding the question on the clarification to approaches to social transition, this was the only question in which Group B respondents were more likely to partially agree than to agree, while they were more than three times more likely to disagree than they were in responses to other questions. There were three main reasons why agreement from Group B respondents was significantly diminished in response to this question: objections to social transition itself; feeling that NHS England's proposed approach should be more stringent; and to a lesser extent feeling that the wording and language used was unclear and/or inaccurate.

Other views from Group B respondents

Across a range of questions a number of recurring themes and viewpoints were expressed by Group B respondents, as follows:

- Group B respondents were strongly supportive of an increased focus on psychological therapies and mental health, feeling that such an approach would address what they saw as the true causes of gender dysphoria – for example, trauma, misunderstanding, social contagion, or internalised homophobia – and result in far fewer children and young people progressing to "harmful" interventions such as hormone treatment and surgery.

- Some Group B respondents highlighted perceived problems with the current Gender Identity Development Service (GIDS) at Tavistock, believing it to have been guided by unscientific and biased gender-based ideologies which had led to children and young people receiving improper guidance and being placed on pathways to harm. They also believed that whistleblowers and dissenting voices had been silenced by pressures to conform and/or to avoid being publicly labelled as transphobic. For some, it was felt to be important that no current Tavistock staff should play a role in the new service – though there were also those who believed that certain GIDS staff who had resigned should be reinstated to roles within the new service.
- In alignment with Group A respondents, Group B respondents also believed that staff would require significant levels of training in gender dysphoria, and questions were again asked with regard to available resources, staffing levels, funding and investment. Unlike Group A respondents, however, the impetus was less directed towards staff being trained to develop a supportive and affirming understanding of gender dysphoria and was more focused on educating staff away from any pro-transition ideological beliefs and ensuring that they would be guided solely by scientific principles and evidence – with the belief being that the weight of scientific evidence would show that psychological treatment rather than transition represented the solution to a child or young person's gender dysphoria.
- It was strongly encouraged that all ties with organisations such as Mermaids and Stonewall be severed, with respondents feeling that such organisations were ideologically motivated, were sources of misinformation and improper guidance, and that they had been able to unduly influence the current gender identity service at Tavistock and had therefore played a role in causing children and young people harm.
- As above, Group B respondents were significantly opposed to the idea of social transition, feeling that it negatively impacted the mental health and general wellbeing not only of the child or young person in question, but of others around them – parents, family, teachers and peers – who they saw as being put in a position of being forced to "live a lie" by referring to and treating an individual as a gender different to their sex. Related to this were points raised about the use of toilets and changing rooms, as well as participation in sports, which was primarily felt to negatively impact girls. Group B respondents, therefore, felt it necessary that a clear and strong message regarding governmental approaches to social transition should be conveyed by NHS England to schools so that children and young people received consistent and clear information from all authorities and organisations.
- Group B respondents were strongly supportive of the cessation of non-NHS referral sources, with some expressing surprise and shock that this was not already in place. Going forward, they encouraged referral from only impartial health professionals – "impartial" in this case meaning "not pro-transgender" – and believed that the proposed interim change should be made permanent.
- Some Group B respondents expressed concerns that the proposal to require the clinical lead to be a medical doctor would lead to an increased likelihood of medical intervention and eventual surgery for a child or young person who had entered the service.
- Regarding unregulated drugs, respondents who were identified as Group B were strongly in favour of strict measures to counteract their prescription and availability, suggesting legal powers and actions should be applied against buyers, sellers, prescribers, and parents who provided them for their children. Strong views were also expressed against the provision of

all puberty blockers, whether through NHS England or otherwise, as well as support for the proposed safeguarding protocol and the proposals to abdicate responsibility and to not enter into a shared care arrangement.

- Some Group B respondents also expressed concerns that psychologists and psychiatrists were being restricted from effective and proper practice due to outside ideological pressures which conflated exploratory therapies with conversion therapy. These respondents therefore felt that it would serve both patients and practitioners if NHS England withdrew from the Memorandum of Understanding on Conversion Therapy.

Section 3 – Proposed substantive changes to the current service specification

A. Composition of the clinical team

The interim service specification public consultation guide stated that:

> The current service specification for GIDS describes that the service 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 proposes to extend the clinical team so that it is a more integrated multidisciplinary team that, in addition to gender dysphoria specialists, will include experts in paediatric medicine, autism, neurodisability 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.

Respondents were asked to what extent they agreed with the substantive change to the service specification regarding composition of the clinical team. The results were as follows:

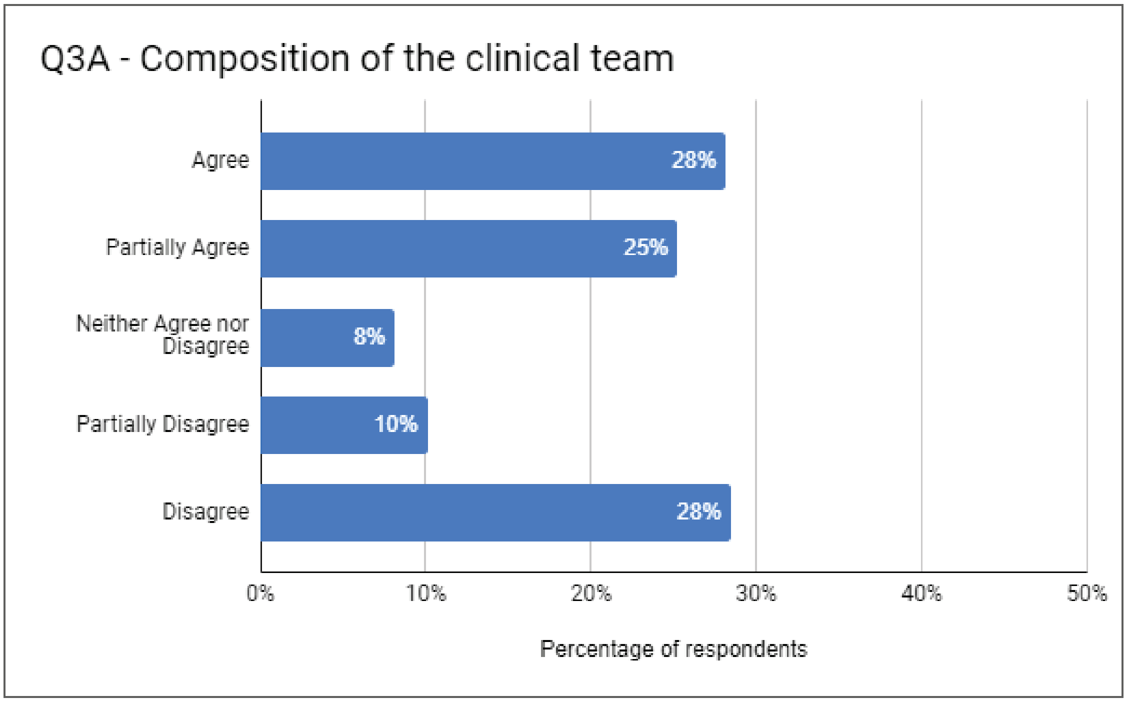

Figure 2. Quantitative results regarding the composition of the clinical team

Parents and clinicians were the two respondent groups most likely to outright agree with the change (47% and 43% respectively) while the majority of members of the public and service providers also at least partially agreed (63% and 57%).

Patients were the most likely to disagree (55%), followed by LGBTQ+ individuals and those with transgender friends or family (43% and 38% respectively at least partially disagreeing).

Summary of themes raised by respondents identified as Group A (n=1912)

Group A respondents said...	Number
The changes will increase delays and already lengthy wait times	1259
The focus on mental health is exclusionary	989
Healthcare staff will need to receive training in gender dysphoria	926
The changes are a form of purposeful gatekeeping	323
Members of the team must be experts in gender dysphoria	168
All staff must be impartial and free from anti-trans ideology	112
The changes will cause harm to children and young people	110
The increased focus on mental health pathologises gender dysphoria	74
Not all patients will want or need to see specialists, this shouldn’t be forced	46
The team should be gender affirming and supportive of trans beliefs	29
The team should have trans staff and members who have “lived experience“	29
The focus on mental health issues makes it sound like conversion therapy	23
Empathy, safety and building trust should be at the heart of the service	20
This change may be distressing for current patients	15
GIDS was working well, it or its staff should be maintained	15
The timeline is unrealistic and overly ambitious	3
This will force children and young people to use unregulated drugs	2

Agreement with the proposal in principle – subject to certain conditions

While a significant number of Group A respondents either agreed (8%) or partially agreed (33%) with the proposal to extend the multidisciplinary clinical team, many also expressed caveats, concerns and stipulations in their qualitative answers, illustrating that their agreement was largely dependent on the manner in which the proposal was carried out and the results it provided for patients:

> “In theory I support the addition of more specialist knowledge to the clinical team [but] in practice I worry that there are already so many steps faced by young people seeking to transition. Waiting to see yet another specialist would likely only add to the already absurdly long waiting times for treatment. I also am concerned that it feels like a move to link gender dysphoria with neurodiversity, playing into the typical anti-trans talking point that neurodiverse young people can’t know their own minds.“
>
> (LGBTQ+ individual – Partially Agree)

> “We welcome further multidisciplinary specialties in supporting children and young people who are gender diverse, however we feel it is crucial that these professionals are suitably trained in gender diverse identities prior to working in this field. We look forward to hearing how such training could be rolled out.”
>
> (Service provider – Partially Agree)

> "I think it's good that a wider range of support will be made available. This is provided that trans patients are not directed away from gender affirming care or forced through years of mental health assessments and screening for autism spectrum disorder. Anyone who has gone down either of these routes via the NHS will know that this leads to excessive waiting times and that the service provided is minimal."
> (LGBTQ+ individual – agree)

Overall, of the 755 identified Group A respondents who either agreed or partially agreed with the proposed change to the composition of the clinical team, 681 (90%) expressed concerns, caveats and stipulations along the lines of those illustrated in the quotes above, with the most common being:

- 497 (58%) who expressed concerns that the extension of the clinical team could lead to delays in accessing treatment and increasing what they considered to be already lengthy waiting lists and times.
- 429 (50%) who agreed in principle but believed that in order to provide a beneficial service all or most staff would require specific and specialised training in gender dysphoria issues (in addition, there were those who felt that all staff should be gender dysphoria specialists or experts).
- 392 (46%) who felt that the increased focus on mental health could exclude neurodiverse children and young people from receiving gender affirming treatment, and/or that this increased focus may lead to an unnecessary and mistaken pathologisation of gender dysphoria.

The above themes are explored in further detail below.

Delays, obstructions, wait lists and gatekeeping

The most common theme raised by Group A respondents – identified by well over half of those who responded – was related to concerns that the proposal to extend the clinical team would add further delays and increase already lengthy wait times to children and young people seeking access to the service. Group A respondents believed that less appointments and less clinicians would be desirable in reducing wait times, feeling that those patients who needed it should be guided as quickly as possible towards endocrine intervention and transition – particularly with the approach of puberty and potentially devastating bodily changes for many gender dysphoric children. Wait lists were quoted by some as already being up to five years long – a situation deemed in urgent need of rectifying, yet curiously and conspicuously unaddressed in the specification – and many felt this change, as well as others, would increase the time spent by patients awaiting treatment. This, along with the belief that in order to progress through the system future patients would need to "prove themselves to" or "convince" an increasing number of clinicians, whether or not the clinicians were necessary or desired, led a significant number of Group A respondents to label the change as "gatekeeping" – that is, a purposeful obstruction designed to prevent children and young people from transitioning, suspected by some to be driven by individuals and groups under the influence of anti-transgender forces in politics and the media.

"It sounds reasonable at first, but I then start to wonder just how many specialists a person will need to see before finally getting the support they are seeking. The great majority of people seeking gender affirming care want and need exactly that, and their needs are quite simple. Conflating gender incongruence with lots of other issues is disingenuous, and while it's nice to have all of the specialists there at once, I really doubt that it's necessary. To me it sounds more like gatekeeping than anything positive."

(Patient – Partially Agree)

"No evaluation has been made regarding increasing the complexity of the clinical team. This will result in 'referral pinball', where a patient must see specialist A, specialist B, specialist C [and so on], each requiring a harmful wait of months or even years. This will harm trans children by inappropriately delaying their healthcare."

(Patient – Disagree)

"Supporting people in a more holistic way is sensible but this should not be used as an excuse to treat every aspect of the patient except their gender dysphoria. Do not set up a system where a patient has to jump through hoops of treating all their other mental health problems before they are allowed to access treatments for their gender dysphoria."

(LGBTQ+ individual – Partially Agree)

"My main concern is one of gatekeeping and of the state placing obstacles in the way of those suffering from gender dysphoria. We have a huge shortage of access, grossly unfair waiting lists, and simply changing how this is handled doesn't diminish the problem. The consequences of allowing puberty to run its course for a child that is dysphoric can have catastrophic consequences and is socially cruel. Gender dysphoria ruins lives and provokes long-term mental health issues unless it is dealt with in an understanding and supportive way. Gatekeeping is not the way."

(Parent – Partially Disagree)

"Expertise is good, but only when it is relevant. It is not clear that the proposed additions to the team size are relevant at all, in which case making patients move through them all is unhelpful and a waste of everyone's resources."

(Member of the public – Partially Disagree)

"While having good access to additional experts seems a good idea, it seems strange to add them to a team when they mostly will not be used. It feels like bloat for the sake of expansion. You'd probably be better off with a slim, agile core team who have a capability to bring in other expertise as necessary."

(Parent – Partially Agree)

"In principle this would be helpful because the lack of connection between the different teams my son consults is a source of constant frustration, and also considerable wasted clinical time. Given the pressure on NHS resources I fear this may also cause further delays. As the Cass report made clear, and as my family have experienced, delays are debilitating and inhumane, and I would urge this review to refocus on this core issue."

(Parent – Partially Agree)

"The interim specifications do not appear to acknowledge that long waiting lists are a systemic issue and resource problem. It is important to note here that in their January 2021 review, the main concerns raised by the Care Quality Commission related to young people's safety on the waiting list and management structures."

(Service provider – Disagree)

Concerns that an increased focus on mental health may exclude neurodiverse children and young people from receiving treatment, and that it further pathologises transgenderism

Many Group A respondents felt that the proposal to "include experts in autism, neurodisability and mental health" was a worrying indication that the extended clinical team may seek to treat gender dysphoric neurodiverse individuals – and in particular those diagnosed with autism – in ways which undermined their abilities to know themselves and to know what they wanted, shifting the focus from their experience of gender incongruence and their desire to transition gender, and moving it to what respondents felt may be becoming viewed as – and in their opinions, mistakenly viewed as – a mental health issue. There were also concerns, shared in response to a number of questions, that this increased focus represented a greater pathologisation of gender dysphoria.

Some Group A respondents felt that NHS England's proposed change betrayed a misunderstanding of what the experience of neurodiversity and autism actually are, while some highlighted concerns that an apparent increase in focus on mental health amounted to conversion therapy. While there were those who welcomed experts in neurodisability and autism, this welcome was extended with the proviso that the extension increased support for such individuals and was offered alongside assistance in moving through transition, not instead of it. There were also those who believed there was no evidence to support an increased focus on mental health, and that the best evidence – i.e., that which resulted in the best outcome for the individual – supported early intervention, the prescription of puberty blockers, and progression along the pathway to transition. Some also expressed the belief that the correlation between autism and gender dysphoria may exist due to autistic individuals being less constrained by pressures to conform, more open to divergent beliefs and experiences, and more likely to question assumptions unquestioned by others.

Finally, in accordance with other themes, Group A respondents highlighted their belief that "experts in autism, neurodisability and mental health" must also be at least highly trained in gender incongruence and dysphoria, if not experts in these fields also.

> "I agree on the proviso that autism, neurodisability and mental health professionals are not sourced from those who believe that being autistic somehow renders us unfit to make decisions about our own care."
> (LGBTQ+ individual – Neither Agree nor Disagree)

> "The implicit assumption behind this change seems to be that some patients may be confused about who they are because they're autistic. That assumption needs interrogating: on its face, it represents a misunderstanding of what autism is (and I write this as, besides a medical ethicist, an autistic person). Autism is a communication disorder. Autistic patients do not have less capacity or less autonomy."
> (Member of the public – Partially Disagree)

> "There seems to be a rather regressive assumption here that young people with gender incongruence present with autism, neurodisability or mental health problems as a matter of course. This is a profoundly discriminatory thing to assume. As your own documents admit, the relationship between gender incongruence and autism is not fully understood and could therefore not be related at all, or it could be that those with autism care less about peer pressure – a well-recognised aspect of autism – and therefore are more open because of this."
> (Has transgender friends or family – Disagree)

> "There should be less emphasis on psychology – gender dysphoria is not a mental illness. The research has already been done in other countries: early intervention with puberty blockers results in better outcomes for trans individuals. The UK is so far behind."
>
> (Parent – Disagree)

> "A major trope in mainstream anti-trans campaigning at present is the idea that autism and related traits imply a reduced capacity to identify the need for and consent to transition-related care. This is incorrect and harmful."
>
> (LGBTQ+ individual – Neither Agree nor Disagree)

> "Where differential diagnoses indicate that the child/adolescent has other mental health issues (e.g., they are on the autistic scale) this should not be used as an excuse to delay, prevent or exclude them from treatment for gender incongruence, except where this is clinically indicated."
>
> (Patient – disagree)

> "At several points during my time with the NHS mental health professionals attempted to push the square peg of my experiences with gender dysphoria into the round hole of a purely mental health-based issue, attempting to deny me access to the care I needed. I am concerned that this will similarly be the case for young people using the service today, and that the increased number of mental health and neurodivergent-focused staff will lead to attempts to [place] their experiences and issues around gender into different fields."
>
> (Patient – Partially Agree)

> "The involvement of more experts in different fields is in no way backed up by any existing medical evidence, and there is no evidence that it would lead to positive changes in patient outcomes."
>
> (Patient – Partially Disagree)

> "My concern here is that this will lead to diagnostic overshadowing, whereby some [clinicians may feel] that gender diversity is a 'symptom' of neurodiversity or a 'special interest' phase (Glidden et al., 2016). This interpretation has led many to mistakenly dismiss the gender diversity [and believe] that conversion practices in the form of 'exploration' are necessary."
>
> (Clinician – Neither Agree nor Disagree)

> "My therapist has told me that being autistic has resulted in some children being disallowed to continue along the transition pathway. I find this horrifying. Had I been diagnosed with autism prior to referral by my GP for transitioning it would probably have been stopped. I would quite likely have taken my own life as a result."
>
> (LGBTQ+ individual – Partially Agree)

> "Whether a child has autism, a neurodisability, or mental health concerns does not impact on whether they are gender diverse or not. Having any of those conditions does not cause one to become transgender, nor does treating those conditions 'cure' someone of being transgender. More support is welcome, but not if it will be used as an excuse not to help gender diverse children who also have other conditions."
>
> (Service provider – Partially Disagree)

Staff experience, expertise and philosophy

Many Group A respondents believed that all members of the new clinical teams would require significant training in issues affecting and experienced by gender dysphoric children and young people, with many expressing a preference for staff who were already experienced and, indeed, experts in the field, and some saying that staff should not be engaged in the service prior to receiving such training. Some also highlighted that members of the clinical teams should be understanding of trans issues;

that they should be gender affirming, supportive, empathetic and compassionate; and that it would be best if they had a "lived experience" of trans issues or were transgender themselves. Some also expressed a requirement for the clinical teams to ensure they maintained an unbiased impartiality and were free from any anti-trans influences or ideologies. There were also some Group A respondents who expressed support for the staff working within the current Gender Identity Development Service, saying that its staff should be retained, that they already represented a professional and highly competent multidisciplinary team, and that new members of a clinical team should work alongside and learn from them. Some respondents also stated that whether the change worked would depend entirely on the competency and personalities of the individual members making up the team.

> "I feel it is incredibly important that any members of the team receive comprehensive training on supporting trans youth, and that this training is received prior to them joining the team rather than them learning it 'on the fly'. They must have an understanding of the language used by trans youth, the social issues they face, and be given the opportunity to ask questions that are answered fairly."
>
> (Member of the public – Partially Agree)

> "Including experts in paediatrics and neurodivergence is an important step in appointing the correct specialists to the team. However, the vast majority of these experts are not trained in delivering transgender healthcare and this must be addressed to make this multidisciplinary approach effective. Without proper training prior to joining clinical work this is likely to result in mismanagement, delays, and wrong treatment for trans youth. Failure to provide gender affirming treatment can cost lives."
>
> (Patient – Partially Disagree)

> "I would like to see a concrete commitment to ensuring that outside experts who are brought into these services would have the appropriate training and education to engage meaningfully with their patients BEFORE beginning in their new roles. This is especially essential because the existence of trans people has been so heavily politicised in recent years, with major news publications and politicians actively spreading harmful misinformation about us. Accurate and compassionate education must be a prerequisite to working with trans people."
>
> (Patient – Partially Agree)

> "Given that trans, non-binary, and gender variant young people report poor experiences and outcomes from the other disciplines suggested, significant training would need to be undertaken by clinicians prior to beginning any work with service users in order to be able to provide a culturally competent service. For example, trans young people and their families report consistently poor experiences of Child and Adolescent Mental Health Services (CAMHS) due to the lack of knowledge and cultural competency of CAMHS professionals regarding trans and non-binary people (Carlile, 2020)."
>
> (LGBTQ+ individual – Partially Disagree)

> "A consistent theme we heard from our service users was about the challenges they faced engaging with GPs or with local CAMHS services who lacked training and understanding of gender diversity. The parents we spoke to were in agreement, stating that there are wildly different experiences of CAMHS therapists, some of whom are completely transphobic, some who have no knowledge [of transgender issues] whatsoever, and some who give massively misleading and inaccurate information. They don't have the training. Who's going to train the [new clinical teams]?"
>
> (Service provider – Partially Agree)

> "I would strongly encourage the NHS to take training from organisations like Stonewall for new staff. I have far too many trans and non-binary friends who have been misgendered and belittled by NHS staff for it to not be a pattern of bad training."
>
> (Patient – Agree)

> "I can see why GIDS staff – highly trained clinicians – might be offended that they aren't considered to already have significant experience in areas such as mental health and neurodiversity (they have). What is a paediatrician going to add in terms of a child's experience of their gender?"
>
> (Clinician – Disagree)

> "The core focus should be, as it is at GIDS, acceptance and respect for young people's gender identity; not taking a view regarding the outcome of an individual's gender identity development; providing a space for exploration of gender; ameliorating any negative impacts on general development; and working with young people to think through all the options open to them."
>
> (Service provider – Neither Agree nor Disagree)

Other issues raised by Group A respondents

A number of Group A respondents expressed concerns that the proposed change could lead to serious negative consequences for gender dysphoric children and young people – particularly due to the predicted increase in wait times and difficulty in being referred to the service and accessing treatment – with some mentioning mental health concerns such as anxiety and depression, while others believed the changes would lead to increases in self-harm and suicide (mentioned in response to most questions, and in particular the question on social transition).

Some respondents believed that the proposed change would cause significant distress for current patients who may have to change the healthcare professionals they see, whom they may have formed trusting relationships with over a number of years. As above, there were concerns that this change may lead to further increases in wait times, while the dissolution of established connections and the possible need to revisit previous discussions and procedures was seen as being detrimental to a patient's wellbeing, and as a negative impact and setback on their pathway to transition.

Some respondents expressed concerns that the timeline proposed was unrealistic and overly ambitious, while a few Group A respondents feared that increased wait times and further barriers to access to care would lead to more children and young people sourcing unregulated drugs.

There were also a number of suggestions put forward for additional members of the clinical team (with figures in brackets showing how many suggested them):

- An endocrinologist (14)
- A youth worker (3)
- A pharmacist (3)
- A fertility specialist (2)
- A child rights activist (1)

Summary of themes raised by respondents identified as Group B (n=948)

Group B respondents said…	Number
It's good that the service will focus on psychological issues	577
General expressions of support for the proposal	538
The service provided by GIDS was poor and even harmful	313
All staff must be impartial and free from pro-transgender ideology	228
The service and all staff working in it must adhere to science	90
The multidisciplinary team must include safeguarding measures	85
The team must feel safe and be able to work free from outside pressures	76
NHS England should leave the Memorandum of Understanding on conversion therapy	68
The team should not include an endocrinologist	62
Patients should never receive surgery, only psychological treatment	55
The multidisciplinary team should also include a counsellor or family therapist	47
The team should have specialists who do not accept that gender dysphoria exists	31
The team should consider a link between eating disorders and gender dysphoria	29
The team should fully understand the challenges of puberty	25
GIDS whistleblowers and resigners should be reinstated	10
The change appears to downgrade experts in mental health	9
The team should be overseen and inspected in order to ensure compliance	8

Support for a holistic, multidisciplinary clinical team focused on neurodiversity, mental health, and psychoeducation

Many Group B respondents used the free text box to further express their support for the proposed change. Often this was not elaborated on – for example, comments such as "this seems like a sensible and positive change" – but where it was, respondents highlighted the increased focus on mental health and neurodiversity, which they saw as the most likely areas where both the cause – often proposed to be linked to bullying, social media, internalised homophobia, trauma, or confusion surrounding gender stereotypes – and the treatment of a child or young person's gender dysphoria would be found. Many respondents expressed the belief that children and young people should never be steered towards surgery, and that they should only ever receive psychological treatment – at least until the age of around 25, when "the brain reaches full development". There were also those who felt that psychologists, psychiatrists, and others working in mental health had previously been hampered in their work and in their ability to help children and young people by both affirmation promoting services within the NHS and ideological pressures from outside, with some feeling that mental health practitioners would have been stifled and afraid to practise what they believed to be the best course of action due to fears of negative repercussions and/or being labelled transphobic. Some wanted to encourage the message that "exploratory therapy is not conversion therapy", while there were also a significant number who felt that NHS England would best serve both its patients and its practitioners by signalling an intent to leave the Memorandum of Understanding on Conversion Therapy.

“Better integration of care across specialisms and with referral from NHS trained staff seems a sensible and positive change that will ensure young people have been appropriately assessed for other factors before transition happens.“

(Parent – Agree)

“I am so relieved that you are bringing in this additional expertise. It feels like you have looked at the complex needs of these children and are no longer commissioning a ‘one size fits all’ service fixated with gender-affirmation.“

(Member of the public – Agree)

“I’ve met a number of young people with genuine mental health needs feeling transition will solve them. Predominantly with autism spectrum disorder, often with abuse histories. Their needs are very complex and a simplistic transitional solution would likely be even more damaging to them.”

(Clinician – Agree)

“I absolutely agree with including autism specialists. I would want to see a psychological assessment of every child which explores their context, individual factors, social media use, and capacity to consent.”

(Parent – Agree)

“Mental health issues should never be treated with medication or surgery as a first port of call. Multiple specialists looking through all options with the patient is a much more robust system.”

(Member of the public – Agree)

“In my research with people who have detransitioned we asked what support they would have liked before they transitioned. The most common answer was support with mental health difficulties and trauma, which many had since come to see as the primary reason for their gender distress. Other participants talked about wanting support with making sense of their emerging same-sex attraction and internalised homophobia, and others with understanding and coping with neurodiversity. Some female participants also mentioned wanting to be supported in making sense of being a girl in a sexist society, including being sexually objectified during puberty. Some also talked about more extreme experiences of sexual abuse and assault as playing a role in their desire to become male. I fully support the approach outlined here to embed expertise and the move to a multidisciplinary team which draws on expertise recognising the complexity of presentations in this population.”

(Member of the public – Agree)

“Gender dysphoria often presents in children and young people with comorbidities in the areas of neurodiversity and mental health, which need to be explored and supported in conjunction with gender services. A model that while supportive is not automatically affirmative or moving rapidly towards social transition is essential. Safeguarding also needs to be embedded into the service – especially for very young children who are unable to understand the implications of any decisions made.”

(Clinician – Agree)

“We welcome the decision to extend the clinical team to include specialists in areas other than gender dysphoria. 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. [Also], the recognition that autism spectrum conditions were overrepresented in GIDS patients represents a marked and welcome shift from the lack of critical inquiry demonstrated by GIDS. [This] represented a fundamental failing 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.”

(Service provider – Agree)

“My child (natal boy) identified as trans at age 13 after reading about it online. He experienced body dysmorphia relating to onset of puberty, some bullying by more stereotypical boys, a falling out with a

> good friend (male), some gender non-conformity in relation to sports, and he enjoyed the company of girls. Undiagnosed autism contributed to a feeling that identification as trans was the simple solution to his depression. This was affirmed by the NHS Choices website and by CAMHS addressing him with his new female pronoun prior to any discussion with us or him, as well as by his school. This all relied heavily on his own interpretation of his distress. We could see that friendship loss, depression and non-stereotypical behaviour were huge factors and yet [because] there was no NHS lead to discuss this with him he has presumed his understanding was right for four years (while on the GIDS waiting list). It can of course feel kind to assume that they are correct, but these are complex issues with life-long impacts and we do not normally trust young teenagers to make such decisions unaided. I really welcome the inclusion of autism experts and mental health experts to the clinical team, and also that someone from the service will be involved at an early stage."
>
> (Parent – Agree)

> "Exploratory therapy is crucial. Our daughter has benefitted hugely from this. Unknown to us she was seeing counsellors at her school who had 'affirmed' her as a trans boy and encouraged her to use different names and pronouns at school. This was on the basis of one meeting with her. They also told her not to tell us as we may reject her and she may even end up homeless. They created a complete disconnect between home and school for her, two separate worlds, and during this period she was self-harming and experiencing suicidal ideation. Since she has stopped seeing the school counsellors and started therapy with a clinical psychologist who explores the whole picture with her things have improved dramatically. She is no longer self-harming or suicidal and has reverted to the happy child she was. She is taking the time to grow up and learn who she is as she goes along."
>
> (Parent – Agree)

Themes related to staff, both past and future

Like Group A respondents, Group B respondents believed that all staff working in the new clinical teams would require significant levels of training. Unlike Group A respondents, however, Group B views tended towards ensuring that staff were free from pro-transgender ideological beliefs; that they felt safe to practise, free from outside pressures and fear of repercussions and reprisals; that they were instructed to abstain from practising anything approaching an affirmation model; that they adhered to "unbiased scientific evidence" – in this case, this was often seen as the promotion of sex as fixed and immutable, and gender dysphoria as being caused by issues other than "being born in the wrong body" – and that there was no repeat of what was seen as the mistakes of the previous Gender Identity Development Service at Tavistock, which many Group B respondents viewed as a hotbed of unwise and damaging pro-transgender sentiment and a place where questioning voices were both silenced and pushed out. Some Group B respondents believed that some who had been fired or forced to resign from GIDS – including so-called "whistleblowers" – should be reinstated, while others encouraged that the new clinical teams should contain clinical specialists who did not accept the existence of gender dysphoria.

There were also those who suggested that all staff should possess a wide-ranging education and understanding of issues that commonly arise in children before and during puberty, and of how these issues may be related to feelings of gender dysphoria, as well as understanding any connection between eating disorders and gender dysphoria and the possible roles social contagion, social media, and trends may play in leading children and young people to believe they are transgender.

> "There will have to be new clinical staff, including mental health professionals, in these new multidisciplinary teams. The fact that a significant minority of therapists resigned from GIDS not long ago leads to the question as to whether they would now be treated as eligible for the new posts. It is clear

> that these therapists believed in talking therapy, not physical procedures such as puberty blockers accompanying gender transition."
>
> (Parent – Disagree)
>
> "The introduction of specialists with expertise in paediatric medicine, pervasive developmental disorders, and mental health is positive. However, there appears to be an underlying assumption that 'gender dysphoria' is a quantifiable condition, whereas the term 'gender' is not defined and a 'gender dysphoria specialist' seems to me to be an ideologically focused role based on the unscientific notion that humans possess a 'gender identity'. Finding the most efficacious treatment pathway for a child with dysphoria should be based on empirical evidence."
>
> (Clinician – Partially Agree)
>
> "The changes suggested in the service specification are mainly positive but I am concerned that the NHS is still not recognising the homophobic and misogynistic attitudes that arise when you let trans groups such as Mermaids influence your care and policies."
>
> (Parent – Agree)
>
> "Although we welcome the further addition of specialists to the multidisciplinary team we are deeply concerned that the pool of professionals who hold the qualifications to fulfil the requirements of the clinical lead is small and has significant overlap with those running the previous service, which has been deemed as failing on several accounts. We are concerned that a specification which has been prompted by the failure and ultimate closure of the previous service will solely rely upon clinicians who operated within disavowed services."
>
> (Service provider – Partially Agree)
>
> "[The clinical team] must be freed from the radical gender ideology which has gripped much of the previous GIDS administration."
>
> (Parent – Agree)
>
> "Please specify that staff need to hold an exploratory, neutral view towards treatment of adolescents and children with gender incongruence/dysphoria. Previous involvement with pro-transition groups such as Mermaids should probably disqualify staff. [Also], young people can be persuaded online that their distress is due to gender issues, and then told what to say to clinicians, and this issue needs to be recognised by staff."
>
> (Parent – Agree)
>
> "How will you ensure neutrality? There are many pro-transition activists, even amongst paediatricians and autism specialists. Many clinicians have been subjected to very partisan 'training.'"
>
> (Parent – Agree)

Other issues mentioned by Group B respondents

A large number of Group B respondents expressed negative sentiments towards gender affirmation practices and social transition, with many supporting a stance of "watchful waiting" and taking a non-affirming position. These themes were more widely raised in responses to Question 4 and are discussed there.

A few respondents believed that the proposed change to the interim service specification "signalled a downgrading of the importance of mainstream psychotherapists and psychologists" due to the inclusion of and perceived weighting towards gender dysphoria specialists and "experts in paediatric medicine, autism, neurodisability" above "experts in mental health".

Some also suggested additional disciplines which they felt should be part of the new clinical teams:

- Experts in safeguarding (85)
- Social workers (71)
- Counsellors and/or family therapists (47)
- Sexual abuse specialists (12)
- Speech and language therapists (8)
- Occupational therapists (8)
- Ethics consultants (5)
- Substance abuse workers (2)
- Clinical neuropsychologists (1)

Group B respondents were also strongly opposed to the inclusion of an endocrinologist within the multidisciplinary team, with some stating that “this seems to pre-empt the outcome of a process before it has begun.”

Summary of themes raised by all respondents (n=3057)

Themes raised across all viewpoints...	**Number**
Concerns and questions regarding resources, investment, and staff levels	79
More information required	26
There should be good levels of communication and agreed principles	16

Resources, staff levels, funding and investment

In response to this question, as well in response to most other questions, concerns were raised and questions asked as to whether there were sufficient resources available in order to provide an extended service in multiple locations catering for a vastly increased and potentially increasing demand. In pointing to lengthy waiting lists respondents felt that current services were clearly insufficient and were failing to provide what was required, while questioning where new and extra staff would be found and how they would be funded. Buildings, administration, and infrastructure were also seen to require significant investment, and respondents felt that little or no information had been provided regarding the sources for this or whether such investment was realistic or possible. Some also drew attention to the pressure this may put on already overloaded GPs and doctors, as well as the knock-on effect it was predicted to have on their other roles and patients.

> “I don’t know how you are going to resource this for a phase 1 interim stage. It seems hard enough to have contact between a GP, GIDS, and an NHS endocrinologist.”
>
> (Parent – Partially Agree)

> “This increase in the disciplines would be really helpful [but] I feel it cannot be achieved. There are insufficient paediatricians (it took three years for an ASD diagnosis due to a lack of paediatricians); there is insufficient capacity in CAMHS (even with suicidal thoughts and threats, the waiting list is 10 months); there are insufficient GPs; and there are insufficient ASD specialists.”
>
> (Parent – Partially Agree)

> "I'm seeing increasing numbers of young people with diverse gender identities [and] we need huge investment in mental health services if they are going to be supported in a timely way. At present we have over 2-year waiting lists for autism spectrum disorder assessments and a year for psychology."
>
> (Clinician – Agree)

> "The NHS is currently under heavy stress and the proposed restructuring of care provided by clinical teams will bring healthcare to an effective stop."
>
> (Patient – Disagree)

Some respondents, both Group B and Group A, also highlighted the need for all members of the clinical team to share agreed principles and maintain a high level of communication with one another, as well as with the patient and their family.

More information required

Some respondents felt they would have benefitted from receiving more detailed information in order to contribute a more well-informed opinion, while others asked questions about how the multidisciplinary team would collaborate or how the individual members would function.

Questions for further information and points of clarification included:

- How will the team be trained and to what extent?
- Will they be competent and fully trained before starting work or will they learn on the job and/or be trained as they go along?
- Will different members of the team be used for different cases or will each case always involve the whole team? If the former, how will this be decided?
- What role will each team member play?
- Is the clinical team to be comprised individually of experts in paediatric medicine, autism, neurodisability, and mental health, or is it to be comprised of clinicians who are collectively experienced in these areas but who principally work with gender diverse young people?
- What, specifically, are "the essential disciplines"?
- How will intra-team disagreements be managed?
- How do the competencies and experiences stated in Appendix B map onto professional roles?
- How will these roles be recruited for? Are there sufficient staff? What is the plan if not?
- How is "gender dysphoria expert" defined?
- What role will clinicians who have experience in paediatric medicine play?
- As used in the interim service specification, what does "psychoeducation" mean?
- What plans are there to ensure that members of the team are unbiased?
- Will the focus on neurodiversity make it more difficult for a young person to receive care for gender incongruence?

B. Clinical leadership

The interim service specification public consultation guide stated that:

> 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; and that oversight of the service by a medical doctor is appropriate given that the service may provide medical interventions to some children and young people.

Note: other documents respondents may have seen differed slightly in their definitions of the clinical lead. The Equalities and Health Inequalities Impact Assessment stated that the clinical lead "will be a consultant medical doctor" while the interim service specification stated that "the key clinical leadership role will be through a medical consultant with significant experience in the developmental needs of children and adolescents."

Respondents were asked to what extent they agreed with the substantive change to the service specification regarding clinical leadership. They answered:

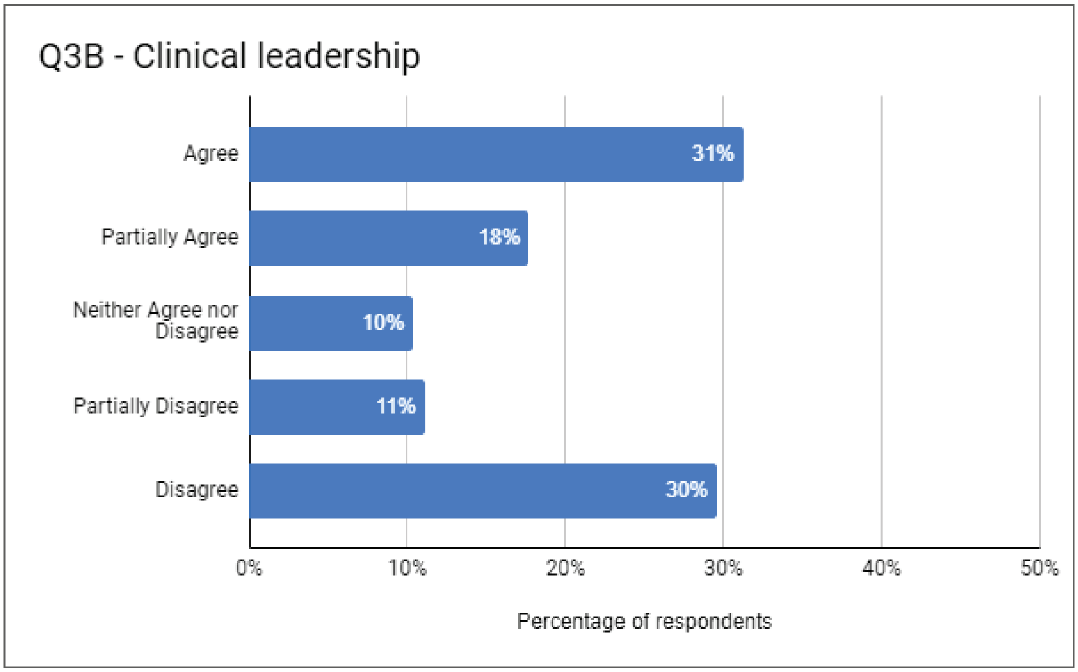

Figure 3. Quantitative results regarding clinical leadership

Clinicians, parents and members of the public were the most likely to agree, with an average of 64% of these three groups at least partially agreeing.

Patients were the most likely to disagree (54%), followed by LGBTQ+ individuals and those with transgender friends or family (48% and 49% respectively at least partially disagreeing) – slightly higher levels of disagreement than in responses to the first question.

Summary of themes raised by respondents identified as Group A (n=1774)

Group A respondents said...	Number
The clinical lead must be an experienced expert in gender dysphoria	1203
The proposed change pathologises gender dysphoria	1005
The lead should be informed by global experts in transgender health	279
The clinical lead should be a trans person	157
The clinical lead will need to be trained in gender dysphoria	149
The change will lead to delays and obstructions	116
The lead shouldn't be a medical doctor	110
The clinical lead should not be anti-trans, they should be impartial	99
The lead should be a trans-affirming person	61
The lead should be supportive, friendly and compassionate	52
The lead should be a person who has lived experience of trans issues	42
The lead should be the right person with the right skills	36
The lead should be monitored	2

Agreement in principle, subject to conditions

As in responses to the first question, a significant number of Group A respondents agreed in principle with the proposal while at the same time expressing certain concerns, caveats, stipulations and conditions that they felt would need to be met in order to feel satisfied with the change. Of the 496 respondents identified as Group A who stated that they agreed (5%) or partially agreed (25%) with the proposal to make the clinical lead for the service a medical doctor, 354 (71%) said that the clinical lead would need to be an expert in gender dysphoria and 254 (51%) said that the change to a medical doctor should not infer that gender diversity is inherently a medical condition, thereby pathologising the experience of patients. Also, as in responses to the question on the expansion of the clinical team, respondents stated that whether the change to a medical doctor was beneficial or not would very much depend on the person in charge.

> "The primary focus for clinical leadership should be based on competence and experience in gender identity issues. If a medical doctor is the preferred option they should have defined experience in working within the field of gender dysphoria. There is a risk that not fully understanding this specialised area could be detrimental to service users."
>
> (Parent – Partially Agree)

> "Clinical leadership should be given to a doctor who is a pre-existing expert in gender dysphoria and transgender-related medicine – ideally someone who has been working with transgender patients or those with gender identity disorder for multiple years."

(Patient – Partially Agree)

> "It is critically important that this change is neither communicated nor interpreted as increasing medical pathologisation of trans identities and that it should recognise the World Health Organisation's commitment to depathologising trans people. As a trans adult I feel very strongly that my gender identity is not a sickness."
>
> (LGBTQ+ individual – Partially Agree)

The clinical lead must be well-trained, with demonstrated expertise and experience in positively benefitting children and young people with gender dysphoria

The most commonly mentioned theme by Group A respondents was to emphasise their belief that the clinical lead must be an experienced expert with a proven track record in contributing positively to the experiences of young trans people. Ideally, they said, there should be no "training on the job", but rather the lead must already have a solid grounding in gender dysphoria issues before beginning work with either the multidisciplinary team or the patients themselves. Some also stated that the clinical lead should be someone known to and trusted by trans people, in order to begin the process from a place of trust and optimism, while others believed that a "lived experience" or being trans themselves was among the most important qualities the clinical lead should possess – indeed, as some explicitly stated, such qualities and lived experiences were seen as being more important and essential than "general medical expertise" and, therefore, some questioned whether it was necessary that the lead be a medical doctor, but rather "the best person for the job."

> "I do not see why a medic needs to be the clinical leader when those from a non-medical background can still have extensive knowledge of current research and best practice. Children with gender incongruence will likely have a complex set of needs, therefore the clinical leader role would be best suited to someone with the adequate background of working with gender dysphoria and have evidence of engagement with research and best practice and a willingness to continue to transform clinical practice. None of these requirements are medic specific."
>
> (Member of the public – Partially Agree)

> "Agree on the proviso that the medical doctor is someone who specialises in working with transgender individuals and has a good relationship with the community rather than seeing us as a problem to be solved."
>
> (LGBTQ+ individual – Neither Agree nor Disagree)

> "Clinical only leadership is problematic because our evidence indicates that clinical service providers do not currently have adequate or appropriate understanding of trans and gender diverse young people's lives, identities and needs, and as such risk exacerbating existing problems faced by young people trying to access healthcare."
>
> (Member of the public – Disagree)

> "The primary focus for clinical leadership should be based on competence and experience in gender identity issues. Leaders may make use of experts in their field to deliver appropriate treatment and should be suitably knowledgeable of their subject area to do this. If a medical doctor is the preferred option they should have defined experience in working within the field of gender dysphoria. There is a risk that not fully understanding this specialised area could be detrimental to service users."
>
> (Parent – Partially Agree)

> "Clinical leadership should be given to a doctor who is a pre-existing expert in gender dysphoria and transgender-related medicine, ideally someone who has been working with transgender patients or

> those with gender identity disorders for multiple years. A clinician who also has experience with how overseas medical systems treat transgender patients would be a great benefit to the system.”
>
> (Patient – Partially Agree)

> “The clinical lead must be an expert in the care of trans and gender diverse young people, recognise the wider health and social issues that young people face, and be a champion for their rights around consent and decision-making. The emphasis on a medical doctor as clinical lead ought to be at least equally weighted towards a gender specialist that understands the wider mental health and wellbeing implications for young people, and ideally they should identify as a trans or non-binary person themselves.“
>
> (Service provider – Partially Disagree)

Concerns that having a medical doctor as clinical lead further medicalises – and therefore pathologises – being transgender

As in responses to Question 3A, many Group A respondents felt that the proposed change with regard to the clinical lead represented an increased movement towards the pathologisation of transgenderism – however, as they stated, this would be a mistake as “being transgender is not primarily a medical issue” nor “an illness”, and that seeing it as such appeared opposed to guidelines promoted by organisations such as the World Health Organisation.

> “It is important that this does not further pathologise being trans in the NHS. Trans people need medicine in the same way that pregnant people do, to improve their quality of life, and not because they are diseased.”
>
> (Parent – Neither Agree nor Disagree)

> “Introducing a medical doctor should not infer that gender diversity is mainly a medical issue and should not pathologise patients, in line with the World Health Organisation and other leading health bodies’ attempts to depathologise trans people.“
>
> (Patient – Partially Disagree)

> “So what if a trans person also has a mental health problem? So what if a trans person is also autistic? Imagine replacing ‘trans’ with ‘gay’ and saying that the NHS was recruiting a team to see if gay people are really homosexual or ‘just mentally ill’, ‘just autistic’ etc. And imagine how confusing it will be for young people, who know who they are, to be constantly gaslighted and told they are ‘wrong’ in some other part of their brain. I know a young trans person (who is now a post-transition adult) who kept having their referral to the Gender Identity Clinic refused by CAMHS, who blamed their trans-ness on depression. Guess what? They’re still trans, they’re post-transition and happy, and the CAMHS battle caused a significant amount of stress and trauma at a young age. Please don’t make this the case for thousands of trans young people.”
>
> (LGBTQ+ individual – Disagree)

> “There should be acknowledgement that gender diversity and transness is not simply a medical issue, although medical intervention can be an important part of supporting trans people. The WHO have committed to depathologising trans people and therefore any clinical lead should be positioned as someone whose medical expertise can inform the treatment of trans people without assuming that medical intervention is the only necessary factor in a trans person’s experience.“
>
> (Member of the public – Partially Agree)

> “As a trans adult I feel very strongly that my gender identity is not a sickness or something that a cisgender clinician can or should be able to diagnose, and it’s unfortunate that some aspects of trans identities require medical care because this puts medical professionals in the roles of gatekeepers of

> something they're largely not well-equipped to gatekeep. I realise there are additional complexities when it comes to the care of children, but even so I think it's vitally important that having a medical doctor lead this service does not contribute to the undue medicalisation and pathologisation of atypical gender identities."
>
> (LGBTQ+ individual – Partially Agree)

> "I am confused as to why a medical doctor needs to be the clinical lead. This to me implies that the trans identity is being 'treated' as a medical condition, as opposed to being something that maybe needs more of a psychosocial approach. Please be mindful of invalidating these children's trans experiences by employing a more medical model."
>
> (Clinician – Neither Agree nor Disagree)

The lead should be informed by global experts in transgender health

Many Group A respondents believed that the clinical lead should be guided by worldwide experts in transgender health, with many citing organisations such as WPATH, AUSPATH, the World Health Organisation (WHO), as well as the healthcare systems of countries such as the Netherlands and Australia, which were seen by Group A respondents to be significantly more advanced than the UK in terms of transgender healthcare, as well as in terms of evidence and research.

> "It is important for the leader to work collaboratively with the World Health Organisation and the Professional Associations for Trans Health. There has been a lot of research published in the last five years which does not appear to have been included in your proposal."
>
> (Parent – Partially Agree)

> "The training and expertise of the clinical lead must be informed by international best practices and global expertise in the form of WPATH Standards of Care 8, not the failed UK equivalent BAGIS. There is a wealth of information available globally. The UK is exposed by its lack of collaboration and clinical research."
>
> (Service provider – Partially Agree)

> "The premise on which to base this measure is not well founded. Have other countries been researched into its impact on society?"
>
> (Member of the public – Disagree)

Other objections to the clinical lead being a medical doctor

Some Group A respondents objected to the clinical lead being a medical doctor on the grounds that it seemed to imply that transgenderism was always a medical issue ultimately requiring a medical intervention, and that it prioritised medical support over less pathologising models like social transition or other forms of psychological support. Some also felt that non-medical professionals such as those working in services in a community setting, possibly with greater experience working with trans individuals, would be better placed to serve individuals than a medical doctor specialised in paediatrics.

> "I'm not sure this is necessary as being transgender is not a medical condition, the medical bit comes when people need medical transitioning. Ultimately my child does not need a diagnosis to live as trans, they need support to live as themselves."
>
> (Parent – Disagree)

> "The medicalisation of this process negates any recognition of social transition, which is arguably as important if not more important. Many young people who are supported through social transition are happier with their bodies if they can express themselves in other ways with support. Medical transition should be one of the other paths forwards, but not the only path forwards, and presenting a medical lead undermines this."
>
> (Service provider – Disagree)

> "Having a clinical lead who is a doctor is great, but it feels quite arbitrary for why it requires them to be a medical doctor since giving medical interventions would be only one aspect of the service. Taking a holistic approach, it would be great to see clinical leads from various healthcare backgrounds – e.g., occupational therapy – who are also experts in gender identity."
>
> (Clinician – Disagree)

> "Why does all child transitioning need to come under the control of a medical doctor? If the child has dysphoria it may be necessary, but not for those who do not need a diagnosis because they can manage their gender incongruence with social transitioning, which is not medical."
>
> (Has transgender friends or family – Partially Disagree)

> "The specification outlines that the majority of the work delivered by the new services will be psychosocial, so it is unclear why the lead should be a medical doctor. Joint leadership between a medical professional and a psychosocial professional would make more sense given the staff mix and service delivery being indicated – especially so that all staff can be sure of appropriate clinical supervision."
>
> (Clinician – Disagree)

> "Gender diversity is not inherently a medical issue in all cases. A medical doctor should not be required at the beginning when an individual has many options to consider, such as social transitioning."
>
> (Parent – Disagree)

Other suggestions for the clinical lead role

Some Group A respondents who felt that the clinical lead did not necessarily need to be a single person or a medical doctor suggested other ideas for either non-exclusive leadership or other professionals who could occupy the role, such as:

- Shared leadership with other members of the multidisciplinary team (57)
- Psychiatrists or psychologists (35)
- Endocrinologists (10)
- Nurses (9)
- Any qualified doctor (8)
- A flexible, rotating lead drawn from the members of the multidisciplinary team (8)

> "I wonder if having a joint clinical lead here would be appropriate, to avoid having a single polarised opinion at the top of the clinical tree."
>
> (Clinician – Partially Agree)

> "If a team of specialists are all collaborating and listening to one another then it doesn't matter who is leading the discussion, only that it happens."
>
> (Has transgender friends or family – Disagree)

> "I'm concerned that a single individual will make the decisions rather than a panel."
>
> (Parent – Partially Agree)

> "Having all clinical decisions on one doctor would be a lot of pressure, as well as a high potential for bias and misunderstanding, whereas a team with more collaborative leadership would be beneficial so that understanding of trans people can be discussed and opinions of care can be more flexible. This would be similar to community mental health teams, where referrals are discussed collaboratively to understand outcomes and would ensure the patient is definitely listened to."
>
> (Service provider – Disagree)

> "I fear this will cause a bottleneck in the service as the person with the correct range of knowledge is found. Wouldn't this role be better served by having a diagnostic sheet of weighted 'opinion' from the multidisciplinary team?"
>
> (Member of the public – Partially Agree)

Themes already raised in responses to Question 3A

A number of themes raised similar (and the same) issues to those raised in answer to the question on the composition of the clinical team. These were:

- Concerns that the proposed change to the clinical lead will cause delays and obstructions, and also represents a form of gatekeeping.
- The lead should be trans-affirming, and certainly not anti-trans or transphobic.
- The lead should be sensitive, compassionate, empathetic and understanding of trans issues.
- The lead should be regularly monitored to ensure quality of service and impartiality, and important decisions cross-checked by experienced people in positions of authority.
- There should be avenues for complaints, appeals and second opinion.
- Whether the shift to a medical doctor as clinical lead results in a better service for gender dysphoric children and young people very much depends on the skills, beliefs, competency and personality of the individual doctor appointed to the position.

> "I believe that it would be appropriate for care to be managed by a medical doctor, so long as they were properly trained in how to provide care for trans people. I also believe that it is vital this doesn't slow the process or make it more difficult to access healthcare. There is significant evidence that shows that suicide rates are higher in young trans people that do not have access to healthcare. Making the process harder would only harm young people, so I believe that changes should be made with this in consideration."
>
> (LGBTQ+ individual – Agree)

> "This implies a single medical doctor for a patient. Overall I agree with this, [as long as it] does not allow a single person to be a gatekeeper, who can simply remove a patient from the waiting list."
>
> (Has transgender friends or family – Agree)

> "Leadership should be specialised in gender affirming care and meeting the patients' needs, not general psychiatry and safeguarding. The NHS has always had safeguarding measures in place to minimise medical errors, and those measures have always applied excessively to transgender healthcare making accessing services extremely difficult. We need easier access to lifesaving treatments, not more safeguarding measures."
>
> (Patient – Disagree)

> "The medical doctor [should] handle gender dysphoria in line with research that suggests that gender affirmation is the correct option. If this is not the case then this is actively going to hurt children."
>
> (Patient – Neither Agree nor Disagree)

> "I would be inclined to favour the clinical leadership being assigned to a medical doctor; I am one after all. However it depends on the flavour of medical doctor. A medical degree is no guarantee of clinical objectivity, we are as prone to bias and error as the next person. I would be as averse to the appointment to leadership of an unambiguously pro-trans clinician as I would be to the appointment of a militantly Group B one. I also believe that no one person should hold the ultimate decision without the reassurance of accountability. It is important to remember the life-changing and potentially life-threatening procedures we are considering are unique in medicine, being offered to physically healthy children. This is so consequential that any ambiguity should be referred to a clinical court of appeal. The hospital's ethics board is both a precedent and possibility; doing this would open the decision up to scrutiny by a wider range of ideologically neutral people. This should continue until such time as the evidence base for intervention is robust enough to make clinical decisions obvious."
>
> (Clinician – Partially Agree)

Views put forward by Group B respondents (n=875)

Group B respondents said...	**Number**
General agreement with the proposal to make the lead a medical doctor	434
The clinical lead must not be a pro-transgender person, they should be impartial	298
Concerns that medical interventions might increase	133
Shock and surprise that this wasn't already the case	90
The clinical lead should be a psychiatrist or psychologist	66
The leadership should be shared with a psychologist or psychiatrist	42
The lead needs to engage ethically with hormone treatments	31
The lead must be informed by the latest research and keep up to date with it	30
The clinical lead should be a person trained in mental health	30
The lead should be a doctor who understands all specialisms	21
The clinical lead should play a role in safeguarding for the patient	19
The lead should be someone who was not involved with GIDS/Tavistock	17
The lead should have knowledge of the negative effects of medical intervention	11

General agreement with the proposal, with the assurance that the clinical lead is unbiased

Many Group B respondents expressed general agreement with the proposal to make the clinical lead a medical doctor, with a significant number expressing shock and surprise that this wasn't already the case. Some, however, expressed concerns that steps would need to be taken to ensure that the lead was objective and impartial – meaning that they were neither pro-transgender nor supportive of any kind of affirmation model – and that they were free from any ideological pressure from either NHS England or outside agencies such as Mermaids or social media. Some also said that all new clinical leads should have no previous ties with the Gender Identity Development Service at Tavistock due to fears that staff working there were more likely to express a bias towards affirmation.

> "I am aghast that the clinical lead wasn't [already] a medical consultant given the medical interventions. I'm happy to hear that this will change."
>
> (Member of the public – Agree)

> "I agree with there being a clinical lead and I think that this may help with the current difficulties with who takes responsibility for what, as shown by the poor record keeping at GIDS and the confusion with

> regard to who assessed the young person for what. I would hope that clearer science-led leadership would help with this."
>
> (Member of the public – Agree)

> "Leadership should be carefully monitored for signs of cultural biases being allowed to flourish among a variety of different specialisms. If the leader is convinced by trans ideology there is little chance that the child will be steered towards other care areas."
>
> (Parent – Partially Agree)

> "I believe this should be medically led and in line with the GMC and the principle of first do no harm. The leadership should be open to challenge on the basis of research and data and not ideology."
>
> (Clinician – Agree)

> "An unbiased, informed medical professional is an obvious choice for clinical lead and this should have been the case all along."
>
> (LGBTQ+ individual – Agree)

> "Very necessary and long overdue. Complex child medicine with long-term, irreversible implications and significant mental health components should never have been left in the hands of a handful of overly powerful gender extremists with an unchallengeable belief system. Decisions should ultimately be made, and full leadership responsibility be taken, by fully medically-trained specialist doctors."
>
> (Clinician – Agree)

> "You need to address the issue of activist-clinicians – many in this field think they are saving kids from 'the wrong puberty' and will bend the rules to do this. They see themselves more as social justice heroes than clinicians. How will you stop these people and ensure staff remain committed to the practice you propose?"
>
> (Member of the public – Agree)

Concerns that medical interventions and surgeries may increase

Some Group B respondents expressed concerns that placing a medical doctor in the position of clinical lead may lead to an increase in children and young people progressing to endocrine treatment (puberty blockers and cross-sex hormones) and gender reassignment surgeries – two things many Tran Critical respondents were strongly opposed to. They therefore expressed hopes that the clinical lead would ethically engage with such interventions and consider very seriously all evidence and research as it related to long-term and potentially irreversible health implications.

> "I am somewhat concerned that the insistence that a medical doctor is in charge demonstrates a presumption in favour of medical treatment when (on the basis of first do no harm) a presumption in favour of a psychotherapeutic approach initially would be both ethically and clinically more sound. It is of course imperative that the clinical lead is motivated by clinical not ideological factors."
>
> (Clinician – Partially Agree)

> "The clinical lead needs to be someone who does not automatically medicalise the issues reported by people who identify as trans. The present practice of prescribing puberty blockers or performing surgery in order to make bodies look like someone of the opposite sex is cruel. That this is being done within the NHS without suitable evidence, and that this is being recommended to children, will be looked upon by future generations as one of the worst mistakes ever [committed by] the NHS."
>
> (Parent – Partially Agree)

> "The clinical lead has a duty to engage in an evaluation of the ethics and evidenced-based medicine and explain the decision-making process whereby a child would qualify for medical interventions (puberty

> blockers in particular). Ethical concerns include: the uncertain evidence around the risks/benefits of puberty blockers; impacts on fertility and sexual function; the unreliability and subjective nature of a 'gender dysphoria' diagnosis; the evidence that the vast majority of those who have historically undergone the Dutch Protocol were LGB children; the current sociocultural background (online, at school, among peers) influencing the child, which itself may have induced and entrenched their distress about the body; and the issue of whether a child is truly in a position to provide informed consent."
>
> (Parent – Agree)

> "There is uncertainty around the long term health risks of puberty blockers and how they affect bone density, cognitive function, and sexual function, while almost all children who start on puberty blockers proceed to cross sex hormones. The ethics of hormonal intervention should be evaluated by the clinical lead in terms of their long-term physical impact."
>
> (Parent – Partially Agree)

> "I am wary of the lead being a medical lead for what is a psychological phenomenon involving, most likely, social contagion."
>
> (Service provider – Partially Agree)

Specific skills

Some Group B respondents suggested skills, experiences, and qualities that they felt the clinical lead should possess, in addition to being a medical doctor, including training in mental health issues, experience and expertise in autism and neurodiversity, and good knowledge of the most recent research and evidence with regard to issues concerning gender dysphoria. Some also suggested that the clinical lead should be someone who contributed to the knowledge base, while others encouraged that the lead should be a doctor who was able to take into account many disciplines and areas of study and apply a broad viewpoint to each client and case they were responsible for. Some also felt that the lead should be responsible for safeguarding measures, and that the lead should have a good knowledge of the negative consequences, both physical and mental, that may arise from pursuing transition and be willing to share these with each child or young person in their care, as well as with their family or carers.

> "Leadership needs to have a duty to engage with and keep updated with evidence-based approaches and understand the unknown consequences of prescribing puberty blockers and cross-sex hormones to children and young people. They need to be able to neutrally consider the ethics and use critical thinking to consider all aspects rather than taking an ideological stance."
>
> (Parent – Partially Agree)

> "The clinical lead should have a significant training in and understanding of specialist psychotherapeutic approaches such as dialectical behaviour therapy (DBT) or mentalisation-based therapy (MBT) that have been shown to benefit this population."
>
> (Parent – Partially Agree)

> "It is critical that the leadership of the team is with those who have expertise in child mental health, developmental psychology, and are able to form a well-rounded picture of how best to manage a young person's distress. They should be able to probe the reasons that underlie the presentation of each patient and undertake thorough assessments of comorbidities, autism, risk of sexual abuse, and other issues."
>
> (Parent – Agree)

> "It is right for the clinical lead to be a medical doctor, but it is essential that the person appointed takes a wide viewpoint, not just of the medical treatments available, but the societal and safeguarding issues and the holistic needs of the patients. This cannot just be a 'gender doctor.'"
>
> (Not stated – Agree)

> "The specification states that the lead will be 'a medical consultant with significant experience in the developmental needs of children and adolescents'. I have no problem with the service being overseen by a doctor, but it is important to note that UK paediatricians currently are not expert in gender incongruence/diversity/dysphoria. I am a paediatrician myself so I have insight into the very low level of training, experience or understanding of most paediatricians, and the tendency to look for pathology. I do not see it as a given that the lead should be a paediatrician rather than, for example, a CAMHS consultant who will also be an expert in conditions such as autism and trauma, which seem to be a particular focus for the specification."
>
> (Clinician – Partially Agree)

> "Clinical leadership needs to include a designated professional for safeguarding. The number of neurodiverse patients I am caring for who have a joint diagnosis with a personality disorder, gender dysphoria, and learning disability is increasing day by day. This issue needs appropriate recognition and support, and further research to explore these links."
>
> (Clinician – Agree)

Other suggestions for the clinical lead role

Similar to Group A respondents, some Group B respondents felt that there were other healthcare professionals who would be better suited to the clinical lead role than a medical doctor, while others believed that a system other than an outright individual lead would be preferred in order to fine tune the role to the specialisms required, to share workload, and to help ensure that any patient would receive an impartial and objective diagnosis and service, with other suggestions including:

- A psychiatrist or psychologist (66)
- Shared or rotated leadership (60)
- An unspecified mental health professional (30)
- A paediatrician (18)
- An autism specialist (3)
- A social worker (3)

Some also stated, as they had with regard to the multidisciplinary team in Question 3A, that the clinical lead should not be an endocrinologist.

> "Why return to a medical model? I work in adult gender identity and medical doctors quite literally tick off a list of diagnostic criteria and prescribe treatment (I'm sure our psychiatrists would see that as a reasonable assessment of their role in the service). For any deeper understanding of complex clients, extended psychological assessment is always required and ends up being the most helpful way to understand a person's experience. Returning to a medical doctor taking the lead seems to be a step backwards."
>
> (Clinician – Disagree)

> "As the Cass Review did not show medical problems to be an underlying factor in referrals for gender dysphoria it would be inappropriate for the new lead to be a medical doctor. Instead, I would like to see the clinical leadership rotated between members of the different professions represented in the teams."
>
> (Member of the public – Neither Agree nor Disagree)

> "I am concerned that the service specification mandates that the leadership is inherently a clinical issue. This fails to satisfactorily address the importance of the social aspects of the care of transgender people. Generally, where multidisciplinary teams are under the leadership of medical professionals, non-medical disciplines and issues have a tendency to be sidelined and under-resourced."
>
> (Member of the public – Partially Disagree)

Views expressed by all positions

Themes raised across all viewpoints...	Number
Concerns and questions regarding resources, investment, and staff levels	39
More information required	21

As in answers to the previous question, both Group A and Group B respondents wondered whether sufficient resources and funding would be available in order to implement the proposed change, with some speculating that the pool of eligible candidates who were able to tick all required boxes, as well as who would desire the position, would be very small. This was felt to be even more of an issue if the clinical lead was required to be a medical consultant (as stated in the interim service specification) rather than a medical doctor (as stated in the public consultation document).

Some respondents also said that there was insufficient information provided in the attached documents to be able to make a fully-informed decision. The questions they felt would need answering in order to do so included:

- What will the clinical lead do? Will they take the main role interacting with the patient; assess the collected evidence and define the treatment pathway; or merely sign off paperwork? Or something else?
- What kind of treatments will they prescribe?
- What is the planned balance between talking therapies and medical interventions?
- Are medical interventions other than hormone blockers and oestrogen/testosterone going to be provided by the new service?
- What are the requirements for the clinical lead in terms of experience and qualifications?

C. Collaboration with, and support for, referrers and local services

The interim service specification public consultation guide stated that:

> 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.

Respondents were asked to what extent they agreed with the substantive change to the service specification regarding referrers and local services. They answered:

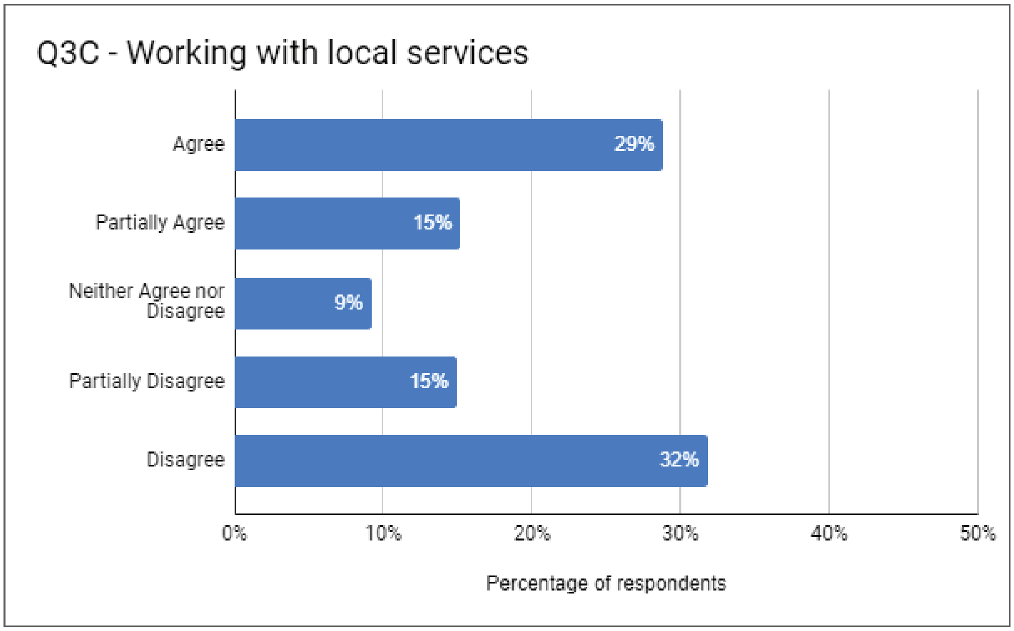

Figure 4. Quantitative results regarding collaboration with referrers and local services

As in responses to the previous two questions, parents, clinicians and members of the public were the three groups most likely to agree with the proposed changes, with a majority of all three groups at least partially agreeing.

The majority of patients once more disagreed with the proposal, while LGBTQ+ individuals and those with transgender friends and family at least partially disagreed in greater quantities than in response to the previous two questions (61% and 57% against averages of 45% and 40% respectively).

Summary of themes raised by Group B respondents (n=531)

Group B respondents said...	Number
Local services must be impartial and not following an affirmation model	188
General expressions of support for the collaboration with local services	92
All staff and local services must be free from ideological pressure	85
All staff and local services will need training and support	78
Resources aren't sufficient to cope with increased demand	71
Services must be free to use explorative therapy	47
Local services should be vetted and overseen	45
The focus should be on the mental health of the child	45
Local services should not include charities or non-NHS organisations	34
All referrers must be familiar with the patient	20
Safeguarding protocols should be in place	18
The proposal should be permanent rather than interim	7
Services need to take responsibility for their actions	3

As in responses to the previous two questions, most answers submitted by Group B respondents revolved around the requirement for local services and their staff to be impartial, free from any pro-transgender bias, and able to perform their work with children and young people without outside ideological pressure or fear of repercussions such as being labelled transphobic or being accused of practising conversion therapy.

Likewise, most other issues raised with regard to working with local services were equivalent to issues already raised in the questions on the clinical team and the clinical lead, such as:

- All staff involved in local services would require training in order to ensure that everyone was working in accord with the same principles and overarching techniques and goals, as well as to ensure all treatment was science- and evidence-based and free from the aforementioned ideological influences.
- Concerns regarding – and the belief that – current service provision is insufficient for the task required, necessitating increased funding, recruitment, training and education.
- Vetting and regular monitoring of all involved services and referrers to ensure consistency of provision and an absence of ideological influence and bias.
- To focus on psychological and situational issues – such as trauma, abuse, neurodiversity, familial and school situation, bullying, and internalised homophobia – rather than on pathways towards transition, such as gender affirmation or endocrine intervention.
- The desire for organisations such as Mermaids and Stonewall to have no role in the new service, nor to be collaborated with in any way – with some expressing concern that Section 8.4 of the interim service specification may allow such organisations in by the "back door".
- The need for local services and all those working with them to understand and adhere to safeguarding protocols, with well-communicated systems put in place.
- That all referrers must have a good level of familiarity with any patient and have seen them over a prolonged period of time covering a reasonable number of sessions.
- That the proposal should be made permanent rather than temporary.

Those working in local services should take responsibility for their decisions

Some Group B respondents also felt that local services should be held accountable for both the short- and long-term results of their interactions with children and young people in order to ensure that any practitioner found guilty of poorly-considered advice, referral, or direction would be considered liable in the event that a child or young person suffered as a result of their decisions.

> “All players in the system need to take responsibility for the outcomes of these children. There should be less hand washing and passing on to other services.”
>
> (Clinician – Agree)

> “The more holistic this is, the better for the young people concerned. They’re growing and changing so much, I’m worried that we box them into a corner if we are too prescriptive. And where partner services are involved, we need everyone to be working together.”
>
> (Parent – Agree)

> “I strongly support using local services to support children as close to home as possible – particularly for those in rural areas.“
>
> (Parent – Agree)

> “It states that children will be referred onto other resources while awaiting assessment. I am concerned which resources this refers to. Specifically I am concerned it could be Stonewall, Mermaids and other gender lobby groups based on no evidence and research. Groups such as these should be scrapped from signposting as they are not neutral.”
>
> (Clinician – Neither Agree nor Disagree)

> “Staff may be wary of being accused of conversion therapy if they carry out any exploratory therapy. They must be secure in knowing that exploratory therapy is expected, as with any other mental health service for children. Fear has been created in this area of the NHS, with many who have spoken out against the transitioning of children losing jobs. Many stay silent.”
>
> (Clinician – Partially Agree)

> “I am concerned about how local services can be monitored. Children not seen at the central service still need to be followed up in a consistent way so it is possible to ascertain how well services in the community are working and even whether they are causing harm by promoting unnecessary irreversible changes which a person may regret later.“
>
> (Parent – Partially Agree)

> “At the moment there is a national crisis in mental health provision. Need far outstrips provision. The failure of local mental health services such as CAMHS to meet this need is one of the main reasons for the huge increase in referrals to GIDS. In order for these well-meant proposals to work, there will either have to be a huge increase in funding for local mental health services, or a radical rethink into how these services are provided. Perhaps it is time for better collaboration between statutory and the private, charitable and voluntary sectors.”
>
> (Clinician – Agree)

Summary of themes raised by Group A respondents (n=1816)

Group A respondents said…	Number
The change is a barrier to access and represents a form of gatekeeping	1003
This change will increase wait times	916
There is no information on appeals, complaints, or second opinions	696
Concerns regarding the implication that no new referrals will be seen	690
There are no timelines or clear pathways	611
Some GPs and local services are transphobic.	527
Some GPs and local services are unsupportive and act as a barrier	392
GPs lack education in trans healthcare. They need training and support	349
Local services lack knowledge of trans issues and will need to be monitored	198
NHS England should honour its commitment to a maximum 18-week wait time	189
Resources are inadequate and there is no detail on addressing this	188
It's a plan to divert patients from gender services into mental health	175
The change is harmful and dangerous	166
The patient will require multiple sessions with the same practitioner	158
This looks like a plan to falsely make wait times seem shorter	83
There is no information on those who don't meet the referral requirements	80
GPs don't have time for seeing gender dysphoric patients	54
Local services and staff should be supportive, understanding, and affirming	50
There is no information on how this will work in practical terms	47
Concerns about geographical differences	46
The initial consultation should involve the patient	43
There is no information on the criteria for obtaining access to the service	41
All patients must see a specialist in gender diversity	30
The tiered system will cause delays and children will be lost in the system	27
Patients should always see specialist gender services	26
It's not clear what happens to those who "meet the criteria but aren't seen"	25
All referrers should know the child or young person well	18
This system encourages patients to lie to healthcare practitioners	17
GPs should be able to provide puberty blockers while a patient is waiting	14
The change may lead to an increase in the sourcing of unregulated drugs	8
The change may lead to an increase in the sourcing of unregulated drugs	8
If beneficial, patients should be able to use services outside their local area	2

Delays, wait times, gatekeeping and harm

As was the case with Group B respondents, many of the response themes raised by Group A respondents were equivalent to those raised in earlier questions, with a large number of respondents once again feeling that the proposed change appeared to add layers of complication and complexity to a system that was already beleaguered by inordinately lengthy waiting lists. Requirements for pre-referral consultations and the addition of increasing numbers and tiers of healthcare practitioners and unnamed local services caused Group A respondents grave concerns, with many feeling that significant numbers of children and young people would be harmed by the change, and/or that they would be in danger of becoming lost in the system. Some also felt that this change, among others, was being introduced as a way to manipulate statistics and falsely reduce wait times and patient lists by changing the criteria – i.e., by introducing the potential to consider those waiting for pre-referral consultations, those post-consultation, those declined, and those being seen by local services as existing on different lists or in separate sectors, thereby appearing to reduce the main gender dysphoria services waiting list when in reality many would still be in the same position of 'waiting'.

> "This gatekeeps trans people who aren't considered 'trans enough' by people with no knowledge or authority to make such harmful judgements. This proposal will cause young trans people to attempt suicide and self-harm and must be immediately scrapped."
>
> (Patient – Disagree)

> "Working with other involved professionals is always helpful and if this process could be streamlined without all the delays/barriers to sharing information that would be good. However, the way this document is phrased it seems to be cynically trying to use other sources of information or support to 'filter out' referrals to gender services."
>
> (Clinician – Partially Agree)

> "The proposals that you will a) exclusively gatekeep access to treatment; b) will not let all children who meet the criteria access treatment; and c) that you will impose a 'care plan' instead are chilling. The reality is that you are already proposing a politicised and transphobic model of care. Families of dysphoric children do not trust the NHS – the phrase 'care plan' sounds a lot like 'conversion therapy', and the mention of social workers is simply going to deter and frighten families. This isn't care; you're just trying to deter families from seeking care."
>
> (Member of the public – Disagree)

> "You're essentially threatening parents who are already at their wits' end with this ridiculous, convoluted, impossible system. Transgender kids are significantly far more likely to self-harm or commit suicide, and not supporting them makes that even more likely. I'll continue to do everything possible to ensure my child doesn't become a grim statistic, no matter how many gates/layers/obstacles you put up."
>
> (Parent – Disagree)

> "This system inherits the worst parts of the prior structure but seems to deliberately exacerbate the issues. The current structure has added significant time to the waiting list and creates hugely unnecessary barriers to service. All it will lead to is desperate patients being left without any treatment or therapy and will frankly lead to significant deaths, as is the case for the GIDS waiting list currently (see publications for suicides on the waiting list). This structure should be entirely abolished and replaced by a simple system of self-referral and referral by GP to the specialist service, with the patient then joining the waiting list. Anything else will exacerbate waiting times and patient distress."
>
> (Patient – Disagree)

> "Our first CAMHS worker tried to close the case without speaking privately to our child, three days after his suicide attempt. At our child's second meeting with CAMHS services he had to explain basic trans terms and language to the worker as they had no knowledge or experience. He only engaged positively with the local therapeutic CAMHS worker once he was already on his transition journey: the therapeutic support would not have worked if it had been viewed as a 'hoop' he had to jump through to get treatment."
>
> (Parent – Neither Agree nor Disagree)

GPs may be unknowledgeable, unsupportive, or transphobic

Likewise in responses to earlier and subsequent questions many Group A respondents highlighted their belief – often supported by personal anecdotes – that rather than expressing the desired characteristics of compassion, empathy, affirmation and support, some GPs were either: unknowledgeable of the varied and complex issues surrounding trans healthcare and/or unknowledgeable about trans people themselves; were unsupportive, unsympathetic, and either unconsciously or subconsciously placing barriers to access in front of their patients; or, at worst, were actively transphobic, explicitly hostile, and consciously barring children and young people from accessing services by refusing to refer and either denying assistance outright or steering patients in alternate and undesired directions (into, for example, exploratory therapies which were once again labelled as appearing dangerously similar to so-called 'conversion therapy'). This was seen as an especially large concern if an unsupportive or transphobic GP was part of the pre-referral consultation meeting, which some felt patients and their families should be able to attend in order to ensure a fair hearing.

Some Group A respondents stated that GPs and other healthcare and local services staff were in urgent need of education and training in order to be brought in line with global standards of transgender medicine and would need to be regularly monitored and observed in order to ensure that they provided the necessary quality of service. Some again brought to attention that there appeared to be no mention of any appeals or complaints procedures, which in the case of unsupportive or transphobic GPs they felt would be crucial to a young person's well-being and long-term chances of survival and happiness.

> "I believe this would be beneficial but my biggest concern is ideological transphobia among healthcare professionals, as evidenced by Mackereth v Department for Work and Pensions[5]. There are problems with transphobia in the NHS that need to be addressed or this collaboration could result in competing ideas of transgender healthcare. Some people do not believe that transgender children exist or that it is a result of social conditioning/contagion. As a transgender adult I was once a transgender child and if social conditioning was a factor then I can assure you that I would not be transgender."
>
> (LGBTQ+ individual – Agree)

> "Collaboration is needed but there also needs to be a fundamental change in education and prejudice from intake physicians. Britain has a growing problem with trans misinformation and indoctrination of anti-trans views. Medical professionals need to be reviewed for their commitment to providing positive care to children and young people and regulated if they cannot or will not provide such services."
>
> (Parent – Partially Agree)

> "This is a good change but GPs are severely lacking in training with transgender issues. The 2021 TransActual Trans Lives Survey states that 14% of trans people said their GPs refused to refer them. Please make sure these people are properly trained before they become one of the only ways of entering the service."
>
> (Patient – Agree)

> "Giving GPs the sole right to refer is a disaster unless they are properly trained. Already many GPs refuse to refer. There is a severe lack of knowledge which leads to an arrogance and point blank refusal to help trans patients."

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[5] https://www.gov.uk/employment-appeal-tribunal-decisions/dr-david-mackereth-v-the-department-of-work-and-pensions-1-advanced-personnel-management-group-uk-limited-2-2022-eat-99

(LGBTQ+ individual – Disagree)

> "Unsupportive GPs could stop trans youth receiving medical care based on their subjective opinion. This option will not lessen the waiting time for trans youth and will add more burden to the NHS."
>
> (Parent – Disagree)

> "Most local services are not knowledgeable at all about transgender people and their needs, and are often directly against transgender rights. Collaboration with non-specialist services serves no purpose, as all relevant information can be gathered from previous medical records and the assessment of the patient."
>
> (Patient – Disagree)

> "I am cautious about the possible burden placed on GPs with regard to the referral pathways and clinical meetings. GPs are 'specialist generalists' and do not have the specialist knowledge and skills required to manage these complex cases. Currently a lot of emotional pressure is put upon GPs to prescribe and care for these children beyond their levels of clinical competence and this needs to change. I would prefer a model where GPs referred to local specialist services who then liaised with the gender dysphoria directly. These local services would then be able to manage the common additional needs that these children have, which GPs do not always have the skills or capacity to manage."
>
> (Clinician – Partially Disagree)

> "This suggests that a large amount of power will be given to GPs to make decisions about whether or not to allow patients access to care, but according to the NHS's own reports and the Royal Society of General Practitioners, GPs are rarely trained in this area, even to the extent of being able to make an initial assessment."
>
> (Patient – Partially Disagree)

Not enough information on which to base a decision

For a large number of Group A respondents there was a significant lack of detail provided both within the consultation document and the interim service specification itself. This, therefore, made it difficult for respondents to agree or disagree with the proposal, as well as to comment on it, given that it remained, for a large part, unknown and unknowable to them. Chief among the information gaps, questions and uncertainties expressed by Group A respondents were:

- While on the one hand the interim service specification redesigns and lays out a new referral process, it also appears to somewhat contradictorily imply that no new referrals will be made or seen by the interim service. There does not seem to be sufficient detail or explanation for such an apparently large-scale, important and impactful change. Nor is there sufficient explanation of what plans or support will be put in place for those who are likely to be referred but who are not currently on the waiting list, apparently being left in limbo.
- No timelines or care pathways are outlined in detail. It's not clear whether NHS England are committed to an 18-week maximum wait list; whether this applies to urgent cases only; or whether local services will also be expected to adhere to an 18-week commitment.
- Because there was no mention of how NHS England will ensure the quality and safety of the unnamed local services, respondents found it difficult to comment on whether working with them, and in what capacity, would be a good idea.
- There was no information outlining exactly how collaboration with local services would function in a practical, tangible way.

- There appeared to be no mention of a plan or pathway of support for those who don't meet the requirements for referral yet who will likely feel that they need support and will continue to pursue it, whether with NHS England or elsewhere. This runs the risk of them feeling abandoned by the system and could cause them considerable harm.
- There was no information concerning exactly what the criteria for accessing the service or for accessing triage is.
- Further, there was no information as to why some children or young people would meet the criteria but not be seen, implying to some either that there was another hidden and secret level of criteria or that the current criteria had been deemed as unfit for purpose – or, worse, that somewhere along the line an individual GP or healthcare provider could veto a referral based on their personal opinion.
- In addition, there was no information regarding what exactly would happen to those who met the criteria but were denied direct access to the service.
- There was also no information on why a pre-referral consultation had been deemed necessary or why this was seen as an improvement to the previous service specification.

> "We're concerned that with no specified destination for new referrals and no waiting times for the interim service, the level of clinical risk for the young people in our care will increase even further. Local services like ours need the resources and the information to be able to plan around a high risk group who are potentially going to get no other support."
>
> (Service provider – Partially Disagree)

> "The concern here is that children will be refused service without ever actually being seen or assessed, and that this decision will be entirely based on the discussion with the referrer who is unlikely to be an expert and who may have had limited time with the child. I'm baffled by the decision that even those who meet the criteria might not be seen. What is the rationale behind this? The wording seems like some children (chosen by who? based on what?) will just be sent back to their GP. This seems like a massively mentally damaging move to the children."
>
> (Clinician – Disagree)

> "It appears that, by design, the new service does not intend to deal with any new patients, and it is unclear whether those on the existing waiting list – or 'waiting list for the waiting list' – will ever be seen by the service. Coupled with the increased barriers to accessing care and the lack of detail around care pathways and timelines this leaves transgender children, young people and families with nowhere to turn to for treatment."
>
> (Service provider – Disagree)

Resources

In addition to comments in earlier questions on NHS England-specific resources, respondents once again highlighted perceived issues of a lack of available resources, staffing and funding, with some illustrating through personal experience that services such as CAMHS were already failing to cope with the demands that had been placed on them. Respondents felt that the requirement for at least 5,000 pre-referral consultations and potential referrals – along with all that this would entail – would necessitate a substantial increase in all aspects of the services expected to supply provision, yet there didn't appear to be any details as to how capacity, structure and personnel were planned to be increased, nor on how local services, charities, mental health services and others would cope with the increase workload and the knock-on effect expected to impact their other patients and clients.

Likewise, as discussed in responses to previous questions, there were also questions about how GPs would cope with an increased workload; how already difficult to make appointments would be obtained; whether given stretched services patients would be able to see the same healthcare professional each time; whether increased funding and investment would be made available; and whether all such targets and plans were realistic.

Geographical concerns

Some Group A respondents expressed concerns over regional variations in services and provision, feeling that whether a child or young person received quality, supportive care or was referred or not would be something of a "postcode lottery", very much dependent on who and what was available to them in their local area, with particular concern for those in remote and rural areas. Some also felt that a patient should be granted the option of accessing and using services outside of their local area if such services were either more suitable to the particular case, of better quality, had greater availability, or could be accessed more quickly. Others, however, highlighted potentially prohibitive issues of costs and time for parents or family of gender dysphoric children and young people, feeling that the requirement to travel may incur a significant financial strain.

It was also noted that the wording of the public consultation document, where it was stated that "there is currently only one provider of specialist services for children and young people with gender dysphoria in England – [GIDS in London]", appeared to give a misleading impression that geographic bases were being increased from one to two, whereas it was argued that they were actually being reduced from four (or five, including outreach).

> "This appears to suggest that GIDS only delivers services in London, when it also has services in Leeds, Birmingham, and Bristol, and delivers outreach clinics in Exeter. This is potentially misleading to the public, who upon reading the Interim Service Specifications might assume that opening two new [Phase 1] clinics in London and Manchester in 2023 would represent an increase in service provision (in terms of locations and capacity), whereas it is in-fact a decrease in both. Phase 1 will not expand service provision but will instead reduce it – from four locations (five including outreach) to two."
>
> (Service provider – Disagree)

> "We live in a rural area and we were unable to obtain a GIDS referral from either CAMHS or our GP as both were highly transphobic and had a very limited understanding of gender dysphoria."
>
> (Parent – Disagree)

> "Will the resources provided be consistent across different areas, or will it be a 'postcode lottery?'"
>
> (Member of the public – Partially Agree)

Other issues raised by Group A respondents

- Some respondents felt that using local services would result in a lower quality interaction for a patient if the local services were not specialists in gender dysphoria, with some stressing that all gender dysphoric children and young people should see specialists and that referrals and support should only be given by experts in gender care. Some felt that "outsourcing" provision to local services – speculated by some to potentially be underfunded and undertrained volunteers – represented an alarming "palming off" of patients.

- In connection with themes that highlighted perceptions of barriers and obstacles, as well as in responses to other questions, some Group A respondents felt that the proposed changes represented an increased pressure on gender dysphoric children and young people to “prove“ to healthcare providers that they were “trans enough“ to receive a referral and care. Some also pointed out that this may encourage prospective patients to lie to doctors and others involved in services in order to obtain the best chance of proceeding to treatment. This issue was seen as being exacerbated by the implication that patients could propel themselves up the waiting list if their case appeared to require more urgent attention than others, thereby rewarding those who could signal greater levels of jeopardy and distress. Some also pointed out that certain organisations provided scripts for children and young people to follow, instructing them on what they should and should not say in order to give themselves the best chance of referral and treatment.
- Some believed that GPs should be able to prescribe puberty blockers to gender dysphoric children and young people who were currently within the process of consultation or awaiting referral and treatment. This was felt logical given that GPs had been given the power to refer, and were therefore deemed knowledgeable enough in certain areas.
- Some expressed hopes that organisations such as Mermaids and Stonewall would be among those used as local services, with some sharing positive anecdotes regarding the quality of the care, support and advice they had received from such organisations.
- Some speculated that the expected increases in delays, wait times and difficulties in accessing the service resulting from the perceived increase in complexity in entering and navigating the system may cause some patients and their families to give up on the NHS and turn to unregulated “black market“ hormone treatments due to “desperation“.

D. Referral sources

The interim service specification public consultation guide stated that:

> 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 [only] 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.

Respondents were asked to what extent they agreed with the substantive change to the service specification regarding referral sources, as follows:

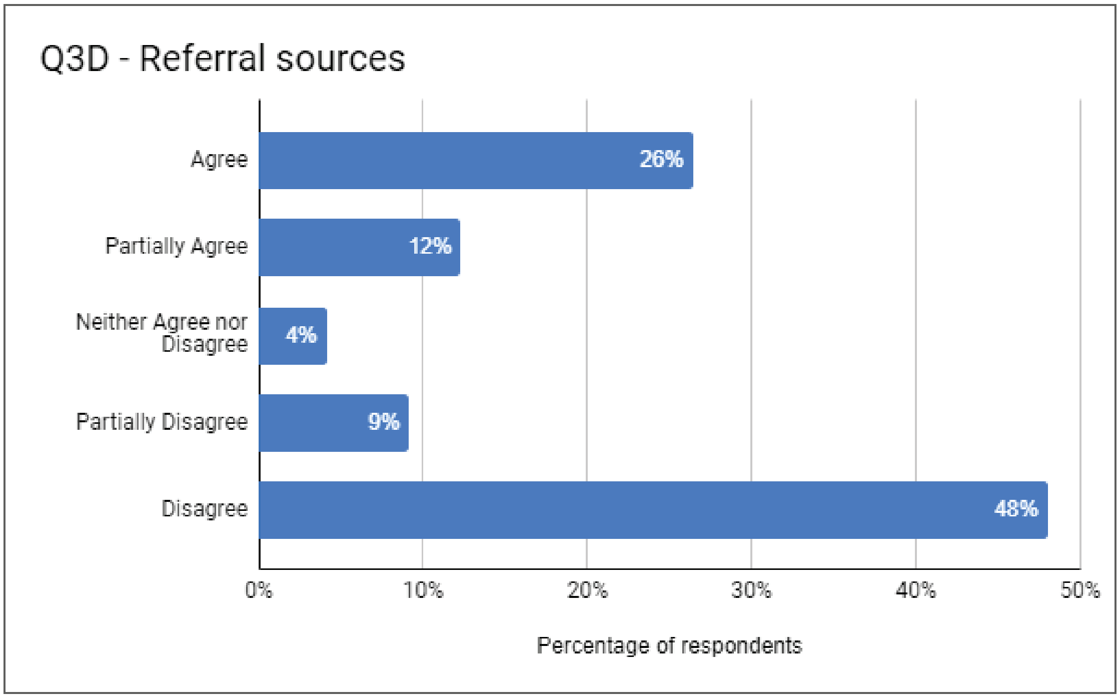

Figure 4. Quantitative results regarding referral source

As in responses to previous questions, the majority of parents and clinicians were once more in at least partial agreement with the proposed change, while exactly half of members of the public were.

Patients, LGBTQ+ individuals, those with transgender friends and family, and service providers were strongly in disagreement with the proposed change, averaging disagreement rates of 70%, with a further 11% partially disagreeing. Among patients and LGBTQ+ individuals only 9% of respondents at least partially agreed, compared to an average of 26% across the first three questions.

Responses were also much more polarised than in answers to the first three questions, where those who answered “neither agree nor disagree” averaged 11%. Here, only 4% of respondents selected “neither agree nor disagree“.

Issues and themes raised by Group B respondents (n=791)

Group B respondents said...	Number
Only NHS professionals should refer	228
The change should be made permanent	191
It’s good that schools and teachers can no longer refer	179
Very good that organisations (such as Mermaids) can no longer refer	158
General expressions of support	114
Referrers must not be pro-transgender, they must be impartial	81

Referrers must know the patient well	78
Expressions of surprise that non-NHS parties were previously able to refer	60
Referrers must be free from ideological pressure	35
Referrers should be held responsible for the consequences of their referrals	21
All referrers must be science and evidence-based	16
Referrers should be monitored and screened	11
This will positively aid safeguarding of children	6
Referrers need to be aware of "rehearsed speeches"	5
Only psychologists or psychiatrists should be able to refer	4
Only GPs should refer, not psychiatrists or psychologists	4
There should be no referrals when the parents object	4
Referrals should require consent from multiple health professionals	4
There should be no self-referrals	4

General support for the proposal

In general, Group B respondents who provided an answer to the qualitative question reiterated their agreement and support by echoing the substance of the proposal: that they were pleased to hear and desired that only NHS professionals should be able to refer; that schools, organisations and charities could no longer refer; and that self-referrals would no longer be possible, with some Group B respondents expressing shock and surprise that non-NHS referrals from such sources had previously been possible. In particular, respondents felt that the change would help alleviate safeguarding concerns, as well as ensure less influence and pressure from pro-transgender lobby groups, as well as from untrained but possibly "ideologically captured" individuals such as teachers.

There were also a significant number of Group B respondents who encouraged that the change be made permanent.

> "I agree referrals need to be robust, regulated, specific and a detailed narrative from a recognised NHS professional who has met and knows the child well over time."
>
> (Clinician – Agree)

> "A strong, controlled clinical pathway from GPs or NHS departments is a necessity from a safeguarding perspective."
>
> (Clinician – Agree)

> "I think it is important that there should be some form of 'gatekeeping' to specialist services. The significant rise in numbers of people being referred is probably in part due to the existing 'open door' referral policy."
>
> (Service provider – Agree)

> "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 are not subject to the political or ideological positions of lobby groups.“
>
> (Service provider – Agree)

> “That voluntary organisations can currently do it is news to me. I’m appalled by that given that the voluntary organisations involved in this sector seem to be radical campaign groups more than patient care professionals.“
>
> (Parent – Agree)

> “I’m not aware of other secondary/tertiary health services which allow referrals from sources such as Mermaids, where safeguarding concerns are rife. Like all other health services this needs to come through proper channels, with carefully monitored processes.”
>
> (Parent – Agree)

> “I agree that the current service specification permitting referrals by schools and colleges is far too broad: these institutions have no formal expertise in mental health and the delivery of training programmes on this issue has been captured by many now largely discredited transgender lobby groups and activists. This has meant that teachers and children at the receiving end of such training and materials have been greatly misled.”
>
> (Member of the public – Partially Disagree)

> “The consultation on this issue seems to say that the new referral arrangements are for the interim service specification. Why? This should be a permanently different arrangement to what went before. If it is an interim arrangement, who or what is to stop those with radical gender ideologies re-imposing their damaging influence on the system? Please close this loophole.”
>
> (Member of the public – Partially Agree)

Referrers should be held responsible for the consequences of their referrals

Some Group B respondents felt that any health professional who referred a child or young person into gender identity development services should be held responsible for any eventual negative outcomes which the child or young person experienced, such as mental or physical health problems, regret, detransition, or infertility, as well as health costs and legal cases (across a range of questions some Group B respondents believed that at some future point widespread litigation would be an issue). This suggestion was seen as both a deterrent to referral and as a necessary retribution, given the Group B viewpoint that the path to eventual medical transition was a path to harm.

> “Referrals must come from a medical professional who is professionally accountable for any decision to refer.”
>
> (Parent – Agree)

> “As there could be potential for risky medical procedures with children presenting with gender issues, it [should be] possible to hold a GP to account for promoting a course of treatment that could subsequently prove harmful to a child.”
>
> (Parent – Agree)

Referrers need to be aware of “rehearsed speeches“

Some respondents warned that all GPs and other NHS professionals who found themselves in the position of contemplating a referral must have awareness of and training in what was referred to as “rehearsed speeches” – that is, children and young people who had been coached, shown ‘scripts’, and otherwise been encouraged to act or lie in order to give themselves the best chance of being referred into the service. Ideological lobby groups, it was suggested, were well-versed in the answers and behaviours GPs and health professionals were looking for in order to refer someone, including the faking of anxiety and distress in order to meet the requirement for "clinical distress."

> "My personal experience is that the GP refers these children to get rid of them. Our GP diagnosed my daughter after a 20-minute appointment where she was giving the answers needed, easily available online for anyone who wants to receive medical intervention."
>
> (Parent – Agree)

> "Pressure groups have been grooming kids to say the 'right words' in order to access cross-sex hormones. Clinicians must be aware that children will be lying, parroting the words of online influencers, or being influenced by homophobic parents."
>
> (Parent – Agree)

> "Healthcare providers should also be resilient to any manipulation from adolescents, particularly aware of rehearsed answers which are given in order to expedite the referral process."
>
> (Parent – Partially Agree)

Only psychologists or psychiatrists should be able to refer (and vice versa)

There were some Group B respondents who believed that only unbiased psychologists or psychiatrists – preferring those who were specialists in fields other than gender dysphoria – should be able to refer, in order for any child or young person to have received a thorough psychological analysis before progressing any further along the path to transition. GPs, it was felt, were both too busy and lacked the necessary specialisms, understandings and tools to be able to properly engage with children and young people seeking referral into gender dysphoria services. As noted above, some believed that lying, acting, and rehearsed answers would be a problem, and that engaging successfully with a child who had fixed their mind on the goal of accessing the service would require a skilled mental health professional learned in child psychology.

There were, however, those who believed that a local GP was the preferred option, partly due to the view that psychologists and psychiatrists were not medical staff, and partly due to the perceived benefit of maintaining a single point of accountability with a doctor who may have had and may continue to have a consistent association with the patient.

A few respondents also suggested that all referrals should have to be authorised and sanctioned by a small team of mental health professionals.

Other issues raised by Group B respondents

Several issues raised by Group B respondents were counterparts of those raised in response to previous questions, with many of the same themes running throughout each set of responses to the four substantive changes. These were:

- The necessity and assurance that all health professionals who were involved in referring were ensured to be unbiased, impartial, and absent of any pro-transgender beliefs and ideologies, with screening and monitoring protocols put in place in order to guarantee the service was fully free from such influences and continued to be so in the future

- All GPs and other NHS professionals who are involved in referring must be able to perform their jobs in accordance with science and evidence, free from all pressures, outside influences, and fears of losing their jobs, attracting negative attention, or being labelled transphobic, with protection from such influences and consequences explicitly and publicly offered and assured by NHS England
- Referrers must know their patients well, and have taken the time to engage with them thoroughly, with no referrals being given within a small number of appointments

Issues and themes raised by Group A respondents (n=1864)

Group A respondents said...	Number
GPs may be unsympathetic or uneducated	846
Schools and teachers should also be able to refer	419
Social and youth workers should also be able to refer	388
Patients should be able to self-refer	327
The change appears to be a gatekeeping measure	320
Other organisations (such as Mermaids) should be able to refer	309
Some GPs are transphobic	294
This needs to define who exactly “NHS professionals“ are	292
Requiring more GP appointments is unrealistic	279
Any referrer must know the patient well	257
There should be alternative routes to care outside of GPs	158
This change will lead to a significant increase in harm and distress	103
This is an unnecessary change given only 5% of referrals are non-NHS	88
This change will limit access for the most vulnerable	77
This change will make it harder for children from unsupportive families	71
Private clinics should also be able to refer	68
This change pathologises being transgender	61
Less sources of referral may dissuade some from seeking necessary help	59
GPs must be better trained on the referral procedure	52
There is no information given on any appeals process	49
Regional differences will lead to negative care experiences for some	45
No analysis of why 5% of children and young people seek non-NHS referral	37
There should be more avenues to referral, not less	33
What is the benefit of removing avenues to referral?	28
It doesn’t take into account how difficult it may be to find a sympathetic GP	28
This is a dishonest way to make it appear that wait times have decreased	19
Anyone the child deems safe should be able to refer	16
All referrers should be experts in gender dysphoria	14
This will negatively impact BAME individuals	11
There’s no information on what the referral criteria is	9

General opposition to the proposal

Many Group A respondents expressed opposition to the removal of the avenue of referral which had previously been available to non-NHS professionals, with a large number believing that, in particular, schools and teachers, social and youth workers, and organisations (such as Mermaids) should still be allowed to refer. The reasons given chiefly centred around three main areas of argument: 1) that some GPs and other NHS England health professionals may be unapproachable, unsupportive, and/or transphobic; 2) that many children and young people would find it difficult to access health services and obtain appointments – particularly those living in difficult situations and/or with unsupportive families or carers (i.e., the most vulnerable); and 3) that adults such as teachers, social and youth workers, and volunteers with pro-transgender organisations, as well as private clinicians, counsellors and therapists, may be much more likely to have a more in-depth association with a potential patient; more knowledge of the subject and the issues involved; and more empathy, compassion and understanding for the individual in question. Some Group A respondents also described GPs as having struggled with the referral procedure in the past, whereas organisations such as Mermaids were described as being experienced with it and knew how to navigate it skilfully.

Some Group A respondents stated that it was likely that there were very good and valid reasons why 5% of referrals had come from non-NHS professionals and that it was disappointing that these reasons didn’t seem to have been examined or presented – particularly as they believed the proposed change would impact on some of the most vulnerable and marginalised.

Some respondents also believed that children and young people should still be able to self-refer into a gender identity service, and some felt that any adult who knew the child well and/or who the child trusted and considered safe – including parents – should be considered suitable for providing a referral. It was also suggested that there needed to be an avenue for urgent referrals, as recommended by Dr Cass.

> “The headteacher of our school was incredibly helpful in the process for our son and I would want other children to benefit from that. A GP often does not see a child who has otherwise been healthy and therefore does not have the same knowledge of that child’s behaviours and motivations.”
>
> (Parent – Disagree)

> “The very best support our child has had is from the mental health lead at their school, who knows them far better than a GP since we can never see the same one twice. The referral sources need to include those professionals who know the child best.”
>
> (Parent – Disagree)

> “Schools and colleges have a statutory duty to safeguard children. The mental health issues that can arise in gender questioning young people fall within this remit. KCSIE 2022 states that ‘No single practitioner can have a full picture of a child’s needs and circumstances. If children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.’ Removing the ability of these organisations to refer children directly contradicts KCSIE 2022 in promoting that the welfare of children is everyone’s responsibility. A better way to coordinate this information and relay it to GPs and local services should be investigated.”
>
> (Parent – Disagree)

> "I think this lacks consideration of families and children who may not be in contact with traditional healthcare due to cultural or systemic reasons. Looked after children, children from ethnic minorities, and LGBT families [are all] groups [that] may be less likely to trust or engage with traditional healthcare and GPs. I think referrals from social care should still be considered. Social workers spend time with families and children and know their needs well."
>
> (Member of the public – Partially Disagree)

> "Removing the ability to refer for social workers [and] school counsellors is likely to disadvantage vulnerable families. Many of the most disadvantaged families accessing GIDS have very limited contact with health professionals and face well-documented systemic barriers in terms of healthcare access. This also poses the risk of reducing access to BAME families and others with protected characteristics, as it is well researched and evidenced that these marginalised groups struggle to access healthcare via their GP surgeries."
>
> (Clinician – Disagree)

> "There is no reason why a GP untrained in trans issues who occasionally sees a patient for a mere 15 minutes would be the only one in a fair position to refer a trans child for care. A social worker or teacher would arguably have a better idea of the child, and a parent a better idea still."
>
> (Has transgender friends or family – Neither Agree nor Disagree)

> "Eliminating the ability for non-medical professionals to refer young people to this service is deeply concerning. GPs do not receive specialist training in gender incongruence and the fact that so much emphasis will be placed on the decision of the GP to refer a young person to this service will inevitably prevent all of those who need to access this service from doing so. Charities such as Mermaids are specialists in the needs of gender diverse children, they're able to dedicate hours to ensuring the child or young person is a good fit for The Service and to co-produce a referral. GPs have 10 minutes to see patients and write a referral, [and may be transphobic]. How is the latter deemed a better option?"
>
> (Service provider – Disagree)

> "Reducing the referrals to GPs and NHS professionals removes access to care for young people who may not feel safe to go to their GP as they may not have their family's support. It should be reviewed why this 5% is accessing the service in this way and if removing it will disproportionately affect members of other minority groups – e.g., people in care, people from particular religious or ethnic backgrounds, etc."
>
> (Patient – Disagree)

> "Provision needs to be made to allow some referrals for young people who are in need of more urgent support or intervention to be differentiated and prioritised. This was recommended by Dr Cass in her 19 July letter and I am very disappointed that it has not been acted upon, as the current [waiting time] situation is placing many young people at risk, as was noted by the Care Quality Commission (CQC)."
>
> (Service provider – Disagree)

Issues with GPs and other health professionals

As in responses to other questions, many Group A respondents expressed concerns – as well as experiences and anecdotes – that GPs and other NHS professionals that children and young people may go to for care may be unsupportive, unknowledgeable, obstructive, and/or transphobic. Gatekeeping was again a concern, as was the apparent lack of options for appeals, complaints, second opinions and other routes to access, with respondents pointing out that accessing a suitable GP may represent an insurmountable challenge for some children and young people – particularly those from unsupportive families; those who lived in rural areas; those whose GPs may be difficult to arrange an appointment with; and those who were members of communities which tended to have historically lower levels of engagement with healthcare services.

Increasing the workload on GPs was also seen as a concern, as was the knock-on effect this may have on their other patients, with respondents, in accordance with other questions, believing that they would need to receive training and education that would further impact on their time and availability.

Some also felt that NHS England should have acknowledged some of these difficulties in the interim service specification.

> "Removing referral sources is extremely irresponsible. GPs are not experts in gender and a vast majority of trans people have been discriminated against by their GPs by being denied care due to their personal lack of understanding. With the amount of misinformation spread online a single misinformed medical professional in the chain of support and referrals could grind an entire referral to a halt, [while] those facing a lack of support from their current GP will simply be advised to 'find another GP' – but this is not sustainable. Also, we should not be encouraging people to just move GP when the service is bad, we should be encouraging the service to improve."
>
> (Patient – Disagree)

> "It is essential that if a patient has an unsupportive or openly hostile GP that they are able to have a route around this. I think it is unreasonable to assume that a teenager or even a parent will be able to shop around for GPs; there must be other routes."
>
> (LGBTQ+ individual – Neither Agree nor Disagree)

> "As someone with experience of the existing system I cannot agree with reducing the number of referral pathways. Our GP, while supportive, failed to make the referral as they did not understand the process. Luckily we had access to a private paediatrician through health insurance and they were able to make the referral for us."
>
> (Parent – Disagree)

More information required

Some Group A respondents felt that insufficient information had been included in the interim service specification to be able to make an informed decision, as well as to understand exactly how the new referral procedure would work. Chief among the perceived missing information was a clear and thorough definition of who exactly "NHS professionals" referred to, with many respondents feeling they were unable to agree or disagree with something that didn't appear clear.

Other questions regarding further information were:

- Does this include care providers who are contracted but not employed by NHS England?
- Why is this change considered beneficial?
- In what circumstance would it be deemed appropriate for a non-doctor/nurse practitioner to refer?
- Why would private clinics, paediatricians, and therapists be disallowed from referring?
- If this only affects a small number of referrals – presumably the most vulnerable – why is it important?
- What is the evidence base to justify this proposal?
- Were GPs consulted on the proposal?

Other issues raised by Group A respondents

Several other themes raised in response to this question were equivalencies of themes raised in responses to previous questions, detailed therein. These included:

- The belief that this change will result in an increase in gender dysphoric children and young people's mental health problems, self-harming, and suicidal ideations due to being forced to engage with potentially unsupportive GPs and NHS professionals and greater levels of difficulty in accessing gender identity services.
- The belief that this change pathologises being transgender due to further medicalising access and care procedures and removing avenues from non-medical sources.
- That regional differences will disproportionately and negatively impact certain individuals due to variances in quality of care and the numbers of GPs and NHS professionals available to them.
- That limiting referral sources is being done to reduce the number of children and young people entering the service and to therefore present the false impression that service has been improved by making it appear that waiting list lengths and times have been reduced.
- That all GPs and NHS professionals involved in referring should be experts in gender dysphoria.

Section 4 – Clarity on approaches to social transition

The interim service specification public consultation guide stated that:

> The current GIDS service specification acknowledges that social transition in prepubertal 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 prepubertal 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.

Respondents were asked to what extent they agreed that the interim service specification provided sufficient clarity about approaches towards social transition.

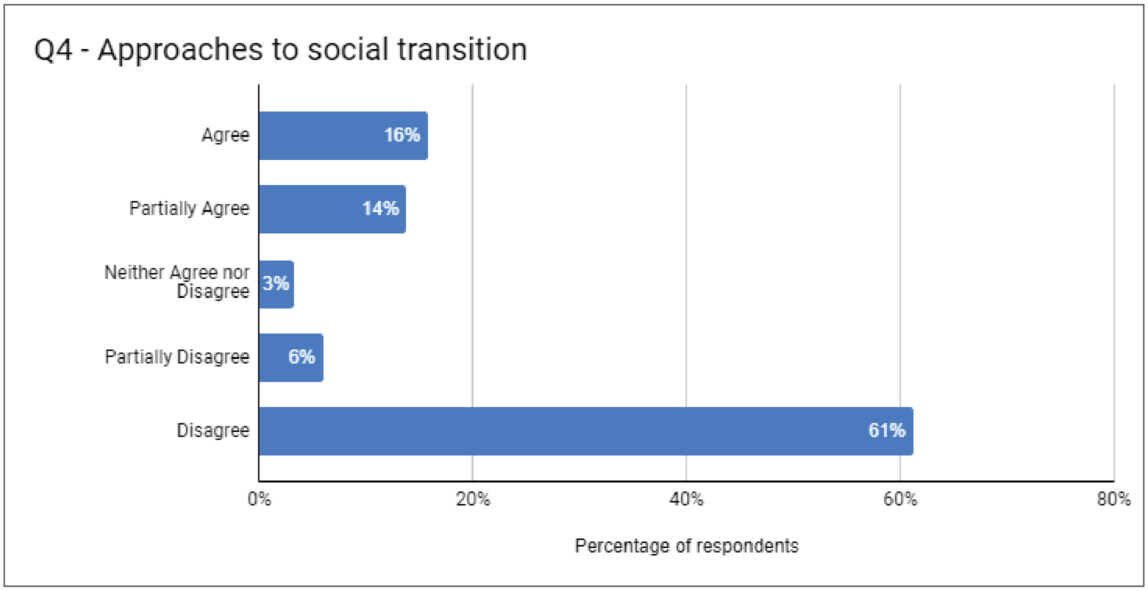

Figure 5. Quantitative results regarding approaches to social transition

Patients, LGBTQ+ individuals, those with transgender friends and family, and service providers were very strongly in disagreement with the question on the clarity of the wording regarding approaches towards social transition, averaging 72% disagreement and 6% partial disagreement, while parents, clinicians and members of the public were much more likely to select disagree (45%) than they were in response to the first four questions (26%). Again, the responses demonstrated a strong polarisation of opinion, with only 3.7% selecting “neither agree nor disagree“.

By analysis of the qualitative questions, however, it was noted that only a small percentage of respondents appeared to have addressed the question of clarity, with over 90% of respondents commenting instead on the issue of social transition and NHS England’s approach to it. It appears much more likely, therefore, that most respondents who answered the quantitative question were actually agreeing or disagreeing with the approaches themselves, and that those who chose to disagree mainly did so because they believed either: a) the proposed approaches were unsupportive of gender dysphoric children and young people; b) the approaches were not stringent enough; or c) they disagreed with the notion of social transition itself.

Respondents’ views on the clarity of approaches to social transition

In total, 289 respondents (9%) addressed the question of whether the new approach to social transition was sufficiently clear, with 66 (23%) saying they felt the approach was clear and 223 (77%) saying they felt there were areas within this section which required further clarification, as summarised below:

Respondents said…	Number
No, it’s not clear at all	103
The term “social transition“ itself is not clearly defined	77
Yes, it’s clear	33
The approach is clear, but it’s not the right question	33
The word “gender“ is not clearly defined	31
“Significant clinical distress“ is not defined	29
The stance on affirmation is unclear	26
The stance on the potential harm of social transition is unclear	15
It’s not clear on how this would work in practical terms	12
“Impairment of social function“ is not clearly defined	9
It doesn’t differentiate between children and adolescents	8
“Risks of an inappropriate gender transition“ is not explained	7
It’s clear for professionals but not for others	3

While a number of respondents simply stated that they either felt it was clear or unclear without elaboration – as well as those who said they felt it was clear, but that clarity wasn’t the question – there were also those who highlighted particular words and phrases which they felt were unclear:

- A significant number stated that the term “social transition“ had not been sufficiently defined and were unsure exactly what this referred to – where, for example, the lines had been drawn between non-social transition, social transition, and post-social transition. Did this refer to children and young people experimenting with clothes and hairstyles more predominantly associated with the opposite sex? Did it necessitate the use of other-gender pronouns or did it mean living fully as a different sex?

- Some also felt that more clarity was needed with regard to NHS England's actual position on social transition – e.g., does NHS England consider it harmful? – given what many saw as a bias towards a negative understanding of social transition. While some believed this was implied or hinted at, they felt that greater clarity would have been welcomed, with Group B respondents supporting a stronger and more stringent message that could be broadcast publicly and promoted – especially in schools – while Group A respondents desired transparency and to know exactly where they stood.
- Some respondents felt that the use of the word "gender" – both here and elsewhere in the specification – was unclearly defined, with some feeling it was being confused and conflated with the term "sex", as well as being used in a way that appeared ideologically influenced and informed (further objections to the language used in the specification documents is detailed in the summary of responses to Question 6: Any other suggestions).
- Some respondents felt that the term "significant clinical distress" was an important and key one, and that it should therefore have been specifically defined and also illustrated with examples, with questions being asked about how this would be measured and who would decide whether it was significant or distressed enough.
- Some respondents wondered how approaches to social transition were envisioned as working in a practical sense, both within the family and within clinical practice, as well as in places such as schools (if this was intended to be applicable), feeling that the outline was vague and lacked specific detail regarding actions and interactions.
- Some Group B respondents encouraged NHS England to clearly define its stance on "affirmation", believing that it should make a distinction between "therapeutic affirmation" and "gender affirmation" (i.e., that practitioners could accept a child or young person's belief that they were the opposite gender without being expected to treat them as though they actually were the opposite gender).
- Some felt the terms "implications of affirming a social transition" and "risks of an inappropriate gender transition" were important but had been left undefined and unsupported by references or evidence.
- Some believed that the proposals outlined didn't sufficiently address that approaches to social transition would necessarily vary according to age group.

> "The service specification should define clearly what 'social transition' means. It may sound benign but in reality it means telling a child that they are really the opposite sex. The NHS cannot collude in telling lies to children about the fundamental reality of their sex."
>
> (Parent – Disagree)

> "It is not clear at all. Furthermore, as long as terms [are used] that cannot be clarified (such as 'gender identity' and 'gender incongruence' and 'gender' instead of 'sex') then young people are no safer than before."
>
> (Member of the public – Disagree)

> "This section needs more clarity: it appears to put the psychological functioning of 'children' and 'young persons' in the same category, where in fact the reasons and outcomes of social transition are very

different for these two cohorts and any active intervention will take a different form. It is critically important not to conflate the needs and experiences of different cohorts."

(Parent – Partially Disagree)

"It's not clear what is meant by social transition. The wording seems to suggest concerns about negative effects on the psychological well-being of kids and not the major positives simple social transition can bring."

(Parent – Partially Disagree)

"Not clear at all – I got no sense of what this process will be, other than that any gender issues will seemingly be minimised and pursuing full social transition discouraged."

(Clinician – Disagree)

"'Sufficient clarity' is a weasel-word in the phrasing of this question. This question is deliberately phrased to make disagreement with the question easily dismissed. The question should be whether the specification's approach is good or agreeable."

(Parent – Partially Disagree)

"It states that an open minded non-confirming approach is required – but how does the service actually do that?"

(Clinician – Partially Agree)

"There is no definition of social transition here. Will children be punished for having the wrong length hair? Will girls be allowed to wear trousers, or is that considered 'gender-role transition'? This whole section is dangerous nonsense."

(Member of the public – Disagree)

"Please can you clarify what 'the provision of approaches for social transition' means? In my understanding, 'social transition' can include anything from a change in hairstyle, clothing or physical appearance, to a change in pronouns or name. Are there other acts of 'social transition' meant here? What is an 'approach' to social transition? What does 'provision' of such an 'approach' mean? Who is 'providing' it? For example, do the guidelines intend to say that the service/a school should only 'consider' the 'provision' of a change in hairstyle if it 'is necessary for the alleviation of, or prevention of, clinically significant distress or significant impairment in social functioning'? Or are we only talking about a *full* social transition – i.e., one in which for all intents and purposes, the child is treated as the opposite gender in day-to-day life? Given that steps for social transition appear to be fully reversible, this seems an unusually stringent position, which provides little room for children to freely explore and experiment with their sense of themselves and their gender identity."

(Has transgender friends or family – Partially Disagree)

"It is not clear what is meant by 'The therapeutic approach for younger and prepubertal children is not directed at gender dysphoria itself but instead focused on other clinical presentations and needs, or familial/social circumstances that may impact on the child's psychological health and gender dysphoria.' What if there are no other obvious presentations? This reads like professionals do not want to consider the reality of it being gender dysphoria."

(Service provider – Disagree)

"The NHS should clearly distinguish between 'affirmation' as standard therapeutic practice (i.e., a patient is 'affirmed' as how they present as a first step to exploring underlying meanings and understanding) and 'affirmation' as it is understood and promoted by gender activists (i.e., a girl is 'affirmed' in her belief that she is really a boy or a boy is affirmed in his belief that he is a girl, as a fact which requires no further examination). The service specification should clarify that 'gender affirmation' is the first step to social transition."

(Service provider – Disagree)

> "How is clinically significant distress defined? Moderate-severe anxiety surrounding dysphoria? Mild anxiety which persists day to day? Or long-term dissatisfaction?"
>
> (Has transgender friends or family – Partially Disagree)

> "The Interim Service Specification does not define what is meant by 'social transition'. It uses ambiguous terms such as 'gender expression', 'changes to gender role' and 'affirming social transition' rather than stating what is being proposed specifically, particularly in relation to accommodations expected in institutional environments such as schools. This leaves scope for too much ambiguity and negotiation."
>
> (Member of the public – Neither Agree nor Disagree)

> "The phrase 'the risks of an inappropriate gender transition' should have been immediately followed by a citation or an explanation of these risks. If you do not provide these things then it just appears to be an assumption. This is leagues below the minimum standard of quality."
>
> (Patient – Disagree)

In addition to the above, while not directly addressing the question of clarity, a large number of respondents (n=3,116) put forward ideas and views related to social transition itself, as noted and summarised below, with a view that some themes and suggestions may help provide an indirect answer to the question of clarity by highlighting areas where respondents understood NHS England's proposed approaches in different ways to those intended.

Views from Group A respondents (n=2008)

Group A respondents said...	Number
Social transition is not a clinical or medical issue	910
NHS England's supportive evidence is cherry picked, inaccurate and outdated	892
Children should be encouraged to explore and express themselves	870
The change is dangerous, harmful, and chilling	733
The proposed approach is equivalent to conversion therapy	725
Social transition provides many benefits and is not harmful	711
The approaches are opposed to WPATH and the World Health Organisation	578
NHS England doesn't have the power or remit to restrict social transition	389
The proposed changes equate to gatekeeping	343
Watchful waiting is harmful and wrong	291
These proposals violate the Memorandum of Understanding	282
Requiring distress to obtain treatment is unevidenced and cruel	265
The proposed approaches to social transition are anti-transgender	242
It reads like NHS England is attempting to discourage social transition	140
Young people are free to do what they like	112
How would this be enforced?	89
The proposed approaches are transphobic	85
This proposal lacks compassion, is unsupportive, and sounds threatening	52
Doing nothing is not neutral either	37
Social transition is not a big deal	17
Parents should have more say than medical staff	15

Primarily, Group A respondents were opposed to the proposed changes because they believed, as in accordance with other questions, that they represented a move by NHS England to restrict avenues to transition and impinge on the rights of children to be what they naturally are. The proposals were labelled by some as dangerous, harmful, chilling and even “evil“, with the moves far exceeding NHS England’s powers and remit. Group A respondents saw the proposed approaches as an attempt to gatekeep and police children and young people, prescribing what they could do and how they could be not only within the confines of NHS England services, but also in schools, in homes, and elsewhere, with some respondents wondering how these controls would be “enforced“.

Many Group A respondents also believed that the evidence on which the proposals were based was inaccurate and outdated – as detailed in answers to Question 6 – and that it had been selectively “cherry picked“ in order to support what was, at best, an agenda that lacked caring and, at worst, was deeply transphobic and politically/ideologically motivated, with many Group A respondents – as they had done in most questions, but particularly in response to this one – equating the proposed approaches to “conversion therapy“ and in violation of the Memorandum of Understanding.

In support of social transition a large number of Group A respondents again highlighted the protocols and practices of organisations such as WPATH and the World Health Organisation, as well as citing the United Nations Convention of the Rights of a Child (UNCRC), which they believed “the attempted medicalisation of social identity transition“ breached in several ways (for example, Articles 3, 8, 12, and 13: the rights of children to have their best interests prioritised; to have an identity; to have their views given due weight; and to have freedom of expression) as well as failing the NHS’s own Outcomes Framework.

Social transition, it was stated, was not evidenced to cause harm – indeed, Group A respondents believed that both evidentially and experientially the opposite was true – while watchful waiting – also viewed by Group A respondents as a “non-neutral intervention” – and, worse, repression and suppression of a child’s desire to explore and express themselves in accordance with their natures were both seen as potentially deeply damaging. Group A respondents found the requirement that “clinically significant distress or significant impairment in social functioning [should be observed before] the provision of approaches for social transition should […] be considered” particularly disturbing, as well as unevidenced and, again, in contradiction with international best practice and their own lived experience.

Some Group A respondents opined that social transition was neither a significant event in a child or young person’s life, nor an issue that necessitated such “stringent” attention and measures, with some wondering what was motivating such proposals – particularly in light of what they saw as far more pressing concerns, such as the size and length of the wait list, and the question of how gender services would be resourced, funded and staffed. Some Group A respondents highlighted that social transition could be as insignificant as changing one’s hair, dressing differently, or using a different name or pronoun – the policing of which seemed perplexing and unnecessary.

> “The specification demonstrates a lack of care or consideration for the health and wellbeing of gender variant children and young people, and fails every single one of the NHS Outcomes Framework. Suicide and self-harm rates are already incredibly high, and the proposed approach will only exacerbate the acute distress experienced by those with gender dysphoria. It directly violates national and international

guidelines for the care of children and adolescents with gender dysphoria in favour of a medicalised approach that rejects vital aspects of care."

(Service provider – Disagree)

"This is characterised as a clarification but makes significant material changes. The approach currently taken by GIDS is certainly different to the one in the draft, and none of the changes were recommended by Dr Cass, who simply said that 'better information is needed on outcomes' of social transition. This approach towards social transition actively discourages young people from exploring their gender identity, and amounts to a strange and unfounded medicalisation of the practice when in reality it is easily reversible and harmless. This encourages an outdated and binary view of gender, in which 'gender roles' are 'changed' as a result of 'distress'. It is especially bizarre from the perspective of a young person who has seen the reality of social transition – young people who are exploring their gender often ask others to use different pronouns or names, and later ask them to change them back, or to different ones. As a young person this is probably the most worrying point as it is completely at odds with my experiences and is an actively harmful approach."

(Patient – Disagree)

"You have misinterpreted the literature about persistence/desistance, or stability of gender identity from childhood to adolescence to adulthood. Please read the criticism by Temple Newhook (et al)[6]. Discard the studies that were done in clinics which took referrals for feminine boys, many of whom did not have gender incongruence at the start of the study (Zucker's older papers[7]). The study population in these studies is not comparable to the population of children and adolescents who present to a modern clinic requesting gender affirmative care. Ask yourself 'what was the study population? How were they selected? Are they comparable to the population I wish to understand?'"

(Clinician – Disagree)

"Social transition is harmless and proven to reduce depression/suicidal tendencies in nearly 100% of kids suffering from gender dysphoria. Please just let trans kids be themselves and express themselves as they wish – the alternative is horrific. This has been studied extensively and we know what the effects of affirmative care are and that they are overwhelmingly positive. Decisions should be led by science, not by the fear and stigma that adults attach to social transition."

(Patient – Partially Disagree)

"Ultimately, social transition is a collection of minor changes – clothing, perhaps hairstyle, chosen name, chosen pronouns, perhaps some school accommodations. It's not a magical transformation, and it is really not such a big deal. These are personal and family decisions. It is not normal for doctors or governments to intrude on this kind of personal and family decision. A family should not need medical permission to talk with their child's school about what is needed to help their child thrive and feel comfortable. A family certainly does not need medical authorisation to call their child by a nickname or pet name, or to shop from one aisle of the store instead of another."

(Clinician – Disagree)

"Social transition covers what someone wears, what name they ask people to use, and how they express themselves. None of these things are things medical providers have any control over, and it is bizarre (and deeply immoral) that this proposal wants to impose medical control over them. Importantly, you are only suggesting the clothes and presentation of gender diverse children is controlled, and not that of cisgender children. If a young girl asks to wear a Spiderman outfit and play with trucks is that allowed up until the point she asks you to call her Nathan, wherein the medical profession steps in? Why is that?"

(Service provider – Disagree)

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[6] Temple Newhook J, Pyne J, Winters K, Feder S, Holmes C, Tosh J, Sinnott M, Jamieson A, Pickett S. A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children, International Journal of Transgenderism, 2018; 19(2):212-224.

[7] See Section 6: Objections to the evidence used to inform the interim service specification.

"We are very uncomfortable with the suggestion that clinically significant distress must be present before social transition is allowed. Social transition could prevent distress for a gender diverse child, so allowing them to pursue it before they experience distress would be the best way to reduce harm to them. Forcing them to become distressed before granting them the easiest route to reduce that distress is cruel and pointless, will lead to them suffering, and it won't stop them being transgender or gender diverse. There is a great wealth of evidence that social transition is incredibly effective at reducing distress and improving wellbeing and quality of life for gender diverse children, and no evidence to support this proposal, as shown by the dearth of citations. Denying them this option, or gatekeeping it behind cisgender medical providers, is counter to the evidence, to international guidelines, and to morality."

(Service provider – Disagree)

"I think that the Cass Review is honest in its conclusion that there may be positive advantages to social transition for some children and young people with gender incongruence. My concern is that the new interim guidance seems to suggest that children/young people should be actively discouraged from socially transitioning, when the Cass Review says it may have negative consequences if that happens."

(Member of the public – Disagree)

"I find 'clinically significant distress' a troubling phrase in the document. This is not an objective measure and is not backed by evidence. There needs to be a strong evidence base supporting recommendations and I am concerned that there seems to be little backing for this. We as clinicians should refer to and respect the autonomy of our patients in line with the Gillick competencies as is well established. To treat gender variant children differently is unfair."

(Clinician – Partially Disagree)

"The question isn't if there's clarity, the question is if it's right. No clinician in any environment would suggest that you start by repressing issues – and this is what is being presented here. It's fundamentally against good clinical practice for any sort of psychiatric/psychological condition. Why is this so different for trans people?"

(Parent – Disagree)

"Allowing children to express themselves without fear is fundamental to safe psychological growth. Not only will this change result in draconian implementations of ideas of female and male presentation, by discouraging this you remove the easiest way for children to understand more about what makes them feel best. Having grown up as a trans person, and knowing many others, I can say that it was only a detriment to our mental health being in environments where we did not feel safe to experiment with our gender presentation, name or pronouns. Lastly, how on Earth are you going to even enforce that? Are you going to tell parents to not cut their child's hair or use a nickname? Are you going to take dresses away from kids who are just trying to be themselves? This should not be done to cis children, let alone trans ones."

(Member of the public – Disagree)

"The lack of evidence is clear throughout the specification, with only one flawed citation in the entire document used to justify the statement that 'in most prepubertal children, gender incongruence does not persist into adolescence'. More recent studies refute this claim."

(Clinician – Disagree)

"This discourages social transition in prepubertal children. This is despite recent evidence pointing to positive mental health and social well-being outcomes in children who are allowed to socially transition in supportive environments before puberty (Durwood et al., 2017[8]; Gibson et al., 2021[9])."

(Clinician – Disagree)

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[8] Durwood et al. "Mental Health and Self-Worth in Socially Transitioned Transgender Youth." Child & Adolescent Psychiatry, 2017, https://doi.org/10.1016/j.jaac.2016.10.016

[9] Gibson, D. J., Glazier, J. J., Olson, K. R. "Evaluation of anxiety and depression in a community sample of transgender youth." JAMA Network Open, 2021, 4, e214739. https://doi.org/10.1001/jamanetworkopen.2021.4739.

"It is not up to someone else to determine the level of my child's distress. Social transition is not a medical issue, is not dependent on drugs or surgery, and no attempts should be made to block it."

(Parent – Disagree)

"It is important to note that there is no evidence that delaying or preventing social transition is an effective approach to care; on the contrary, contemporary research evidence overwhelmingly points to the mental health benefits of social transition for transgender children and young people (for example, parents of prepubertal trans children reported "profound and sustained improvements in mental health, well-being, educational attainment, and happiness once their children had socially transitioned," according to a 2022 study by Horton[10])."

(LGBTQ+ individual – Disagree)

"In a recent statement WPATH condemned this interim service specification for making 'outdated and untrue [assumptions], which then form the basis of harmful interventions' and representing 'an unconscionable degree of medical and State intrusion into personal and family decision-making'. If the authors of the new service specification are of the opinion that social transition causes harm to children and should be delayed until adolescence, the onus is on them to provide evidence for that, and they have not cited any."

(LGBTQ+ individual – Disagree)

"My understanding of the writing in this section is that your intent is to force children to begin undergoing puberty, which is itself not a neutral act, as it causes irreversible changes that are likely to cause significant distress for trans children. It also appears inconsistent with actual trans experiences, and I believe it is critical that further studies not funded by trans hate groups are undertaken to ensure the issue is properly researched. As it stands, I believe your science is not robust on this topic, and that the resulting policy violates the Hippocratic Oath to do no harm."

(Patient – Disagree)

"Is this a joke? Who will decide what social transition is? Will boys with long hair or girls with short hair be reported to social services? Social transitioning can take many forms and they only need to be decided between the parent and the child."

(Parent – Disagree)

"The guidance does not appear to take into account what research is available on social transition. For example: 'Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behaviour Among Transgender Youth'[11] which found that simply using a young person's chosen name has a profound impact on their well-being. 'Mental Health of Transgender Children Who Are Supported in Their Identities'[12] [which found that] 'Socially transitioned transgender children who are supported in their gender identity have developmentally normative levels of depression and only minimal elevations in anxiety.' 'Dynamic gender presentations: Understanding transition and 'de-transition' among transgender youth'[13]: 'The process of going from he-series pronouns to she-series pronouns and back again is not inherently dangerous.' The fact is that the available research is currently unanimous: yes, there is not very much of it, but to ignore these findings is negligent at best and malicious at worst. This unclear, vague guidance on social transition goes directly against the only available evidence on the topic."

(Patient – Disagree)

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[10] Horton, Cal. ""Euphoria": Trans children and experiences of prepubertal social transition." Family Relations, 2022 (https://doi.org/10.1111/fare.12764)

[11] Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018). Journal of Adolescent Health, 63(4), 503–505. (https://doi.org/10.1016/j.jadohealth.2018.02.003)

[12] Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Pediatrics, 137(3). (https://doi.org/10.1542/peds.2015-3223)

[13] Turban, J. L., & Keuroghlian, A. S. (2018). Journal of the American Academy of Child & Adolescent Psychiatry, 57(7), 451–453. (https://doi.org/10.1016/j.jaac.2018.03.016)

> "This is an apologia for conversion therapy. Requiring 'clinically significant distress' to gatekeep any act of transition is a form of torture. You state that trans people must suffer to be allowed to transition; you are saying that being trans requires suffering. You should instead be working towards a future where being trans is not a form of suffering at all. Further, requiring that someone 'fully comprehend the implications' of transition is effectively a ban on transition at any age. If you had consulted with trans groups when writing these guidelines you would understand that pre-transition it is entirely possible to be unable to imagine being happy because your dysphoria taints everything in life. This requirement is worded far too strongly and will inappropriately lead to the denial of life-saving healthcare for trans people."
>
> (Patient – Disagree)

> "As the parents of a 16-year-old who has socially transitioned we feel that the current wording appears threatening and will hinder the ability of parents to provide support to their child. Given the current long waiting times it is unreasonable and unsafe to expect a child to await a medical diagnosis before socially transitioning. In our experience social transition had a major positive effect and may well have prevented further significant mental health issues. We suggest this section be reworded to be more supportive of social transition, understanding that in the current situation this is a decision that has to be made by the parent and child together."
>
> (Parent – Disagree)

Views from Group B respondents (n=972)

Group B respondents said…	**Number**
Social transition is harmful	336
Agreement with Cass that social transition is not a neutral intervention	273
Social transition can solidify a young person's gender dysphoria	269
NHS England should promote 'social detransition'	174
There should be no social transition at all	169
Gender affirmation is wrong	103
There is no scientific evidence that social transition alleviates distress	95
Social transition negatively impacts on others	93
The role of schools should be made clearer	92
No adult should collude in the lie that sex is mutable	74
Clinicians must be free from external pressures and gender ideologies	63
Schools should stop encouraging social transition	57
There doesn't seem to be any evidence either way	54
Children and young people can't understand the implications	40
NHS England should publicise and share social transitions gone wrong	37
Gender non-conformity is normal	33
Support for watchful waiting	32
NHS England should commission a large and thorough study	29
Educate people on the risks of affirmation and social transition	25
Social transition for prepubertal children is abuse	24
There should be a strong, less child-led approach	20
Social transition is homophobic	15
Clinicians and services need clear guidelines on how to respond	14
The approach promotes acting and lying to earn treatment	5
There should be more guidance for social workers	5

Primarily, Group B respondents agreed with Dr Cass's statement that social transition was not a neutral intervention, as well as the interim service specification's statement that most cases of prepubertal gender incongruence do not persist into adolescence, largely viewing social transition as misguided, harmful, and potentially dangerous to a child or young person. They therefore supported NHS England's proposed measures to tighten control on social transition and reduce the number of individuals who took this step. Group B respondents felt that not only was social transition itself likely to cause significant mental health problems – as well as impacting negatively on those who would come into contact with it – but that it was the first step on a "slippery slope" to far more damaging aspects of transition, such as endocrine intervention, surgery, infertility, and possible detransition and regret. Fundamentally, Group B respondents believed that the impetus for social transition was a mistaken one, and that non-affirming psychological explorations and therapies were the answer, while also believing that evidence showed that social transition was ineffective in alleviating symptoms of distress and that approaches such as watchful waiting had been satisfactorily deemed successful.

For some Group B respondents there should be no gender affirmation or social transition at all, and NHS England's proposals that it may in some cases be necessary to alleviate distress and prevent impairment in social functioning were seen as catering to an "emotionally charged" ideological viewpoint that was "demonstrably false". Some also believed that encouraging social transition was a safeguarding issue and that, when encouraged in prepubertal children, it was tantamount to abuse.

As in other questions, Group B respondents once again emphasised their belief that clinicians and other adults working with children and young people must be free from pro-transgender pressures and beliefs, and that they should be issued clear guidelines and instructions about how to put the proposals into action, with some Group B respondents believing that neither clinicians, parents, nor any other adult should "collude" with a child or young person in affirming a gender different to their biological sex, believing that this was encouraging them to "live a lie" and at odds with the reality that sex is binary and immutable.

Group B respondents also encouraged NHS England to promote "social detransition" and to support and assist children and young people who wanted to take this step, with some feeling that it would not always be easy for them to go back on their initial decision to social transition. Some also encouraged that schools and services such as voluntary organisations and non-NHS mental health services were ensured to be on the same page with regard to the new, more anti-affirming and more stringent protocols, and that warnings on the risks of affirmation and social transition, as well as examples where social transition had led to serious negative consequences, should be published.

For some Group B respondents, as outlined in responses to other questions, the encouragement of social transition was seen as an expression of homophobia or as an outdated adherence to gender stereotypes betraying a narrowness of thinking that failed to allow for previously normalised archetypes such as tomboys or effeminate/androgynous males, with some now-adult respondents sharing that, were they children today, they would probably have been set on the path to affirmation and social transition – and in their views, mistakenly so, given that they believed they had been completely normal, merely differing from stereotype.

There were also some Group B respondents who felt that robust and compelling evidence on social transition in either direction was lacking, and therefore encouraged NHS England to conduct a thorough and large-scale study, with the results published widely and used to inform future policy both in health and throughout government – especially in schools.

> "We welcome the fact that the interim service specification warns about the need to watch for 'the risks of an inappropriate gender transition' but at the same time it is a serious problem that this warning is issued in the context of acceptance of prepubertal children changing gender. This is inappropriate given that affirmative treatment is harmful. Contrary to what the consultation says it is incorrect to assume that 'social transitioning' is 'necessary for the alleviation of distress'. To assume this is to cave into emotionally-charged and ideologically driven dogma and not the facts. It also suggests that social transitioning is the only way to alleviate distress, which is not only demonstrably false, it is promoting a form of treatment that many experts in the field (including those cited in this consultation) find harmful. In reality social transitioning is itself both a sign and instance of significant impairment in social functioning as a member of one's actual sex."
>
> (Member of the public – Disagree)

> "Social transition is not a neutral act in children or in teenagers. At the moment, children of all ages who do not conform to old-fashioned, stereotypical behaviours for their sex are easily persuaded by their peers, their schools and sometimes their parents that they must therefore be trans. No child is 'born in the wrong body' and social transition is dangerous. My granddaughter started to bind her breasts aged 13 having been persuaded by her peers at school that she must be a boy because she enjoyed science, had no interest in fashion, and was tall for her age. When my son and daughter-in-law found out they explained that nobody was born in the wrong body and girls could be brilliant scientists. They also restricted and monitored her internet use. Now, three years later, she's a very happy 16-year-old who's hoping to read genetics at university and thinks she might be a lesbian. Had she been 'socially transitioned', the story might have ended very differently."
>
> (Member of the public – Agree)

> "I think it should go further and be clear that social transitioning heavily influenced by parents or carers could be seen as a safeguarding issue."
>
> (Clinician – Partially Agree)

> "We know from existing research that around 80% of prepubertal children desist from a cross-sex identity without affirmation and social transition, and become resolved and happy with their biological sex without having been harmed. The only research to draw on in the case of the current cohort of adolescents who have been affirmed and socially transitioned is the testimony of detransitioners, who desist after having been medically harmed by the NHS. This is reason enough to exercise the same level of caution about affirmation and social transition for the adolescent age group."
>
> (Clinician – Partially Agree)

> "As a parent I would like the Department of Education to be very clear in not supporting any social 'transition' without parental consent for children. Regardless of what a clinician says, parents should be involved and have the final say. I do not appreciate people conflating Gillick competence for decisions such as contraception usage (which is temporary) with decisions to socially or medically 'transition' which can have irreversible long-term effects on the child."
>
> (Parent – Neither Agree nor Disagree)

> "It would also be useful to know what the revised guidance for social transitioning of adolescents means in practice at school and at home, and include guidance for adolescents who have already socially transitioned or are in the process of doing so. Parents have been put in a difficult position by trans ideology being promoted in schools and need help and clarity."
>
> (Parent – Agree)

"Affirmation as a first stage support should never have been introduced, it has caused so much harm to children and damage to family relationships. What schools and health services have been doing [is] completely at odds with [the new service specification] and it has caused irreversible harm to children and families."

(Parent – Agree)

"Social transition has profound psychological consequences for a child, their family and their peer group. It involves dangerous practices such as binding and tucking and carries a high risk of inducing body dysmorphia around sex characteristics at both onset and post puberty, and thus can be considered a form of iatrogenic harm. There is no robust evidence that clinical distress can be alleviated via social transition – in fact, clinical distress is frequently a symptom of coming to believe that the only solution to distress is transition, and reflects a lack of capacity to make an informed decision. High rates of desistance and the lifelong consequences of a cross-sex identity provide sufficient evidence for an even clearer recommendation by NHS England against social transition for children, [and] this message should form part of a public information campaign that sets out the risks of cementing a cross-sex identity before a child is sufficiently developmentally mature to understand the consequences. Parents and schools should be discouraged from seeking advice from 'support groups' that encourage this approach and NHS England should ensure that official signposting to support backs up that approach, across all of NHS Digital."

(Parent – Partially Disagree)

"We welcome the proposal that children who have not reached puberty should be prevented from social transition. However, we disagree that the prevention of social transition should not be applied to adolescents. Lesbian teenagers have been the largest group that have sought medical intervention through the GIDs clinic at the Tavistock, usually as a result of rapid onset dysphoria. This rapid onset has a number of causal explanations, including the bullying of girls at school who do not conform to sexist sex role stereotypes and define themselves as lesbians, and they may also experience sexual harassment from male peers. Allowing teenage girls to socially transition in secondary schools and change their pronouns, often without the agreement of their parents, will usually encourage them to seek medical transition. However if a watchful waiting approach is taken children will usually accept they are lesbian or gay as they mature. Research with female detransitioners, the majority of whom are lesbians, also indicate this. By their early 20s many young women regret that they took on a transgender identity and had medical and surgical interventions."

(Service provider – Partially Agree)

"I would go further and state that no school, further education college, youth group, CAMHS or any professional or group involved with children should be able to engage in socially transitioning a child. Children cannot consent to this. A 'watchful waiting' approach has been proven to work in the past, very successfully, and we need to get back to that. No-one should be forced to deny reality and socially transition a child, especially at the expense of a child's psychological health. Children still believe in fairies and Santa. Let them be children!"

(Parent – Agree)

Section 5 – Accessing prescriptions from unregulated sources

The interim service specification public consultation guide stated that:

> The current service specification for GIDS states that GIDS does not offer shared care with private clinicians, and that in cases where puberty blocking drugs or hormone drugs are prescribed or accessed outside the service, GIDS will make the young person and their family aware of the risks, contraindications and any irreversible or partly reversible effects of any interventions, and will be unable to provide ongoing clinical supervision for the management of these interventions.
>
> The proposed interim specification states that: “Children, young people and their families are strongly discouraged from sourcing GnRHa and masculinising/feminising hormone drugs from unregulated sources or from online 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 care 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.“
>
> The reason for the revised wording is to provide greater clarity and retain and strengthen current safeguards. Senior clinicians have advised NHS England of the need for the new interim service specification to have much clearer wording in this regard so that the interim service specification is less open to interpretation, so that young people, families and professionals are clear on the approach that will be adopted by the NHS in such cases.

Respondents were asked to what extent they agreed with the approach to the management of patients accessing prescriptions from unregulated sources. They answered:

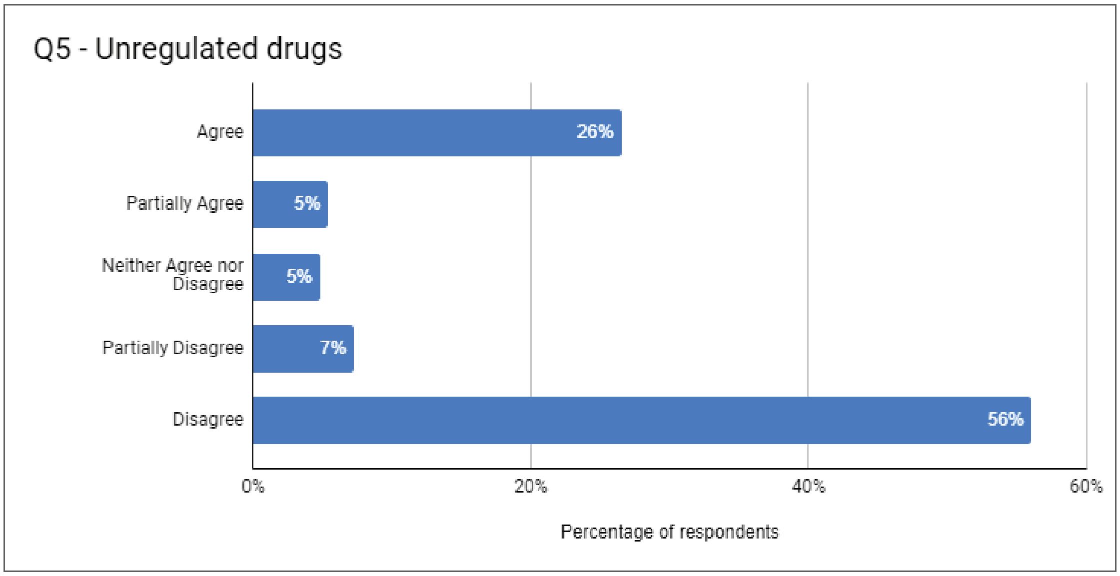

Figure 6. Quantitative results regarding accessing prescriptions from unregulated sources

Parents and clinicians were the most likely to agree with the approach to the management of unregulated drugs (46% each) while a third of members of the public also agreed.

Almost half of those responding as a member of the public, however, disagreed with the proposed approach, while an average of 74% of patients, LGBTQ+ individuals, those with transgender friends and family, and service providers also disagreed.

This question also represented a strong polarisation of opinion, where an average of only 5.8% selected either “partially agree“, “neither agree nor disagree“, or “partially disagree“. This compares with an average of 11.4% across the first five questions.

Views from Group B respondents

Group B respondents said...	Number
General support for the stance on unregulated drugs	185
Safeguarding measures should be applied to buyers and users	113
This neglects NHSE’s duty of care for its patients	95
It’s right that NHSE doesn’t accept clinical responsibility	87
There should be laws against hormone blockers and cross-sex hormones	71
General support for all changes in the revised specification	66
There should be a public health campaign	56
The risks should be made known and widely publicised	56
NHSE should pursue legal action against prescribers	37
More must be done to prevent the prescribing of unregulated drugs	32
NHSE should stop prescribing puberty blockers	28
There should be legal ramifications for parents and carers who provide these	27
GenderGP should be closed down	24

Online marketing of hormone blockers should be combated	20
Cross-sex hormones are dangerous and should never be prescribed	18
Breast binders should also be included	13
Users of unregulated drugs should be excluded from referral	13
The safeguarding protocols puts doctors in a difficult position	12
Doctors who prescribe unregulated hormone blockers should be struck off	11
Combat organisations (such as Mermaids) that produce misinformation	7
The use of unregulated drugs should be treated as a drug problem	6
The length of the wait list is the source of the problem	6
There should be no connection with Mermaids or GenderGP	5

Support for the new approach

Group B respondents who answered the qualitative question most often shared sentiments of agreement and support for the approach outlined in the interim service specification, with most respondents expressing strong messages of disapproval for all involved in the chain that led to children and young people using GnRHa and masculinising/feminising hormone drugs obtained from unregulated sources. Prescribers, sellers, promoters and buyers – as well as users themselves – were all deemed deserving of sanctions and legal ramifications, with some respondents encouraging that NHS England should be granted legal powers to pursue and prosecute anyone who contributed to the supply of these “illegal and dangerous” medications. Organisations such as GenderGP and other UK-based online sellers should be closed down, respondents said, while doctors who prescribed unregulated drugs should be struck off the medical register. A public health campaign and educational outreach program was suggested to warn children and their families of the risks and dangers, as was the introduction of a taskforce that could combat online providers, engage with social media, limit international supply, and address and correct misinformation disseminated by lobby groups such as Mermaids.

> “I think this could go even further. There is no place for unregulated prescription dispensing in Britain. Patients who have taken such medication should be treated in the same manner as patients who have taken recreational drugs – with sympathy and compassion, but with the consumption being considered an active problem.”
>
> (Member of the public – Agree)

> “We agree that patients should not access hormones online as this is dangerous. There have been many cases of the online provider GenderGP prescribing drugs to children after just one online consultation. In one case this led to the suicide of one of the young people involved. We agree that if children are accessing drugs from providers such as GenderGP then local safeguarding protocols should be initiated. We urge the government to shut down such providers and strike off doctors who are involved in prescribing drugs in this way as they are causing irreversible harm to children and families.“
>
> (Parent – Agree)

> “If they are receiving medication illegally the matter should be referred to the police for criminal prosecution of the suppliers and the parents should be referred to the local authority to be investigated for child abuse/neglect.”
>
> (Parent – Partially Agree)

> "More proactive education in lay terms is needed given widespread misinformation by unregulated commercial providers in this field. Maybe this could be covered in sexual health education curricula and in-reach programs in schools and youth organisations."
>
> (Clinician – Agree)

> "No patients should be accessing drugs from unregulated sources, and I think the definition of unregulated sources should include the proliferating profit-making mass of private gender clinics such as GenderGP, which appear to make their own rules, have little true clinical oversight of their patients, and treat gender medicine as a sort of lifestyle pursuit. All care should come from the NHS and in my view the rest should be outlawed."
>
> (Clinician – Agree)

> "I think this could be further strengthened. One angle would be clear public health campaigns about the risks of unregulated drugs. Another would be work combating unregulated and black market supply of hormones/drugs."
>
> (Parent – Partially Agree)

> "This section should refer to other unregulated interventions such as breast binders which have known risks. All links with third party provider private organisations such as GenderGP and charities such as Mermaids need to be permanently stopped. All care interventions should be provided by GIDS and the NHS only."
>
> (Parent – Partially Agree)

> "If family members help children obtain GnRHa and masculinising/feminising hormone drugs from unregulated sources or online suppliers, this should be reported to the police and the family members should understand that they could be prosecuted for harming children, if such harm occurs."
>
> (Parent – Partially Agree)

> "We believe that NHS England should support professional and criminal sanctions being applied to those involved in the supply of unregulated hormones or GnRHa."
>
> (Clinician – Agree)

Support for not assuming responsibility, opposition to not providing care

Some Group B respondents also expressed support for the proposals to not assume responsibility for prescribing recommendations or management of endocrine interventions, or to enter into shared care arrangements – although it often appeared that they understood this to mean users of medications from unregulated sources would be denied all medical care by the NHS, even in the event of something serious befalling them. There were, therefore, a significant number of Group B respondents who objected to this stance, feeling that it neglected NHS England's duty to care.

> "I think that the NHS should refuse to treat anyone who takes hormones illegally or be held responsible for side effects when they weren't prescribed. I think this could be made a lot clearer. If potential patients know this will not be tolerated, although I understand their distress at having to wait, it might give the children and teens the time they need to consider their decision."
>
> (Parent – Partially Agree)

> "If patients access prescriptions from outside the NHS then they should find appropriate aftercare elsewhere and the NHS should not be responsible in any way or forced to take these patients into care if things go wrong."
>
> (Parent – Agree)

> "The Service is right not to assume prescribing until the NHS has carried out its own assessment. Doing so would otherwise undermine the service and send the wrong message to children, families and professionals."
>
> (Clinician – Agree)

> "Refusal of treatment for those who access what they can could be seen as discriminatory and will do nothing but worsen the problem. Instead, harm reduction protocols should be employed and more education about the risks of unregulated hormones should be given."
>
> (Patient – Partially Agree)

> "This approach is unethical, as it ensures that the service washes its hands of all legal and clinical responsibility for minors who access dangerous drugs. It is a cynical approach that shows NHS England has given up on any intention to get to know teenage patients and their families, to try to steer them to live in harmony with their biological sexes. If this were the approach taken towards teenagers taking classified illegal drugs there would be public outrage and calls for a public inquiry."
>
> (Parent – Disagree)

Safeguarding

A significant number of Group B respondents also expressed support for the proposed safeguarding protocols, feeling that parents and carers who supplied their children with hormone blockers and cross-sex medications obtained from unregulated sources represented a risk to a young person's safety and that it would be in the best interests of the child if these adults were reported to authorities. There were some, however, who believed that requiring GPs to initiate safeguarding procedures would put them in a difficult position, as well as those who believed safeguarding responsibilities should be shared among a number of different healthcare professionals.

> "The advice around safeguarding should be made stronger – namely it should be stated that this 'must' happen rather than 'should' happen. Safeguarding referrals can and should be made directly by the Service rather than merely giving advice to the GP."
>
> (Clinician – Agree)

> "This is a difficult issue for practitioners, but if children are using drugs which have not been prescribed, safeguarding procedures should be commenced in the same way as if they were using amphetamines and other illegal drugs."
>
> (Member of the public – Disagree)

> "Advising the GP to initiate safeguarding protocols is too vague. This needs buy-in from social services and GPs who are also stretched and in our experience very unlikely to escalate safeguarding processes in this situation."
>
> (Clinician – Partially Agree)

> "It is right to initiate local safeguarding protocols, but as safeguarding is everyone's business it might be that the Service should also make multi-agency referrals if necessary."
>
> (Clinician – Agree)

> "All staff involved in caring for a child on GnRHa from unregulated sources would carry equal responsibility with the GP to initiate safeguarding procedures according to protocols."
>
> (Clinician – Partially Agree)

Other issues raised by Group B respondents

- Some Group B respondents used this opportunity to propose that the NHS should cease from prescribing puberty blockers.
- Some felt that similar protocols – including the suggested legal and criminal measures outlined above – should be applied to other harmful unregulated interventions, such as breast binders.
- Some proposed that those who had used drugs obtained from unregulated sources should be excluded from being able to be referred into the service.
- A few Group B respondents believed that the cause of children, young people, and their family/carers sourcing unregulated drugs was the length of the waiting list and that this problem should be addressed first, prior to imposing stringent and potentially harmful measures.

Views from Group A respondents (n=2011)

Group A respondents said...	Number
People use unregulated drugs because wait times are so long	1488
Private and overseas healthcare providers *are* regulated	884
These proposals run counter to NHSE’s duty to care	815
The proposals are coercive, threatening, and punitive	746
The proposals are unethical and will cause harm	710
This is not a safeguarding issue	578
The approach deters people from seeking support and damages trust	390
Using private or unregulated sources is often the best option/last resort	358
The approach is a form of gatekeeping	201
This appears different to how other illnesses are treated	115
Hormone blockers are not “unregulated“	107
The proposal will push the market for unregulated drugs underground	89
It’s not clear what “unregulated“ means	87
Some private clinics are both good *and* regulated	83
There should be a provision for shared care with private providers	82
GPs should still assist with health checks and blood tests	80
This won’t stop the use of unregulated drugs, it will merely increase risks	79
This proposal confuses “private” with “unregulated”	72
Access to private healthcare is an individual right	68
NHSE should provide a list of approved private providers it works with	41
Reconsider the use of the term “unregulated drugs”	35
Policing young people like this will cause resentment	32
What is the support for those who have already started non-NHS treatment?	31
What is the pathway for those coming from overseas with prescriptions?	30
Changing prescriptions from private/unregulated to NHS should be easy	24
Have GPs been consulted?	23
Private care is frequently superior compared to NHS care	22

Wait times are the real problem

A large number of Group A respondents expressed dismay at NHS England's proposed approaches to the management of patients accessing prescriptions from unregulated sources, feeling not only that the proposals lacked care, support and understanding, but that they failed to consider or address what they believed was the real problem, as well as the reason young people and their families felt that utilising unregulated sources represented their best and least harmful option: the issue of the prospect of a waiting list that was already several years long; that showed no signs of being reduced in length or size; and, indeed, which they believed would only become longer because of the proposals outlined in the interim service specification. Group A respondents urged NHS England to tackle the issue of wait times first, before removing care options from patients, and to recognise that gender dysphoric children and young people wouldn't have turned to private clinics and unregulated sources if they had been able to find and access a timely and quality service with the NHS – which, it was stressed, would have been preferential given the benefits in terms of financial outlay and trustworthiness of provision – yet, given the choice between utilising unregulated sources or facing potentially devastating consequences in terms of harm, severe distress, or the death of a child or young person, unregulated sources represented the best option.

> "I had to wait almost ten years before I secured medical intervention for my child from a private provider I didn't previously know existed. They began self-harming while waiting an eternity for help from the NHS and were suicidal. If I hadn't intervened by using a private provider they would be dead. All I care about now is that I keep my teenager with me and enable her to be as happy as she can be. You will not stop desperate parents doing what they need to do to stop their children self-harming and committing suicide due to crippling dysphoria."
>
> (Parent – Disagree)

> "We disagree with the principle of coercion that forces individuals to choose between accessing medical help via the NHS as opposed to private healthcare providers that are regulated by other bodies. Due to the extremely long waiting times to access NHS care it is not surprising that parents or carers who can afford private care access these services. Accessing regulated private healthcare, especially given the 3+ year waiting time, should not be treated as a safeguarding concern. We feel that the interim service specification fails to deliver on the principle of healthcare free at the point of delivery. If the NHS service cannot meet the needs of patients within the 18-week time directive, access to private health providers, supported by a GP in shared care agreement with health monitoring should be part of the new service specification."
>
> (Service provider – Disagree)

> "If you don't treat people properly for years due to wait times that go well beyond the required 18 weeks you are simply not providing care to most of the trans people in the UK. This is the state of things. To then suggest that trans people can't seek hormones elsewhere is ridiculous – yes it's not ideal, but the NHS is the one gatekeeping the hormones to begin with. If you don't want them to do it, have better healthcare."
>
> (LGBTQ+ individual – Disagree)

NHS England must honour its duty to care

Group A respondents were further dismayed by what they saw as NHS England's strong statement of disregard for its duty to care in terms of the proposed approaches to the management of medications obtained from unregulated sources, feeling that it was unethical, discriminatory, dangerous, and self-defeating. Group A respondents predicted a long sequence of negative consequences that would result from the instigation of such protocols, including children and young people being placed in a position where they would understand that it may benefit them to lie to doctors and other healthcare practitioners about which medications they may or may not be taking; that it may deter them from seeking help and support from the NHS both in the present and in the future, either through fear of triggering safeguarding procedures or through losing their access to treatment; that a policy which appeared to be a form of gatekeeping and policing would cause resentment and mistrust of a crucial, lifelong service; and that it may cause children and young people to miss out on potentially critical check-ups, exams, and blood tests due to the policy of refusing to enter into a shared care agreement and to refuse any clinical responsibility for treatment.

Group A respondents felt strongly that these proposals were in contradiction to NHS England’s commitment to harm reduction – as well as being in opposition to international organisations such as the World Health Organisation and the United Nations – and that they represented a stark contrast to how NHS England approached and treated other illnesses and conditions, such as those caused by smoking, drinking, and illegal drug use, as well as the way other patients who may use private and even “unregulated“ treatment for their medical care were considered. For Group A respondents, these issues represented strong suggestions of double standards and discrimination, once again strengthening the view that political and ideological influences must be at least in part driving the motivation for such change.

Some Group A respondents suggested that GPs had a duty to provide health checks, blood tests, and other basic care provisions that would accompany endocrine interventions regardless of where the medications had been sourced, while others proposed that shared care between the NHS and private providers benefitted all parties, including NHS England, by reducing costs to the service, providing treatment where the NHS couldn’t – and thereby reducing the waiting list – and engendering a relationship of mutual trust, openness, honesty, and respect.

There were also those who pointed out that refusal of service and provision, as well as threats and coercion, very rarely causes young people to cease from sourcing and using drugs, regulated or otherwise, and that problems such as health risks and the growth of a black market would more than likely increase because of these measures.

Some also raised issues and questions of how this approach would impact on those who may have already begun treatment with services outside of the NHS – private, unregulated, or international – as well as what care pathways would be available to those entering to England from overseas who already had prescriptions, but which NHS England may view as “unregulated“.

It was also encouraged that NHS England introduce procedures to enable changing from private or unregulated prescriptions to NHS prescriptions should be made as easy as possible – whereas this proposal appeared to make changing prescriptions increasingly more difficult.

> “It’s entirely unreasonable to deny people endocrinological care because they have accessed unregulated HRT. If they have resorted to this measure it is already extremely likely that the person suffers/suffered from debilitating dysphoria, and leaving them without proper support from endocrinology opens them up to unnecessary risk. I understand this is not exclusively the fault of the

> NHS, but waiting times for access to transgender care are ludicrous, and those who cannot afford to wait for this amount of time should not be punished for it.“
>
> (Has transgender friends or family – Disagree)

> “This approach may be experienced as coercive: the NHS does not, and will not under this service specification, offer a care pathway that meets time limits set out in the NHS constitution. For children and families waiting for years to have a first meeting with a clinician this approach to ‘safeguarding’ may be experienced as a threat: that if they seek care through any other route they will be punished, whether or not that care is clinically indicated for the child.“
>
> (Service provider – Disagree)

> “No healthcare professional should be expected to refuse to treat a person in need, and the NHS specification in this way is patently unethical and compels clinicians to breach the very fundamental obligation to care at the heart of the clinical profession. Patients who access unregulated markets usually do so because they cannot timely and safely access proper clinical care. This clause fails the basic moral obligation of care towards the most vulnerable gender diverse young people.”
>
> (Service provider – Disagree)

> “The consultation states that ‘people accessing hormone blockers or hormones from unregulated sources or unregulated providers will not be managed or monitored by the NHS’ and specifies shared care in this decision. Adults who access HRT from unregulated sources are monitored by the NHS as a form of harm reduction. As are adults that use, for example, steroids in a gym setting, or use illegal drugs. This is obviously to provide a basic level of healthcare under the NHS. So why then is this different for children? If a parent cannot access puberty blockers via the NHS they are unable to access them via private healthcare, and if they provide them from ‘unregulated’ sources their child cannot be offered basic harm reduction from their primary care provider? How is this in line with what the NHS is for, or how the NHS legally operates? This contradicts the harm reduction approach of the NHS (Domain 5 of NHS Outcomes Framework, as stated within the specification), and the General Medical Council’s ethical guidance.”
>
> (Patient – Disagree)

Private healthcare providers and services

Many responses from Group A respondents mentioned private clinics and private healthcare providers, with a significant number stating that the proposal appeared to conflate private or international sources with unregulated sources, tarnishing by association. Group A respondents, therefore, were both supportive and defensive of private healthcare providers, stressing that they *are* regulated; that they offer a great quality service (in excess of NHS England’s in many/most cases); that an individual should have a right to use them without forfeiting access to other avenues of care; and that no one should have to fear safeguarding measures as a result of choosing to use a private healthcare provider[14].

Some respondents also suggested that a “blanket ban“ on sharing care with private providers was both unnecessary and self-defeating, and that a more proactive approach would be to audit and regulate private providers and maintain a list of “approved partners“ with whom patients could safely engage.

> “This point is unhelpfully vague in its definition of unregulated sources. Private healthcare is still very much regulated and to treat it as equal to buying black market drugs is ridiculous. The wait times for NHS

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[14] It may be important to note that the word “private“ was only mentioned once in the interim service specification documents, with regard to the current service specification for GIDS, whereas it appeared over 1,400 times in answers to the qualitative question.

> care can be upwards of three years, which pushes many patients towards private care out of necessity (especially considering the time-sensitive nature of children who want to avoid experiencing a distressing puberty)."
>
> (LGBTQ+ individual – Disagree)

> "The document does not delineate between 'unregulated sources' and 'online providers not regulated by UK bodies', yet these require a different clinical response. Medicines from unregulated sources are potentially harmful to the individual and support-seeking requires a secure patient/professional (GP) relationship. Medicines procured through online (private) providers who are not UK-regulated are significantly more likely to be safe. Additionally, the guidance assumes that not being UK-regulated means the online (private) provider does not adhere to international best practice and is therefore not suitable for shared care prescribing. This is an unhelpful generalisation and potentially misleading."
>
> (Service provider – Disagree)

> "The specification conflates 'unregulated sources,' e.g., online pharmacies and distributors, with private providers and providers not regulated by UK regulatory bodies. This is a dangerous conflation: all doctors are subject to regulation under the General Medical Council, and there are many other relevant regulatory bodies, including but not limited to the Care Quality Commission, the Health and Care Professions Council, and the Professional Standards Authority. Furthermore, providers not regulated by UK regulatory bodies – i.e., providers in other countries – are regulated by their own jurisdiction. The implication here from the NHS is that the NHS are the only providers of safe care. This is of course untrue: the NHS are simply the only providers of publicly-funded care. In various cases, gender specialists working within NHS clinics also have private practices, and are the same individual clinicians. While we recognise that it is a right for all people in the UK to seek and to have access to publicly-funded healthcare provided through the NHS, and would advocate for all people to seek gender-related healthcare pursuant to this right via the NHS, it is also true that insurmountable hurdles (namely, waiting times) mean some people feel they have to seek other options."
>
> (Service provider – Disagree)

Safeguarding

Many Group A respondents expressed strong concerns with regard to the proposal to "advise the GP to initiate local safeguarding protocols [in cases where] children, young people and their families [had sourced] GnRHa and masculinising/feminising hormone drugs from unregulated sources or from online providers that are not regulated by UK regulatory bodies". Sourcing drugs that were unregulated in the UK – but may be regulated overseas – was not seen as an action deemed deserving of warranting the application of safeguarding measures – measures that may ultimately result in children or young people being separated from their families – and, indeed, it was an action that many Group A respondents felt demonstrated a measure of care and of wanting to do the best for one's child, irrespective of cost or personal desire or belief. Again, it appeared to many Group A respondents to be indicative of a lack of care and compassion on NHS England's part, as well as being a coercive and punitive threat made with the primary purpose of gatekeeping services and preventing children and young people from transitioning.

A small number of Group A respondents, as Group B respondents had, wondered if GPs had been consulted with regard to their role in initiating safeguarding procedures considering that these requirements may put them in a difficult position, as well as speculating that others would be just as well-placed for the task, if not more so.

> "NHS England does not maintain accessible services for trans people. Functionally the service does not exist. The only remaining option is private healthcare or legally importing medications. To suggest

removing a child from their loving parents for merely seeking legal medical care where you have failed them so utterly is unconscionable. It is plainly disturbing to read."

(Patient – Disagree)

"To read that young people who have been fully supported by their families (who know them best) may be referred to local safeguarding teams is extremely upsetting and concerning. The NHS have been unable to support many young people with the care that they need and families have had no other option [but to go private]. If treatment is managed well (blood tests, regular medical and counselling reviews) and the young person is thriving then this is the best outcome for the young person."

(Parent – Disagree)

"The proposed approach is vile and goes against everything the NHS stands for. As the gender affirming care provided by the NHS is incredibly difficult to access and often isn't adequate people understandably need to rely on other sources for treatment such as private clinics and online pharmacies. As for the 'safeguarding protocols' mentioned in the proposal, the only acceptable form of safeguarding is shared care agreements, or at the very least providing blood tests and other health monitoring to ensure the medical treatment isn't negatively affecting the patient's physical health. Involving local authorities is not beneficial to the families who have turned to private services for what the NHS fails to provide, it is simply punishment and exerting authoritarian control over transgender people and their families. To be perfectly honest, you should be ashamed to even suggest that the NHS should neglect, threaten and punish a young person accessing lifesaving medical care elsewhere."

(Patient – Disagree)

"What are the safeguarding protocols for? How do you feel this would support the child as opposed to bringing chaos to the family? Why introduce the potential that a child could be removed from their family for having a supportive parent? Why will GPs be responsible for reporting safeguarding concerns when in all other instances it would be the person who witnesses the concern? How will it impact the relationship with the professional and the child's ability to discuss matters with them?"

(Member of the public – Disagree)

"While accessing hormone treatments from an unregulated source may give rise to potential safeguarding issues, each case would need to be assessed on the individual circumstances and whether the threshold for potential or actual serious harm was met to justify escalation to social services, rather than as an automatic requirement. A blanket stipulation that accessing regulated private care or treatment through unregulated sources is in itself evidence of a reportable risk of harm is likely to prevent young people and their families from engaging with healthcare services at all. We query why this particular group of patients and their families appear to be singled out for such a stringent approach, which is likely to lead to increased reluctance to engage with GP services, potentially increasing and entrenching health inequalities and preventing the broader provision of healthcare. This proposal would place doctors in an extremely difficult position with regard to taking a harm reduction approach to the most vulnerable patients, maintaining good doctor-patient relationships and avoiding conflict with distressed patients and their families. Effective therapeutic relationships between doctors and patients are predicated upon trust. We cannot see how the potential threat of a safeguarding referral is conducive to establishing or maintaining this trust. This also seems to contradict the position set out by the General Medical Council which states that doctors should 'encourage [their] patient to be open about their use of alternative remedies, illegal substances and medicines obtained online or face to face, as well as whether or not they have taken prescribed medicines as directed in the past.' We would suggest that this element of the proposal is removed and that any decisions on initiating safeguarding measures, if deemed necessary in the best interests of the child or young person, remain the decision of the professional who identifies such a concern on a case-by-case basis."

(Clinician – Not Stated)

"It is not the GP's responsibility to initiate safeguarding concerns for others. Every person has this duty, and we would expect any safeguarding concerns that are identified by the gender team to be addressed directly while 'informing' the GP."

(Clinician – Partially Disagree)

> "The document states that general practitioners would be advised to initiate local safeguarding protocols if a child or young person obtains puberty blockers or hormones from another source. This recommendation, which would see families reported to child protection services, is gravely concerning. As someone who teaches social workers and youth and community development students and professionals, this is incongruent to established professional standards and assumes harms against the child have been committed by seeking private healthcare. This is a ludicrous and dangerous situation. Similarly, a general practitioner with a better understanding of gender incongruence might be put at risk of censure for refusing to make such an inappropriate child protection referral, against the recommendations of the specialist service. I believe that the appropriate interim service specification should instead be supporting GPs and families to provide the best evidence-based and compassionate care for children and young people with gender incongruence, including access to puberty suppression and gender-affirming hormones where indicated."
>
> (Clinician – Not Stated)

Unregulated drugs

Some Group A respondents stated that hormone blockers and hormone replacement treatments are not actually unregulated and that non-transgender individuals are able to access them freely "over the counter". Some felt that the term "unregulated drugs" was misleading and had been used to elicit fear and conjure up images of damaging illegal drugs by connotation and association. It was suggested that the term be reconsidered and that it needed clarifying in order to differentiate unregulated drugs from: dangerous drugs; illegal drugs; drugs that are regulated overseas but not in the UK; drugs that are regulated for adults but may not have been thoroughly tested in children; safe drugs that are available online or in private clinics; drugs that are primarily designed for certain applications but have other uses also; and drugs that are simply "non-NHS".

> "It is unclear what unregulated means in this report; this causes confusion to GPs, parents and professionals involved in the care of youngsters. Private organisations within the UK and following UK regulations should be respected openly."
>
> (Clinician – Neither Agree nor Disagree)

> "Describing HRT and blockers as 'unregulated drugs' is false, these medicines are very regulated in the UK. Describing them like this gives the impression that they are either black market or illegal. This comes across as fearmongering about medicine that cis people are able to access over the counter."
>
> (LGBTQ+ individual - Disagree)

> "The September 2022 publication used notably different language in this section when compared to the October 2022 version, with the term 'hormone interventions' being changed to 'unregulated drugs'. To non-specialist responders of the consultation this alters the perception of treatments as being more akin to illicit substances; 'drugs' rather than treatments in use for decades in the context of gender identity healthcare."
>
> (Service provider – Disagree)

Section 6 – Suggestions for changes or additions

Respondents suggested a number of changes or additions to the interim service specification. Group A respondents' (n=1802) suggestions were as follows:

Group A respondents said…	Number
All evidence the specification is based on needs revisiting and updating	1059
It is unethical to require participation in research in order to receive care	979
Puberty blockers are not experimental or harmful	643
NHS England needs to acknowledge that not all parents or carers are supportive	627
Explain access and prescription protocols for hormone treatment	615
Public and patient involvement in service development should be reinstated	603
Trans people should have been consulted	598
There should be mention of fertility services	573
Mention local endocrine services	429
Talk about regular reviews and ongoing opportunities for feedback	392
Follow the lead of WPATH and other international standards for care	276
The proposed specification must be completely changed	140
NHS England should make an explicit commitment against conversion therapy	136
Include guidance for endocrine intervention	113
An informed consent model should be adopted	83
There should be more geographic bases	32
Issue a statement of clarity to current users	22
Clearly outline how the new service will run and be resourced	21

Objections to the evidence used to inform the interim service specification

Across several questions a large number of Group A respondents raised strong concerns that the evidence which had been used to inform the interim service specification was "outdated and inaccurate"; that it did not appear to have been properly cited or referenced; and that it was believed to have been taken from a single source – the Endocrine Society's Clinical Practice Guidelines (2017) – whose conclusion has been challenged and superseded by many more recent and better quality studies and research papers. Further, it was stated that the Endocrine Society quote included in the interim service specification was "cherry picked", and that when read in its original context the implication of it changed radically.

The following responses encapsulate and incorporate the beliefs and views of many Group A respondents:

> "There seems a remarkable lack of evidence throughout the proposal – the only citation present is taken from the Endocrine Society's Clinical Practice Guidelines, which in turn is based on outdated studies from the 20th century largely concerned with problematising 'deviant gender role behaviour'. More recent

studies refute this claim, including Olson's 2022 longitudinal study[15] of 317 participants which found that an average of five years after initial social transition, 94% retained a trans identity. Further research[16] supports this, with the longest and largest study to date on the continuation of gender-affirming hormones in transgender people starting puberty suppression in adolescence finding that '98% of people who had started gender-affirming medical treatment in adolescence continued to use gender-affirming hormones at follow-up. And finally, the study [by Vincent[17]] found that 60% of trans male and 53% of trans female clients knew their gender identity before the age of 5. As Vincent states, this demonstrates two important things: 'many people who do transition had a strong sense of their genders from a young age,' and that 'just because someone didn't express gender difference in childhood, this is not evidence that they are not trans.'"

(Clinician)

"There has been zero evidence given to support [the claim that] 'the clinical approach in regard to prepubertal children will reflect evidence that in most cases gender incongruence does not persist into adolescence'. In fact, the opposite is true: a very small percentage of people who start medically transitioning end up stopping treatment, and an even smaller number of that percentage is because said people realise that transitioning medically is not the right path for them. The majority of people who do stop transitioning do so due to financial concerns or experiencing abject transphobia. Many in fact later continue with their transition. One detransition study claims an 80% desistance rate in trans children, however when the study was scrutinised it was discovered that the methodology was deeply flawed. The study in question did not differentiate between young people with gender dysphoria, young people who socially but not medically transitioned, and young people who were simply exploring gender diversity[18]. Also, in a UK survey of 3,398 attendees of a gender identity clinic it was found that just sixteen – about 0.47% – experienced transition-related regret. Of these, even fewer went on to actually detransition and become detransitioners[19]."

(Patient – Disagree)

"Given how poorly this service specification reflects existing evidence I would be extremely concerned about the materials provided to parents. Misguided and misinformed information sent to parents will cause harm and undermine support for trans children. On page 13 it is stated that 'the clinical approach in regard to prepubertal children will reflect evidence that suggests that […] in most prepubertal children, gender incongruence does not persist into adolescence.' The above cites the Endocrine Society statement 'combining all outcome studies to date, gender incongruence of a minority of prepubertal children appears to persist in adolescence.' It is important to note that the Endocrine guidelines themselves provide a longer quote on this topic:

'However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain gender dysphoric/gender incongruent in adolescence. Prospective follow-up studies show that childhood gender dysphoria/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some gender non-conforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad. However, the persistence of gender dysphoria/gender incongruence into adolescence is more likely if it had been extreme in childhood. With the newer, stricter criteria of the DSM-5 persistence rates may well be different in future studies.'

The NHS has here chosen to omit the important clarification within the Endocrine guidelines, that highlights that even back in 2017 it was recognised that the 'desistance' statistics rely on old definitions

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[15] Olson, et al. "Gender Identity 5 Years After Social Transition." American Academy of Pediatrics, vol. 150, no. 3, 2022, (https://doi.org/10.1542/peds.2021-056082)

[16] Van der Loos, et al. "Continuation of gender-affirming hormones in transgender people starting puberty suppression in adolescence: a cohort study in the Netherlands." The Lancet, 2022, (https://doi.org/10.1016/S2352-4642(22)00254-1)

[17] Vincent, Ben. Transgender Health: A Practitioner's Guide to Binary and Non-Binary Trans Patient Care. Jessica Kingsley Publishers, 2018

[18] https://www.huffpost.com/entry/the-end-of-the-desistance_b_8903690

[19] https://epath.eu/wp-content/uploads/2019/04/Boof-of-abstracts-EPATH2019.pdf

that focused on gender non-conforming children rather than trans children, and that newer studies focused specifically on trans children expect to find a different outcome.

The 2017 Endocrine Society citation about collective studies showing high rates of desistance cites a 2013 study by Steensma, which in turn cites a 2011 literature review again by Steensma. In this 2011 literature review, statistics are drawn from studies published in 1968, 1972, 1979, 1984, 1986, 1987, 1987, 1995, 2008, 2008. The vast majority were published last millennium, drawn from research conducted even earlier that focused on gender non-conforming children who were problematised lest they grow up to be gay. Several of those studies were outright conversion therapy studies for gender non-conforming children, with methods that were coercive and abusive.

Ten studies are included in the 2011 literature review and these are the ten studies upon which the NHS is basing 2023 clinical practice. Take a look at the titles of these ten studies:

- Bakwin H. (1968). Deviant gender-role behaviour in children: Relation to homosexuality.
- Davenport C. W. (1986). A follow-up study of 10 feminine boys.
- Drummond K. D., Bradley S. J., Peterson-Badali M., Zucker K. J. (2008). A follow-up study of girls with gender identity disorder.
- Green R. (1987). The “Sissy Boy Syndrome” and the development of homosexuality.
- Kosky R. J. (1987). Gender-disordered children: Does inpatient treatment help?
- Lebovitz P. S. (1972). Feminine behaviour in boys: Aspects of its outcome.
- Money J., Russo A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up.
- Wallien M. S. C., Cohen-Kettenis P. T. (2008). Psychosexual outcome of gender-dysphoric children.
- Zucker K. J., Bradley S. J. (1995). Gender identity disorder and psychosexual problems in children and adolescents.
- Zuger B. (1984). Early effeminate behaviour in boys: Outcome and significance for homosexuality.

Even from the project titles you can see that many of these early research projects had a problem with femininity, ‘sissy-ness; ‘effeminacy’ or ‘proto-homosexuality’ in boys. These were not research projects on trans kids but on kids who were deemed insufficiently masculine, many with explicit goals of teaching young boys to toughen up to prevent them becoming a ‘homosexual deviant’. The fact that many of these young boys grew up to be gay men rather than trans women tells us nothing about outcomes for today’s trans kids.

The authors of the above studies are also synonymous with key figures in conversion practices, especially conversion practices to try to prevent homosexual outcomes. These abusive studies predominantly on boys who were deemed insufficiently masculine are entirely meaningless in driving clinical practice for trans kids in 2023.

In the time since the publication of the Endocrine guidelines in 2017 the validity of the claim that trans children ‘desist’ in their identities has been strongly critiqued [and] challenged by more modern research, with recent longitudinal studies from Australia (Tollit et al., 2021[20]), USA (Olson et al., 2022[13]) and Spain (De Castro et al., 2022[21]) showing a large majority of trans and non-binary children and adolescents continuing to identify as trans or non-binary (96% across child and adolescent age groups in Australia over a ten-year period; 97.5% of children under 12 at 5 year follow up in the USA; and 97.6% of children and adolescents at 2.6 year follow up in Spain).

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[20] https://www.tandfonline.com/doi/abs/10.1080/26895269.2021.1939221

[21] De Castro, et al. ‘High persistence in Spanish transgender minors’. (DOI: 10.1016/j.rpsm.2022.02.001)

> On page 13 of the service specification it states that 'the approach [to social transition] will focus on careful observation of how gender dysphoria develops as puberty approaches and is reached.'
>
> Within older literature there is one study that mirrors this language, which is now considered discredited as a source on this topic: Steensma (et al)'s 'Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study [of 25 Dutch teenagers'.[22] This older 2011 paper has in the past been cited to suggest puberty is diagnostically important for determining which children will persist in their identity. This study in fact is not evidence [for] that. The study mis-cites the conclusions that can be drawn from the evidence at hand, and these mis-citations cannot still be influencing policy over a decade later when they have been called out time and again as flawed and misused."
>
> (LGBTQ+ individual)

Objections to the proposed research program and support for puberty blockers

A large number of Group A respondents – as well as some considered neutral and Group B – strongly objected to the proposal to require children and young people to enrol in a formal research trial in order to receive hormone treatments such as puberty blockers. Again, in accordance with other responses, this was seen as an unethical form of gatekeeping and a barrier to much-needed and even life-saving treatment. Many Group A respondents believed that endocrine treatments such as puberty blockers had already been demonstrated to be effective and safe through a variety of international research studies and objected to the idea that they were considered to be "experimental and harmful". Comparisons and parallels were made with other groups who were able to access hormone medications without such requirements, such as children experiencing early onset of puberty.

Some also felt the requirement would be self-defeating, given the belief that some children and young people – if not many, or all – would provide dishonest responses and feedback if they felt that was what was required of them in order to 'earn' endocrine interventions, thereby corrupting the research data.

> "Don't force people into research projects in order to access treatment. That seems highly unethical. The research is clearly needed, and if given the option most people will surely participate. But don't hold a gun to their heads; that's not what a caring society does."
>
> (Parent)

> "Only allowing access to puberty blockers on the basis that an individual consents to be utilised within trans-related research goes against best practice for research, where consent must be made without coercion or influence. It goes without saying that withholding life-saving care from people unless they comply with the NHS's demands is an act of coercion, thus contradicting the ethical framework that research is based on."
>
> (Patient)

> "The mandatory participation in research is both deeply unethical and profoundly counterproductive. It seems that you forget that your patients have agency, they have objectives, and they communicate. When I went through the gender clinic the standard advice was to wear a dress and lie about your childhood. You simply cannot conduct research on a population that knows you might withhold healthcare if they give the wrong answers."
>
> (Patient)

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[22] https://pubmed.ncbi.nlm.nih.gov/21216800/

"In paragraph 13d of [the General Medical Council]'s guidance on 'Decision making and consent'[23] we say that in supporting patients to make decisions about their treatment doctors should make them aware of their right to refuse to take part in teaching or research; and in paragraph 69 we're clear that nothing should influence a patient to such an extent that they cannot exercise free will. Whilst we appreciate the importance of research and data in medicine it would appear that this proposal may not be compatible with principles about patients freely consenting to take part in research."

(Clinician)

"Patients should not, under any circumstances, be required to participate in medical research as a standard of accessing care. This is contrary to medical ethics standards, patient privacy guidelines, and people's autonomy and self-determination. It's inconsistent with practice in any other major field of healthcare. We would be outraged if people accessing gynaecological treatment had to participate in research as a condition of getting pap smears and this is no different."

(Has transgender friends or family)

"Puberty blockers have been prescribed to patients such as cis children going through puberty too early and there has never been an issue with lack of research, making it feel like a targeted attack on trans children."

(Patient)

"Given that Dr Cass stated that she could not yet comment definitely either way on the use of puberty blockers, if her full report indicates that puberty blockers can be used safely would the specification that patients can only access GnRHa as part of a research trial be immediately lifted?"

(Has transgender friends or family)

"Withholding puberty blocking drugs leads to permanent changes, with these secondary sex characteristics causing transgender adults dysphoria and increasing risks and rates of depression, anxiety, substance abuse and suicide. Denying puberty blockers to youths with gender dysphoria is not a neutral act and potentially risks lives."

(Member of the public)

"This service specification presents the use of blockers as experimental, when in actuality they've been used for a long time, are shown to be safe, and have strong evidence supporting their use."

(LGBTQ+ individual)

"Evangelicals and gender criticals often claim that hormone blockers are experimental and almost always lead to cross-sex hormones. They remain silent when it is pointed out to them that the same drugs have been used on children with precocious puberty or even acne for decades. If [these children are] not trans as well [it] never leads to cross-sex hormones or long-term effects. It is another tactic used by hostile groups."

(Patient)

"You have not given enough weight to the impact of doing nothing and letting my child go through the wrong puberty. You have made the mistake of worrying about the downsides of puberty blockers but barely considered the benefits. My child is living as a girl. Simply put, if she got a voice like Tom Jones she would take her own life."

(Parent)

"The WPATH Standards of Care 8 extensively discusses the evidence base for the use of GnRHas, while the specification presents this medication as experimental. This is demonstrably untrue, as has been established by a number of experts – for example, Giordano & Holm[24] have demonstrated that three of the key reasons GnRHas are framed as 'experimental' are their use off-label; use in a different population

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[23] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent
[24] https://www.tandfonline.com/doi/full/10.1080/26895269.2020.1747768

> than their market authorisation; and lack of Randomised Controlled Trials (RCTs). They underline a number of key considerations that demonstrate why these are not valid reasons to claim that use of GnRHas are experimental. Firstly, they note that the use of 'experimental' drugs does not inherently equate to unethical or inappropriate use. They go on to explain that GnRHas have been in use since the 1990s, and have been recommended as treatment by the Royal College of Psychiatrists since 1998, and have been included in WPATH's Standards of Care since 2001. Importantly, the use of 'off-label' medication is common and necessary in children's medicine, as most drugs have only been tested in adults, and are therefore only licensed for adults. Off-label prescription of medication is recommended by the Royal College of Paediatrics and Child Health, and the British Association of Psychopharmacology.
>
> Further claims around the 'experimental' nature of GnRHas insist there are no long-term studies to demonstrate their safety and efficacy. As stated, Standards of Care 8 lists many studies that have demonstrated this safety and efficacy. These include, but aren't limited to [the studies of Drummond and Bradley (et al); Steensma and Kreukels (et al); Wallien and Cohen-Kettenis; Bungener and de Vries (et al); and Angus, Nolan, Zajac and Cheung].
>
> Another false claim made about GnRHa is around the supposed damage GnRHa has on bone mineral density. When an individual is on puberty delaying treatment their bone mineral density does not increase at the same pace as their peers, as this change is induced by pubertal hormones. However, it has been consistently demonstrated that when GnRHa treatment concludes and the individual moves onto puberty, whether exogenous or endogenous, bone mineral density will develop as expected until it is in line with the bone mineral density of an individual who was not on GnRHa treatment."
>
> (Service provider)

NHS England should acknowledge that some parents and carers are unsupportive

As in responses to several questions, Group A respondents raised the issue of unsupportive and transphobic parents and carers of gender dysphoric children and young people, frequently seen as representing profound and difficult to overcome barriers to much-needed access to care. Here, respondents explicitly stated that NHS England should acknowledge this situation and refer to it in its interim service specification, referencing how a child or young person with unsupportive parents or carers would be affected and what options would be available to them given the extra challenges they face. This was seen as being especially important in terms of accessing GPs and other services which may require parental consent and/or logistical assistance, with some also stressing that such services should be free from requiring parental consent given the possibility of denial from an unsupportive parent or carer.

Related and similar to the above, some respondents also believed that NHS England should make reference to the challenges and potential barriers gender dysphoric children and young people would face from other unsupportive factors, such as GPs, schools, mental health services, and local authorities.

> "Forcing young people to be outed to their parents is not only opening paths to possible transphobia, home abuse and neglect but you are removing safety and control from their hands. There's a reason why sexual health is typically done discreetly, it's in the interest of the person's safety to make sure they are healthy, regardless of what the parents think."
>
> (Patient)
>
> "I think it needs to be very clear on what parental input is necessary at each step and, for the most part, that it isn't. Currently I can't see any guidance on whether parental consent is required and that therefore

> leaves it open to clinicians to deny essential healthcare to a child or young person because their parent has extreme views."
>
> (LGBTQ+ individual)

> "Hormone blockers should be offered without parental consent – not all transgender kids are safe to be out as transgender at home."
>
> (Patient)

> "My biggest worry is that nowhere in the specification does there appear to be any consideration that key people may be unsupportive, and in fact may be actively hostile towards trans people. We know that trans children are often pushed into conversion therapy or even made homeless by unsupportive parents; that some teachers refuse to support trans and gender diverse children; and that some GPs refuse to refer trans people to further treatment."
>
> (Parent)

> "The overwhelming majority of young people we support face homelessness after coming out [as transgender] and many are living in hostile and abusive environments. The interim service specification does not acknowledge that it is not uncommon for young people to have transphobic parents and families, as well as unsupportive carers, schools and local authorities. WPATH Standards of Care 8 recognises this, highlighting that it is not always appropriate to include parents/carers in decision making. We are concerned that this could increase levels of homelessness among young people as they would feel they have no choice but to leave home."
>
> (Service provider)

Public and patient involvement in service development should be reinstated

A large number of Group A respondents highlighted that the previous service specification included a reference to public and patient involvement in innovation and service development, now absent in the revised interim service specification. This was desired to be reinstated, with respondents expressing dismay that the interim service specification (and the EHIA) appeared to have been written without any consultation of transgender individuals and/or their families, carers, and advocates, as well as experts in transgender healthcare. Many Group A respondents felt that it was critical that transgender voices were considered, heard and embedded within the framework of any new gender dysphoria service development.

> "There is no mention about how stakeholders such as service users/carers/advocacy organisations have been included in thinking about this. I am taught they should be included at every stage and it does not feel that is being reflected in this proposal. This proposal feels very done to rather than being supporting and compassionate."
>
> (Clinician)

> "For any service for minority groups they should be consulted, otherwise there is a risk of missing important provisions or developing a service which is just not helpful."
>
> (Clinician)

> "The specification has been released without following the statutory guidance on working in partnership with people and communities. In effect, it has been designed with no patient voice nor input from those with lived experiences, unlawfully. We are unclear why the specification has been written this way, will you please let us know?"
>
> (Service provider)

Areas, services and concerns that could/should be mentioned

Group A respondents felt there were several important aspects of transgender healthcare which had failed to be mentioned in the interim service specification, leaving them in the dark as to their status and whether or not they were still available. These included:

- Fertility services, including fertility preservation (for example, by egg harvesting and gamete storage) with respondents feeling the issue should be addressed before the onset of puberty, and before puberty blockers were prescribed and used.
- Clear guidance as to how cross-sex hormones will be prescribed and accessed, and to whom they will be made available – e.g., it is unclear whether the current age-specific protocols and programs are being changed.
- The responsibilities specialist services and GPs will be expected to provide for patients using cross-sex hormones, puberty blockers, and other hormone treatments.
- Clarity as to whether all young people who are deemed appropriate for the formal research program will be enrolled, or whether this will be dependent on availability and space.
- All other endocrine services and interventions, including local provision.
- Regular service standard reviews, as included in the previous service specification, the absence of which raised concerns regarding how quality would be maintained and improved.

Listen to WPATH and other international organisations

As in responses to most other questions and linked with criticisms of NHS England’s use of evidence, Group A respondents once again urged NHS England to take note of the approaches and practices of organisations such as WPATH and, in particular, their Standards of Care (SOC) 8. Respondents found the absence of reference to this – or to the earlier Standards of Care 7 – conspicuous and puzzling.

> “I am concerned about the evidence base for the planned approach. Nowhere is the international best practice mentioned (WPATH SOC 8). While I do not expect NHS services to simply follow international guidelines without question, the complete omission of any mention of an internationally agreed standard of care is extremely worrying. The omission leads to gaps in the understanding of gender identity healthcare, which then leads to possibly harmful responses. This is particularly noticeable in the approach to puberty blockers, and in the overall approach to the autonomy of patients (the planned approach to social transition, and the plan for mandatory enrolment in research – it is an obvious ethical violation to not allow patients a choice here, and choosing not to enrol should not affect the care provided).”
>
> (Has transgender friends or family)

> “For many years, gender identity services have worked to the Standards of Care of the World Professional Association of Transgender Health (WPATH). For instance, the current adult specifications specifically reference WPATH criteria for endocrine and surgical interventions. The former GIDS service specification also repeatedly mentioned WPATH standards of care. In contrast, this service specification does not mention WPATH at all. Indeed, many sections of it appear not to be consistent with the new WPATH Standards of Care 8, which discusses care for children and adolescents in some detail. Has there been a formal decision to dis-align with WPATH? If so, how and why was this decision taken? If not, why would the child and adolescent service specification not engage with the WPATH standards at all, especially given that they continue to be definitive within adult protocols?“
>
> (Member of the public)

> "The WPATH Standards of Care are developed by experts in the field from countries across the globe and reached by Delphi consensus of 75%. The [interim service specification] appears to imply that there is more disagreement about support for gender-diverse young people than there actually is, and ignores a wealth of peer reviewed and practice-based evidence."
>
> (Service provider)

> "It is unclear as to whether GnRHa provision will continue to follow worldwide best-practice guidance, such as from the WHO, The Endocrine Society, and the WPATH. All of the above recommend that GnRHa provision be possible from Tanner stage 2 when clinically indicated by a strong history of severe and persistent dysphoria, informed consent from the parents, and informed assent from the young person. The guidance does not indicate whether the NHS will deviate from this."
>
> (Patient)

Other themes, ideas and suggestion put forward by Group A respondents

- Group A respondents urged NHS England to make an explicit commitment to abstaining from the practice of conversion therapy, and to recommit to the Memorandum of Understanding.
- Some believed that NHS England should progress to an informed consent model based on Gillick competence – particularly in cases where patients may be hindered by unsupportive parents or carers.
- A number of respondents proposed that the interim service specification was not fit for purpose: that it should be completely changed or even scrapped, and that it should be reconstructed by people who were thoroughly educated in all areas surrounding transgender healthcare in the UK; that they should undertake a thorough evidence review and refer to best current evidential understandings; that the service specification should be made more caring, more empathetic, and more affirming; and that it urgently needed to incorporate the voices, experiences and views of trans children, young people, adults and their families, as well as those of experts in the field and those who worked most closely with the people the specification would impact the most.
- Some suggested that a statement of clarity should be issued to those currently receiving service from GIDS, as well as those waiting for assessments and referrals, as their positions and revised pathways to care did not appear apparent or obvious from the wording of the interim service specification.
- Some also believed that NHS England needed to produce a detailed and in-depth outline as to how the new service would be run, what goals and timelines it would be working to, and how it would be staffed and resourced, feeling that the interim service specification was confusing, scant on information as to what the service would look like in practical terms, and that it left many questions unanswered (as noted in the summaries of earlier questions).
- Some Group A respondents felt that the complete absence of terms such as "transgender" or "non-binary" within the interim service specification reflected poorly on NHS England and was "indicative of the lack of respect and agency attributed to [gender dysphoric] young people by the authors".

Summary of changes and suggestions put forward by Group B respondents (n=924)

Group B respondents said...	Number
Puberty blockers are experimental and harmful	378
Gender services are unnecessary, mental health services are sufficient	248
NHS England should emphasise exploratory and holistic care	143
Prepubertal gender dysphoria is normal	131
There should be mention of services for detransitioners	115
NHS England should extend the age range for CYP services	91
Consider the social influences on young people	73
Children and young people should be educated on gender non-conformity	71
NHS England should research the ‘suicide myth’	64
Adolescents are most likely LGBTQ+ and gender dysphoria is just a ‘phase’	63
Children and young people should be warned about breast binders	59
Schools should be engaged with and reviewed	57
Clarify toilet and changing room policies	55
Inform people that there’s no evidence that watchful waiting is harmful	54
Be clear that medical intervention is not evidenced as an effective treatment	46
Publicise that ROGD in girls is historically unprecedented	46
Fully align the specification with the Cass Report	43
Make children and young people aware of transitions gone wrong	42
No surgery or support with transitioning for anyone under 25	39
Equality, diversity and inclusion must include all beliefs	33
Consult with detransitioners	17
Consider leaving Memorandum of Understanding on Conversion Therapy	13

Negative sentiments towards puberty blockers

Some Group B respondents expressed views that puberty blockers were experimental, unevidenced as producing benefit, and harmful, and that the idea that they were safe and reversible was both dangerous and fictitious. They urged NHS England to align with this viewpoint and to ensure that it was widely publicised so that all and any organisations and individuals who may exert influence on children and young people – for example, schools, charities, and local mental health services – had all the information and facts they required to likewise promote this view.

While some Group B respondents supported the proposal to require all endocrine interventions to take place within the confines of a formal research program there were others who believed that children and young people should never be given puberty blockers and other hormone medications under any circumstances, including research studies, considering it “experimentation on children’s undeveloped bodies“, as well as making it much more likely that they would progress to irreversible procedures such as gender reassignment surgery.

> “There should be more publicity about the dangers of puberty blockers and we must challenge the now unfortunately deeply ingrained idea in the public consciousness that puberty blockers are safe and reversible, while also reassuring parents that they have benefits only for very early onset puberty. The

> NHS should consider providing more evidence-based information for schools to counter some of the former 'expert' advice they received from Mermaids and other politically motivated groups. This is especially important given your statement that social transition is not a neutral act, as many schools have been misinformed it is."
>
> (Parent)

> "All puberty blockers should be banned. Almost all children who have some kind of gender dysphoria at a young age will have grown out of it by the time they have gone through puberty."
>
> (Parent)

> "We should not be experimenting on children by prescribing them with puberty blockers. It is already known that almost all children who use puberty blockers go on to progress to more damaging gender transition treatments, whereas those that do not use puberty blockers are much more likely to see their gender confusion resolve at the onset of puberty."
>
> (Parent)

> "I am concerned that under this specification children could still be prescribed so-called 'puberty blockers' and cross-sex hormones, despite there being no research base to support their use and inadequate knowledge of their long-term effects. This still seems like experimenting on vulnerable children whose problems are entirely psychological and emotional rather than physical. It is hard to see any relationship between the prescription of these drugs, which clearly do have significant physical effects, and the conditions with which the patients present."
>
> (Parent)

Objections to gender services and gender dysphoria

Some Group B respondents felt that gender services were unnecessary and that all focus and provision should be on mental health services and exploratory therapies which, they believed, should lead to children and young people understanding the reality of their sense of gender dysphoria or incongruence – that is, that it is most likely to have a psychological cause; that social contagion, social media, peer pressure, and other societal issues may have played a considerable role; and that it may have resulted from a misunderstanding that their particular sex/gender is supposed to look, feel, and act in a certain way.

Many Group B respondents highlighted beliefs that gender dysphoria resulted from the promotion of "sex stereotypes" and that children and young people had been led to believe that their lack of conformity with said stereotypes – for example, a girl who liked playing football, having short hair, and climbing trees, or a boy who enjoyed dresses, long hair, and playing with dolls – was a symptom and expression of their having been born in the wrong body. Group B respondents encouraged NHS England to support and publicise the viewpoint that it was perfectly normal for children and young people to fail to conform to such stereotypes and to be drawn to behaving in ways more common to the opposite sex, as well as to feel same-sex attraction, and that this message needed to be promoted to parents, carers, schools and other organisations that may influence children and young people, and to children and young people themselves.

Linked to these suggestions, Group B respondents again urged NHS England to clarify that exploratory therapy was not conversion therapy; to ensure that mental health practitioners would be able to freely or fully do their jobs without pressure from either within NHS England or from individuals, organisations and forces outside; and to leave the Memorandum of Understanding.

> “People with mental health conditions need robust mental healthcare. Affirming delusions is not good care. Anorexia is not affirmed, it is treated. Gender disorders are just another type of mental health issue manifested on the physical body.”
>
> (Patient)

> “A properly resourced and evaluated Children and Young People’s Mental Health Service can work in a genuinely holistic way without the need for a specific gender dysphoria service. Such an approach is more compassionate, meets safeguarding requirements, and is an effective use of NHS resources. To remain a ‘specialist service for children and young people with gender dysphoria’ affirms the diagnosis to the child and closes the gateway to a safe multidisciplinary assessment when there may be other conditions that have not been considered.“
>
> (Member of the public)

> “We are concerned about the service being labelled as a specialist service for children and young people with gender dysphoria as this is likely to make a child/young person even more convinced that the problem lies with gender rather than exploring other possibilities for why they feel the way they do. It would be better for children and young people to be managed in a more generic mental health service which could holistically explore their difficulties and look at appropriate psychological interventions. Many LGBT organisations define being transgender as a natural, innate condition, which is a huge part of the problem when children are told this in school. Doctors need to accept that it is not possible ‘to be born in the wrong body’ and stop using the term ‘gender assigned at birth’. Sex is determined at conception and observed at birth.”
>
> (Member of the public)

> “We need to acknowledge nobody is actually ‘transgender’, the entire premise is a lie. Let’s celebrate diversity in gender expression while keeping the NHS firmly planted in the reality of the sex binary.”
>
> (Service provider)

> “The NHS needs to make clear that gender non-conformity is normal and healthy and should not be pathologised by labels such as ‘transgender’ and ‘non-binary’ – terms inevitably based on gender stereotypes that have emerged through political activism. Parents and schools need accurate information: that there is no scientific basis for the concept of innate gender identity (for example ‘a girl’s brain in a boy’s body’) and that these are not clinical terms, nor a clinical diagnosis.”
>
> (Parent)

> “I was a convinced tomboy all my childhood – dolls were useless, cars and climbing trees were the best activities – but I turned into a very feminine woman in my late teens. Today I would have been diagnosed as gender dysphoric – a disaster I’m so glad I was saved from.”
>
> (Member of the public)

Detransitioners

Group B respondents noted that there were no mentions of people who had previously transitioned and then detransitioned, with some feeling that the interim service specification should mention any services that catered to this group, while others encouraged that detransitioners should be included in consultations and that their views and experiences should be considered in the formulation of provision for children and young people currently on the path they once trod.

Some Group B respondents also believed that children and young people involved in gender services should likewise be exposed to the stories and experiences of detransitioners, as well as tales of transitions that had been regretted and/or resulted in unpleasant outcomes (aka, “horror stories“) in order that they: a) were fully informed and had a complete picture of what they were embarking on;

b) had not been corrupted by gender ideologists who only promoted happy endings; and c) may be more likely to be dissuaded from pursuing a course to full medical transition.

NHS England should re-examine the cut-off age for children and young people's services

Some Group B respondents believed that the age at which adolescents progressed to adult services should be re-examined and potentially extended from 17 or 18 to 25, when "the brain is fully developed" and a greater understanding of long-term consequences is believed to exist. For some, it was not possible for those under the age of 25 to give informed consent, given that they were still in the process of maturation, while others felt that those aged between 18 and 25 may be living away from home for the first time and be vulnerable to undue influence from pressure groups.

> "Similar carefully considered provision should be extended to young people of 17+ using adult services, in the knowledge that the brain doesn't mature until at least age 25 and so radical decision-making regarding medical treatment may lead to future regret. Young people seeking help for gender dysphoria share the high incidence of comorbidities like autism with the cohort using children's services, and these should be taken into account when considering the best ways of helping them."
>
> (Parent)

> "This age group is particularly important because many teenagers live away from home for the first time at age 18 and encounter recruiting lobby groups at university who pressure them to become trans. I have personally experienced sexual pressure from university LGBT groups to 'explore my sexuality' with them and 'not be so boring'. The recruitment activity is very real and very persistent, as are the constant free alcoholic drinks. It's sexual harassment of vulnerable teenage women and it particularly recruits autistic women."
>
> (Parent)

> "The NHS must re-examine the current age cut-off for child and adolescent services, and the transfer to adult services which leaves a very vulnerable cohort of older teens and young adults without the same standard of care outlined in this service specification."
>
> (Parent)

NHS England public health campaigns

As mentioned above, as well as in responses to other questions, Group B respondents felt that NHS England should take a leading role in thoroughly researching issues related to gender dysphoria and not only publishing the results but ensuring that as many children and young people were exposed to the findings, particularly through schools and social media. Chief among the ideas suggested were:

- A large-scale study on the effects of puberty blockers and other endocrine interventions.
- Publication of detransitioners' experiences and examples of transitions gone bad.
- A research study on the role social contagion, peer pressure, and pro-transgender media influence has played in the recent increase in the number of gender dysphoric children and young people – particularly with regard to the "historically unprecedented" rise in cases of rapid-onset gender dysphoria (ROGD) in young girls.
- A thorough debunking of what some Group B respondents called 'the suicide myth' – that is, the idea that unless children and young people are assisted to transition they face vastly increased dangers of suicidal ideation, believed by some to be false.

- Education programs on the truth of gender stereotyping and the promotion that gender non-conformity and same-sex attraction is normal.
- Warnings on the potential negative consequences of breast binders.
- Informing that there is no evidence that watchful waiting is harmful and no evidence that medical intervention is an effective treatment for gender dysphoria.
- Group B respondents also desired that NHS England clarify and publicise its policy on the use of toilets and changing rooms, encouraging schools and other government institutions to follow suit.

Issues with the language used in the specification

Group B respondents made a number of suggestions with regard to the language used in the interim service specification, as well as asking for definitions and clarity with regard to several terms. These were:

- Suggestions that the statement "being mindful that this may be a transient phase, particularly for prepubertal children" (page 2) should be amended to align with the information on page 13: "in most prepubertal children, gender incongruence does not persist into adolescence", with the wording changed to "this is most likely to be a transient phase for prepubertal children and there is no evidence to suggest that this would be any different for adolescents who develop gender dysphoria during or after puberty."
- In the statement "service design and improvement is co-produced with experts by experience and promotes equality, diversity and inclusion" (p. 19) it was suggested that the 'experts by experience' should be defined.
- Suggestions that in the phrase "Understanding of the differences in sexual identity and gender identity, and expression" (p. 24) 'sexual identity' be changed to 'sexual orientation' as sexual orientation was considered a fact, not an 'identity'.
- Suggestions to clarify inconsistencies within and between the various documents, particularly around the use of the terms "gender incongruence" and "gender dysphoria": "There is a confused use of 'gender dysphoria' to describe a symptom/experience as well as being a DSM-V diagnostic term (only the latter is included in an appendix), while 'gender incongruence' is exclusively used as an ICD-11 diagnosis and should remain as such."
- The DSM-V's definition of gender dysphoria, which the interim service specification used, was described as relying almost entirely on stereotypes.
- The WHO's ICD-11 (the source of the interim service specification's definition of gender incongruence) was viewed by some as being an inadequate reference point due to the view that it was based on stereotypes of gender and sex and that it used "captured language".
- Some Group B respondents objected to the term "birth-assigned sex", pointing out that sex is neither "assigned" nor does it appear "at birth", but can be observed long before birth takes place. This term was seen as unnecessary, unscientific, unprofessional, non-neutral, and influenced by ideology.
- Likewise, terms such as "gender identity" were seen as unscientific and ideologically influenced, as was the word "gender" itself, with some Group B respondents stating that the biological term "sex" was sufficient for purpose, as well as being clearer in its meaning – i.e.,

that it is generally understood as meaning either male or female, whereas "gender" can have multiple meanings.

- Some asked for clarification of the term "gender role" (with the warning that it shouldn't be based on gender stereotypes).

Group B respondents felt that NHS England's use of language was important for several reasons: chiefly, to align with science-based medicine, healthcare and biology; to demonstrate clear non-ideologically influenced thinking; to align with the language used in other aspects of government, as well as with legal terms; and to safeguard against strengthening the belief among children and young people that they may have been born in the wrong body and that changing their sex is possible.

Other changes and ideas suggested by all respondents (n=3093)

Themes raised across all viewpoints	Number
Increase mental health services for young people	86
Greater resources required	55
Commission a thorough study/evidence review	24
Parents and families need support	20
There should be mention of services for Wales	24
There should be mention of services for Scotland	16

Some themes were suggested more or less equally by both Group B and Group A respondents. Concerns about resources, staff and investment levels – as well as the belief that these would need to be increased – were again mentioned, as addressed in responses to previous questions. Specifically, however, some respondents stated that mental health services in particular would need to be increased and wondered if plans were in place to facilitate this.

Both Group B and Group A respondents also felt that NHS England should commission a large-scale study or review of all available evidence and attempt to arrive at answers and conclusions that, if not definitive, would represent a substantial improvement on what some saw as a puzzling lack of clarity with regard to the facts of transgender issues and transition.

Some respondents highlighted that they felt parents and families were in need of support, whether in terms of clear information and guidance, assistance in navigating what was seen as becoming an increasingly complex system, or in obtaining emotional and mental help in order to alleviate the burdens and difficulties they had encountered as carers for gender dysphoric children.

> "Being the parent of a trans child is a nightmare, watching my child hating and loathing everything about their gender, to the extent that they are clawing at their body and want to cut pieces off. The distress is massive. This has been my life for 10 years. I cannot get any help, and now a group of people are working to make it a whole lot harder."
>
> (Parent)

Finally, although recognised as the service specification for NHS England, some felt it would have been useful to outline how the changes would affect patients and services in Scotland and Wales.

Section 7 – The Equality and Health Inequalities Impact Assessment

An Equality and Health Inequalities Impact Assessment (EHIA) is a way to systematically assess whether an existing or proposed policy, procedure, practice or service does or could affect people differently, and whether it affects them in an adverse way. EHIAs address positive or negative impacts on nine protected characteristic groups: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race and ethnicity; religion and belief; sex; and sexual orientation.

NHS England published its EHIA for the interim service specification for specialised services for children and young people with gender dysphoria (phase 1 services) in October 2022 and included it for consideration with the public consultation documents.

Respondents were asked to what extent they agreed that the Equality and Health Inequalities Impact Assessment reflected the potential impact on health inequalities which might arise as a result of the proposed changes. Their answers were as follows:

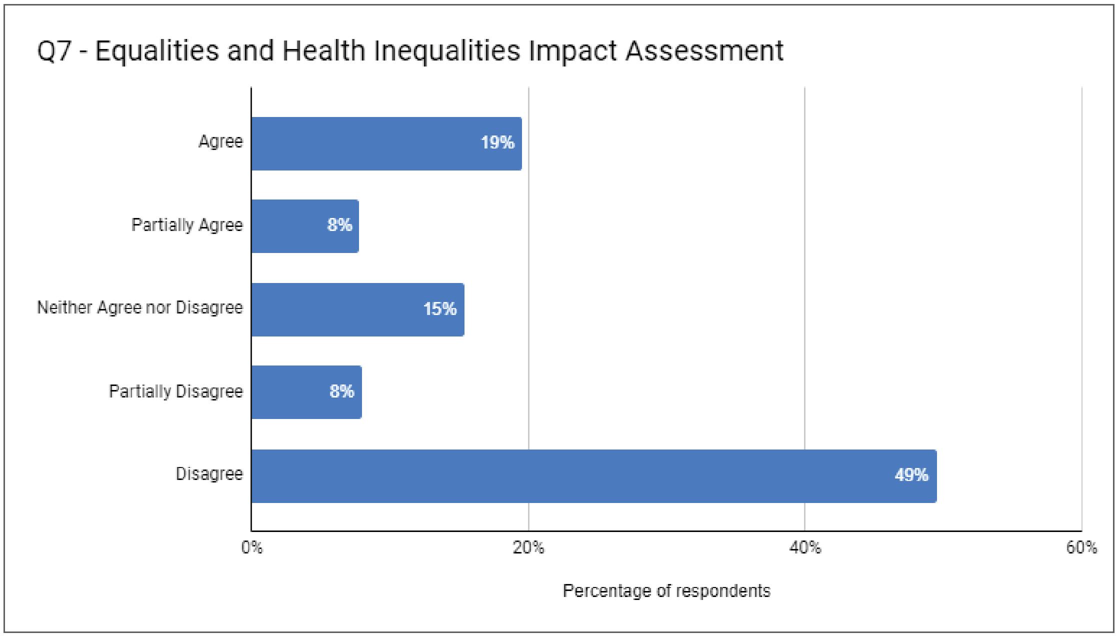

Figure 7. Quantitative results regarding the Equalities and Health Inequalities Impact Assessment

Parents, clinicians and members of the public were the most likely respondent groups to either agree or partially agree that the Equality and Health Inequalities Impact Assessment had reflected the potential impact on health inequalities. No group, however, expressed majority agreement or partial agreement (the question on social transition was the only other question where this was the case).

Patients, LGBTQ+ individuals, those with transgender friends and family and service providers were once again largely in disagreement, with 77% at least partially disagreeing.

In contrast with other questions, where an average of 6.6% of respondents selected "neither agree nor disagree", 15.3% did so here, including almost a quarter of clinicians (24.4%). In combination with other factors, this is perhaps suggestive that: a) many respondents didn't understand either the question or the EHIA; and/or b) that respondents felt less strongly about the EHIA than they did about the draft interim service specification.

In total, 2,149 respondents provided answers to the qualitative question, with 1,670 being Group A and 357 Group B. Group B respondents, therefore, were 56% less likely to answer this question than the questions that preceded it.

Ideas, themes and suggestions raised

Certain protected characteristic groups were highlighted by respondents as being insufficiently or incorrectly represented and reflected in the EHIA. These were:

Protected characteristic group	Number
Gender Reassignment	902
Disability	540
Race And Ethnicity	358
Sexual Orientation	53
Sex	27
Pregnancy And Maternity	16

Gender reassignment

Group A respondents felt that those with the protected characteristic of gender reassignment had been insufficiently represented, primarily due to objections that the EHIA seemed to state that the protected characteristic could not be applied or engaged until a clinical diagnosis had been made. This was seen as incorrect and in violation of the Equality Act 2010.

> "The author argues that since the children awaiting evaluation by GIDS do not have a formal diagnosis of gender dysphoria they therefore lack the protected characteristic of 'gender reassignment'. This is wholly incorrect, as stated by NHS Scotland[25]. The Equality Act 2010 does not require a person to be under medical supervision to be protected. For example, someone assigned male at birth who decides to live permanently as a woman but does not consult a doctor or undergo any medical procedures would be protected as the Act states that 'part of a process' is sufficient to meet the criterion for gender reassignment being a protected characteristic. It is facile to suggest that those who have been referred to GIDS have not undergone 'part of a process' as they have already obtained a referral to GIDS. [Furthermore], the Equality and Human Rights Commission guidance states: 'To be protected from gender reassignment discrimination you do not need to have undergone any specific treatment or surgery to change from your birth sex to your preferred gender. This is because changing your physiological or other gender attributes is a personal process rather than a medical one.' Indeed, the

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[25] https://www.nhsinform.scot/care-support-and-rights/health-rights/gender-identity/gender-identity-and-your-rights

> narrow and harmful interpretation given here of ‘gender reassignment’ as a protected class was specifically ruled out by Baroness Thornton in 2010: ‘Our intention has never been to limit the protection of discrimination law to transsexual people who undergo such supervision or surgery.’ Either this section was drafted in bad faith or this section was drafted by someone completely unaware of relevant Equalities legislation and case law.”
>
> (Patient – Disagree)

> “Have you read the Equality Act? You do not require a diagnosis to fall under the ‘Gender Reassignment’ protected characteristic. Section 7.1 defines the protected characteristic of gender reassignment for the purposes of the Act as where a person has proposed, started or completed a process to change his or her sex. Section 7.2 also explains that a reference to people who have or share the common characteristic of gender reassignment is a reference to all transsexual people. A woman making the transition to being a man and a man making the transition to being a woman both share the characteristic of gender reassignment, as does a person who has only just started out on the process of changing his or her sex.”
>
> (LGBTQ+ individual – Disagree)

> “The EHIA makes some important assertions that are unevidenced and appear to be incorrect when the evidence is taken into account. This includes the assertion that people who consider themselves gender diverse but who have not been able to receive a diagnosis or treatment do not have a protected characteristic under the Equality Act. This is at the very least a matter of legal debate rather than an open-and-shut case, and ignoring this issue seems to raise a clear risk of legal action and/or judicial review.”
>
> (Parent – Disagree)

Disability

With regard to the protected characteristic of disability, many Group A respondents felt that the EHIA failed to sufficiently reflect the potential impact on disabled children and young people – with disability here primarily meaning neurodiversity/autism spectrum disorder. Some also felt that the lack of any recommendation detailing what NHS England proposed to “reduce any key identified adverse impact or to increase the identified positive impact” – i.e., that the column in the table designated for this was left empty – represented an unfortunate omission.

> “On disability, the EHIA should include an assessment of how the service will avoid discriminating in providing access to gender affirming healthcare for people with the protected characteristic of disability. In particular, given the focus on neurodiverse children and young people in the service specification, it is important to demonstrate how this will ensure the provision of better and more holistic care, rather than simply introducing barriers to treatment for children and young people who are diagnosed both as having gender incongruence and neurodevelopmental conditions. Neurodiverse gender incongruent people should absolutely not suffer disproportionately as a result of this service or be discriminated against in any way.”
>
> (Service provider – Disagree)

> “There is reference in the document to neurodivergent children. What assessment has been made to ensure that neurodivergent children will continue to have the same access to trans healthcare as neurotypical children? Disability is a protected characteristic. Any discrimination against neurodivergent children would be a breach of the Equality Act.”
>
> (Parent – Disagree)

> “The idea that those with autism won’t be negatively impacted is wrong – those who can’t express themselves well in words will not get past tier 1.”
>
> (Parent – Disagree)

Ethnicity

Group A respondents also felt that the EHIA had provided insufficient reflection and attention to detail with regard to the protected characteristic of ethnicity – in particular, Black, Asian and minority ethnic groups (BAME), who they felt tended to have historically lower rates of interaction with healthcare services and would therefore be disproportionately affected by any service changes. Many also noted that while it was stated that "transgender people from BAME groups are more likely to face discrimination on the basis of their race" no plans were put forward for how to mitigate for this or for how to offer extra support.

> "Those from racialised backgrounds are currently under-represented in primary healthcare (de Graaf et al., 2018), but NHS England does not consider this in relation to the proposed changes in referral pathways to GIDS."
>
> (Clinician – Partially Disagree)

> "It acknowledges there are barriers for people of colour accessing this care but does not fully detail or discuss how they intend to mitigate these barriers to provide equal access. One of these such barriers is that people of colour, especially black people, have historically been mistreated by medical professionals under the false belief that they do not experience pain either as much as white people do, or even do not experience pain at all. These beliefs are likely to translate to dismissing black trans young people when they talk about the clinically significant distress/impairment they face from their dysphoria. Without specifically stating what they're going to do to prevent this I cannot trust they are actually ensuring people of colour get equal treatment to white people."
>
> (Patient – Disagree)

> "There is insufficient consideration of the service's impacts on the basis of ethnicity, especially as the service model now relies on health service referrals (which has a well-established bias against non-white ethnicities, meaning that the new model of referral aggravates this structural racism). The intersection of identities which are already marginalised with a healthcare service designed to act as a gatekeeper and restrict access to services is bound to disproportionately affect these people."
>
> (Service provider – Partially Disagree)

Sexual Orientation

Some Group B respondents felt that the protected characteristic of sexual orientation had not been sufficiently addressed in the Equalities and Health Inequalities Impact Assessment due to their belief that gender dysphoria services have disproportionately impacted on homosexual or bisexual children and young people in the past. GIDS was seen to have had a significant problem in this specific area, with respondents expressing the belief that many apparently gender dysphoric children and young people are actually experiencing a repressed internalised homophobia possibly inherited from or imprinted by their parents or their culture, and that GIDS failed to account for or adequately address this. The absence of any discussion in the interim service specification of how this internal and external homophobia may play a part in gender dysphoria was criticised and seen as a further indication that those with the protected characteristic of sexual orientation had not been sufficiently considered, as was the statement that NHS England "does not hold relevant data" on sexual orientation – viewed as essential pieces of information.

> "The statement [in the EHIA] ignores how young lesbians receive no support, are bullied into saying they're trans, and are denied the right to explore their sexuality with sympathetic lesbian therapists.

> Furthermore, there is no research or intended research, or support for, detransitioners. Yet a vast number of young women who seek to transition turn out to be lesbian."
>
> (LGBTQ+ individual – Disagree)

> "I am surprised to see that there is no positive impact given for the proposed changes with regard to sexual orientation. The current model of gender care is openly homophobic, as has been confirmed by whistleblowers at Tavistock, and even by the ex-director of the charity Mermaids, one of the most ardent proponents of childhood transition. The fact that most of the young people referred to the service will likely grow into homosexual adults, and that gender transition would prevent them from doing so, should be acknowledged in this impact assessment."
>
> (Member of the public – Partially Agree)

> "Most of the patients who formed the basis of what has become known as the Dutch Protocol were same sex-attracted. The same is true for many children referred to GIDS, and yet the interim service specification fails to mention sexual orientation at all. NHS England need to explicitly address concerns that medical interventions aimed at trans-identified children may be a form of conversion therapy that discriminates against individuals who would otherwise have grown up to be gay or lesbian."
>
> (Parent – Partially Agree)

> "The statement on sexual orientation is concerning. The data from Tavistock was that 70% of referrals were same-sex attracted or bisexual (if these figures are not entirely accurate there was surely data on this important psychiatric evaluation factor). The whistleblowers at Tavistock reported that they had many homophobic parents who wanted to 'trans away the gay.' It would be highly negligent to continue to ignore this important social influence on young people and that 'gender non-conformance' is prevalent in children who grow up to be LGB adults."
>
> (Parent – Partially Disagree)

> "There is a lack of consideration in the document regarding homophobia as a major contributor to young people presenting with gender dysphoria. Homophobia in their families and communities has been identified by many detransitioners as a factor behind pressure to claim to be the opposite sex. Homophobia was identified in the Keira Bell and Sonia Appleby cases against the Tavistock NHS Trust as a major prevailing ethos in the GIDS service. Unlike gender, homosexuality is a protected characteristic under the Equality Act. If children who think they might be gay or are even too young to be thinking like that are encouraged to believe they have gender problems (because they are non-conforming to sex stereotypes, for example) that is a safeguarding and equality matter."
>
> (Clinician – Partially Agree)

Sex

Some Group B respondents felt that the EHIA could have more thoroughly addressed the potential impact on those with the protected characteristic of sex – particularly the impacts on girls who, as recent statistics showed, were now much more likely to seek treatment from gender dysphoria services than boys. NHS England was encouraged to investigate and publicise the degree to which possible causations such as internalised homophobia, exposure to social media, trauma, bullying, difficulties in navigating bodily changes at puberty, experiencing sexual objectification, familial and social situations and social contagion had played a part in this trend.

Some Group A respondents also felt that more could be considered with regard to this characteristic, proposing that the use of the terms girls and boys or "natal" represented a bias in favour of traditional "cisgender" models. Some also believed there should be recognition of how the different sexes experience different pressures and influences to align their gender with their sex – particularly in youth – and that NHS England's proposed approach to social transition may impact more on boys than girls.

> "In misreading the Equality Act 2010 with regard to gender, the NHS has prioritised gender over the protected characteristic of sex and has eroded the rights of women and girls using the NHS."
>
> (Parent – Partially Agree)

> "Disproportionately higher numbers of natal females are currently presenting to gender clinics worldwide. If we are to ensure girls are treated equally we urgently need to understand why this is."
>
> (Clinician – Partially Agree)

> "The gender policing of people assigned male at birth is far stronger and restrictive than that of people assigned female at birth. Thus the impact of obstructing social transition is far more significant for the former."
>
> (LGBTQ+ individual – Disagree)

> "Gendered terms should be avoided for all patients who enter the service. For example, children assigned female at birth (AFAB) or assigned male at birth (AMAB) should be used in place of gendered terms such as girls or boys. Using gendered terminology suggests a level of bias against gender variant children is retained – which is extremely concerning given the role of these services."
>
> (LGBTQ+ individual – Neither Agree nor Disagree)

Pregnancy and maternity

A few Group A respondents felt that the protected characteristic of pregnancy and maternity should have been more fully considered.

> "By not providing nationally commissioned fertility support for young gender-diverse people who physically transition, a barrier to parenthood is being presented. No young person should have to choose between being comfortable and able to live in their body and being able to have children."
>
> (Clinician – Disagree)

> "Trans men should also be offered the chance to keep the ability to give birth as is their right. How are you going to prevent that from happening?"
>
> (LGBTQ+ individual – Disagree)

> "Pregnancy and childbirth cannot be assumed to be irrelevant for young people experiencing gender dysphoria. This would significantly impact trans patients accessing maternity services and needs proper consideration."
>
> (Service provider – Partially Disagree)

Other groups

A number of respondents proposed other groups they felt should have been included or more sufficiently considered in the Equalities and Health Inequalities Impact Assessment, as follows:

Other groups not reflected	Number
Those with unsupportive families	389
Those who have socially transitioned before	234
Those with who do not live in the family home	226
Classmates and peers of trans children	63

Primarily mentioned by Group A respondents, it was felt that the changes to the service specification which limited referral routes – and therefore made accessing the service more difficult – would disproportionately and negatively impact children and young people who either lived with unsupportive families or who lived outside the family home. This was seen as discriminatory and requiring reflection in the assessment, as well as necessitating consideration and proposals of ways to practically address the impact.

Regarding those who will have already social transitioned before becoming involved with the service, Group A respondents felt the Impact Assessment should include some reflection of how the new, more restrictive approaches to social transition outlined in the interim service specification may impact on them, and how discrimination against this group was proposed to be avoided.

Group B respondents felt that consideration should have been made with regard to how the service specification and gender dysphoria services in general would impact on other people – chiefly, classmates, peers and teachers who they felt may be placed in difficult positions by affirming approaches which expected them to “pretend and lie” that a gender dysphoric child or young person was in fact a gender other than their actual sex. Frequently mentioned was the issue of being compelled to use pronouns mismatched to a person’s sex, while the impact on girls having to share toilets and changing rooms with a biological male was considered as requiring acknowledgement within the EHIA – as was the issue of biological males competing in girls’ sports.

Other issues raised

A large number of Group A respondents again highlighted perceived problems with the evidence on which certain important parts of the interim service specification was built – in particular, the claim that evidence shows that “in most cases gender incongruence does not persist into adolescence“ – as addressed in the summary of responses to Question 6: Any other suggestions.

Group A respondents also expressed dismay that the EHIA stated that no “key engagement or consultative activities [were] undertaken [to] consider how to address equalities issues or reduce health inequalities” – i.e., that transgender people had not been consulted on issues affecting transgender people.

> “You cannot argue that your proposed changes would have no impact if you haven’t engaged with or consulted with anyone. It’s like marking your own exam.”
>
> (LGBTQ+ individual – Disagree)

> “In section 7 of the assessment it cites only two sources of information and has left more than half of the boxes blank. Especially egregious is the lack of evidence from participants or experts. This is a wholly unacceptable gap that is not explained in any way. This in my opinion rules this entire assessment invalid. How can you assess the impact on a group if you never even contact the group?“
>
> (Clinician – Disagree)

> “The lack of engagement with service users, trans folk and their families was frankly embarrassing and if I in my role had submitted such a gappy, lacking in stakeholder engagement, dismissive of users piece of work my governing body would have quite rightly handed it back to me with a strong ‘try again’. The fact there has been no targeted stakeholder engagement is one among many failings that should have had this document rejected.”
>
> (Parent – Disagree)

Finally, a relatively large proportion of respondents – relative to other questions, as well as to other public consultation questions – stated that they could not understand the question, while others were of the opinion that soliciting public comments on the EHIA was somewhat ambitious given the nature of the document.

> "Perhaps you have a legal duty to do this impact assessment and ask about it. But really, that is a highly technical document that most people will simply not understand."
>
> (Parent – Partially Disagree)

> "Is this question designed to be difficult to answer? I do not understand it and I am educated to MA level."
>
> (Parent – Neither Agree nor Disagree)

> "I'm unclear on the contents of the impact assessment and the potential impact it might have. The whole thing has not been presented in a way the general public can properly access and comment on."
>
> (Parent – Neither Agree nor Disagree)

> "This is beyond my comprehension. It's too complicated to understand exactly what you are asking."
>
> (Parent – Disagree)

Appendix A – Methodology

Analysis methodology

NHS England commissioned TONIC, an independent social research organisation specialising in public consultations to produce a summary of responses to the consultation. To achieve this, TONIC conducted a quantitative analysis for all responses to the closed (multiple choice) questions and used thematic analysis[26] to summarise the written responses to the open (free text) questions.

Data cleansing

The data cleansing process was carried out in five main ways:

1. The raw dataset was assessed for duplicate responses by: examining all IP addresses from which a consultation response was submitted; checking qualitative answers for identically worded responses; and analysing the demographic information provided for similarities and differences.

   In total, 259 IP addresses were found to have been used by two or more respondents, and following analysis of the question responses and demographic information it was determined that the vast majority of these had been submitted by different people from within the same building – e.g., different members of the same family; different workers in the same office; or different users of an organisation or service provider. Of those that remained, eight responses were found to be identical in every way and each had one complete submission removed, while a further 33 were suspected to be duplicate/repeat submissions. These, however, lacked sufficient information to determine their status with certainty and it was decided to leave them in place as it was felt that: a) relative to the whole the number was small and would have no noticeable effect on the overall results of the consultation analysis; and b) removing a genuine submission mistakenly would represent a less preferred option than leaving a duplicate submission intact.

2. Blank submissions were removed – i.e., responses from those who provided only demographic information but failed to answer any questions. In total, there were five such empty responses.

3. Content-free qualitative answers which consisted entirely of comments such as “I don’t know“, “no comment“, “n/a“, “yes“/“no“ or contained simply hyphens or dots were removed and aren’t included in the figures illustrating response rates.

4. Offensive, joking and unfathomable responses were removed. These consisted of:

   - One respondent who submitted 42,000 words of religious proselytization

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[26] Thematic analysis (Braun and Clarke, 2006) is a simple and flexible form of qualitative analysis that is commonly used in social research. TONIC chose this approach as it provides a way to summarise patterns in a large body of data, highlights similarities and differences across the dataset, and can generate unanticipated insights.

- Three instances where a respondent's entire qualitative response consisted of an explicit instruction to carry out a certain action
- Two instances where respondents submitted nothing beyond eight obscene insults (i.e., one insult for each qualitative question)
- One respondent whose answers consisted entirely of whimsy

In all cases where such qualitative answers were removed, however, quantitative answers were left in place.

5. By fully analysing the qualitative responses as a whole it was discovered that a total of 32 respondents had falsely identified as patients – i.e., the qualitative answers they had given were very clearly not those of a patient and were very clearly in line with responses outlining an unequivocally Group B position (including those of one respondent who submitted a copy of the Christian Concern campaign response).

   These submissions were reclassified as having been made by members of the public.

Appendix B – List of organisations

A total of 180 respondents stated that they were responding on behalf of an organisation, with 171 providing the name of the organisation they represented. In total, 156 organisations were named – some organisations, therefore, were represented by more than one respondent (where this was the case the number of respondents is noted in brackets).

42nd Street
Action for TransHealthIssues
AKt
Allsorts Youth Project
Asda Harrogate Pharmacy
Australian Professional Association for Trans Health (AUSPATH)
Bayswater Support Group
Be Trans Support and Community
Beds and Herts LMC
Bexley Medicines Optimisation Team (SEL ICS)
Birmingham LGBT
Bolton FT
Bolton Local Medical Committee
Bristol Underground Church
British Association of Gender Identity Specialists
British Medical Association
British Medical Council
British Psychological Society
British Society for Paediatric Endocrinology and Diabetes (BSPED)
Brook
Calderdale LMC
CAMHS (3)
Christian Concern (6)
Christian Medical Fellowship
Claire’s Transgender Talks
Dagenham Parish Church
Exeter Trans and Non-Binary Café
Family Education Trust (2)
FFLAG
Free Methodist Church in the UK & Ireland
Free2B Alliance
Frimley ICB
Gateshead & South Tyneside LMC
Gateway Church Ashford
Gateway Church Withernsea
Gay and Lesbian Association of Doctors and Dentists (GLADD)
Gay Men’s Network
Gender Essence

Gender Identity Research and Education Society (GIRES)
Gendered intelligence
GenderGP (2)
Genspect
George Road Community Church, Birmingham
GIC Northamptonshire
GIDS clinicians
GIDS – Tavistock
GIDS nursing staff
Golden Leaf Counselling Services
Greater Manchester's LGBTQ+ Equality Panel
Greater Manchester Better Outcomes Partnership
Guy's and St Thomas' NHS Foundation Trust (GSTT)
Guy's and St Thomas' LGBT+ staff network
Guy's and St Thomas' NHS Foundation Trust
HealthSense UK
Intercom Trust
Ivy Church Manchester
Kent Local Medical Committee
King's Church in Walton-on-Thames
Labour Women's Declaration
Lansdowne Gospel Hall Trust
Leeds Teaching Hospitals
Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB)
Lesbian Labour
Lesbian Rights Alliance, Bristol Branch
Lesbian Rights Alliance/the Lesbian Youth Project
LGB Alliance
LGBT Foundation (2)
LGBT Hero
LGBT Youth Scotland
LGBT+ Consortium
LGBTQ+@cam, University of Cambridge
Longheath Baptist Church
Lucid Oddity
Mayford House Surgery, Northallerton
Mermaids (3)
National Deaf CAMHS Northern Arm
New City Church Milton Keynes
Newham Youth Empowerment Service, CAYA
NHS
NHS Frimley ICB
NHS LGBTI+ Soundingboard
NHS North East London ICB
NHS Surrey Heartlands

Norfolk & Waveney LMC
North Yorkshire Youth
Nottingham & Nottinghamshire Area Prescribing Committee
Nottingham and Nottinghamshire ICB
Off the Record, Bristol
Old Town Community Church, Eastbourne
Oxleas NHS Foundation Trust
Paediatric Health Psychology, Royal Victoria Infirmary, Newcastle upon Tyne
Portsdown Group Practice/Portsdown PCN
Powys Teaching Health Board
Q Space Northants
Queer Futures 2
Renaissance UK
Rowhedge and University of Essex Medical Practice
Royal Central School of Speech and Drama
Royal College of General Practitioners
Royal College of Paediatrics and Child Health
Royal College of Psychiatrists
Safe Schools Alliance
School of Sexuality Education
Sex and Gender Education (Australia)
Sex Matters
South Cambridgeshire Constituency Labour Party
South East Gender Initiative (SEGI)
South London and Maudsley (3)
South Shropshire Women's Rights Network
Spring Road Evangelical Church
St Thomas' Church Blackpool
Stonewall
Stroud High School
Suffolk and North East Essex Integrated Medicines Optimisation Committee
Suffolk LMC
The Apple Tree Centre, Sheffield
The BeYou Project
The Brunswick Centre
The Christian Institute (2)
The Clinical Advisory Network on Sex and Gender (CAN-SG)
The Gender Identity Development Service (TPFT)
The Greater Manchester Medicines Management Group
The Kite Trust
The Market Surgery, Aylsham
The National Autistic Society
The Proud Trust
The Queer Therapist
The Tavistock and Portman Gender Identity Development Service Team

The University of Exeter LGBTQ+ Staff Network
Thoughtful Therapists
Trans Learning Partnership & Gendered Intelligence
Trans Masculine Birmingham
Trans Plus, Chelsea and Westminster NHS Trust
Trans Pride South West
Trans Safety Network CIC
Trans Social Work Network
TransActual
Transgender Europe
Transgender Trend
TransLeeds
TransLucent CIC
Transparentsees
Transpire, South Essex
Trans Widows
Trinity Lane Church, Hinckley
Uniting Network Australia
University College London Hospitals NHS Foundation Trust
University of Exeter
WellBN Brighton
Welsh Gender Service, NHS
Wessex Local Medical Committees
Woman’s Place UK
Women’s Rights Network
World Professional Association for Transgender Health (WPATH)
Youth Voice panel at Creative Youth Network

Appendix C – Campaign responses

a) Stonewall, Mermaids, Gendered Intelligence and Trans Learning Partnership
b) Transgender Trend
c) Christian Concern
d) Katy Montgomerie
e) Gay Men's Network

Response co-produced by Stonewall, Mermaids, Gendered Intelligence and Trans Learning Partnership

The [overall concerns and] key issues we suggest raising throughout are:

- Risk of denying access to the waiting list for children and young people who need assessment and care: Access to the interim service will include an additional consultation stage between Phase 1 services and the patient's GP, before joining the waiting list, which may cause further delays to accessing care or deny access to it.
- Medicalisation of social transition: the service specification attempts to treat social transition as a medical intervention which is only recommended after receiving a diagnosis of gender dysphoria and experiencing clinically significant levels of distress. This is despite there being no evidence to suggest that social transition is harmful. It also seeks to remove from children and their parents the ability to make choices about how to live their day to day life happily, something that is extremely important in the context of a waiting list for services that is now several years long.
- Implications that accessing private healthcare is a safeguarding issue: According to the specification, safeguarding referrals will be initiated when service users are accessing hormones from private healthcare providers, or providers who are regulated outside the UK, and there is a conflation between private and 'unregulated' providers.
- Restricted access to puberty blockers that is not based on clinical need: puberty blockers will only be accessible with mandatory enrolment onto long-term research programmes. This would require children and young people to be part of a clinical trial to access essential care that is clinically indicated for them (and is not in line with ethical standards for healthcare research). The specification also implies that the criteria to access blockers may be further limited.
- Contradictions with international best practice: The specification makes no reference at all to the newest international best practice guidelines for trans healthcare, WPATH SOC 8 (World Professional Association for Transgender Health, Standards of Care Version 8), which outlines the latest evidence and clinical guidance developed by experts in the field.
- Lack of evidence: the previous service specification included a 4-page reference list of relevant research, but this interim service specification cites one flawed study. None of the abundant research in the field, including in WPATH SOC 8, are referenced or reflected.

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

a) Composition of the clinical team

Proposed change: to extend the clinical team to include experts in paediatric medicine, autism, neurodisability, and mental health.

What you might want to raise:

- That more support and expertise are welcomed, but these experts must receive thorough and appropriate training on how to support trans and gender-diverse children and young people prior to beginning clinical work;
- That the involvement of more people should not lead to even longer delays before assessment and treatment. This may be the result of these changes, as this will decrease the number of clinic hours available to other patients, meaning fewer patients are seen;
- That the extension of the clinical team should not lead to differential diagnoses that prevent or prohibit treatment for gender incongruence, except where this is clinically indicated;
- That the focus on neurodiversity expertise must be about ensuring quality of care for patients with neurodiversity, and not negatively impact their access to care.

b) Clinical leadership

Proposed change: the clinical lead for the service must be a medical doctor.

What you might want to raise:

- That this doctor must be an expert in the care of trans and gender diverse children, informed by global experts in the area, prior to beginning clinical work;
- That this shift should not infer that gender diversity is inherently a medical issue, and therefore pathologise the experiences of patients, recognising that the World Health Organisation and other leading health bodies have committed to depathologising trans people.

c) Collaboration with referrers and local services

Proposed changes:

- More collaboration with local services;
- Referrals require a consultation meeting between the new service and local secondary healthcare team and/or the GP to determine if the patient meets the criteria for the service;
- If patients don't meet these criteria, they 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';

- If patients meet these criteria, they may be added to the waiting list or supported through local provision as above. This will be determined by individual needs and through clinical prioritisation processes.

What you might want to raise:

- That having better integration with local services, who are better trained in supporting gender-diverse patients, and providing more support to those on the waiting list, are positive changes; The new requirement for a pre-referral consultation may cause more delays and barriers to access. This is especially concerning for those with unsupportive GPs;
- That this point raises very serious concerns: ‘Although new referrals will be made to the Service it is recognised that it is unlikely that the interim service will be able to offer direct assessment and/or intervention for patients who are new referrals, or to a large proportion of the existing waiting list, before these individuals are transferred to one of the new regional services as they become operational.’ This appears to suggest that the interim service will only see those children and young people who are currently on the waiting list for GIDS at the Tavistock. There is no specified destination for new referrals, which leaves children and families in limbo;
- When practitioners conclude an individual has not met the criteria for accessing the service, there is no information on how individuals can get a second opinion, make an appeal, or whether there is any other recourse to challenge that decision;
- The care pathways have no timelines, which is concerning considering the NHS guidance requires an 18-week maximum waiting time for non-urgent referrals.

d) Referral sources

Proposed change: referrals will only be accepted from GPs and NHS professionals, when previously referrals could also be made by schools or youth workers.

What you might want to raise:

- This raises concerns about what happens if a GP is unsupportive or does not refer correctly. Having alternative referrers such as teachers, social workers and charities, alongside self-referral from the family, can be critical for those unable to access supportive medical professionals.
- There is evidence that GPs already struggle to know how to refer trans adults and children, so adding this extra step could lead to further confusion and delays;
- There is no information about which NHS professionals are included within those who can refer, and whether this will include care providers that are contracted but not employed by the NHS.

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

Proposed change: '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.'

What you might want to raise:

- Social transition (e.g., changing one's name, pronouns and/or gender presentation) is not a medical intervention, and should not and cannot be restricted by medical professionals. Requiring 'clinically significant distress' before recommending social transition is unevidenced as an approach to care and runs counter to the autonomy of young people and their families. Individual children and their families should be free to follow a path of social transition where this makes the child or young person feel happier or more comfortable.
- Contemporary evidence and international best practice (i.e., WPATH SOC 8) document numerous benefits of social transition (including improved mental health and wellbeing), and social transition was supported in the previous specification. There is no evidence cited to support this substantial change of direction.
- The recognition that someone's gender may change or develop over time 'is not sufficient justification to negate or deter social transition for a prepubescent child when it would be beneficial', and that preventing or attempting to reverse an adolescent's gender expression may be tantamount to conversion therapy. The Memorandum of Understanding (MoU), a joint document signed by over 25 health, counselling and psychotherapy organisations which aims to end the practice of conversion therapy in the UK, includes in its definition of conversion therapy 'any model [which] seeks to suppress an individual's expression of sexual orientation or gender identity' on the basis that one orientation or identity is preferable to any other.
- A uniformly applied 'watchful waiting' approach (i.e., preventing any form of social transition until adolescence) is based on a harmful, outdated model which runs counter to evidence.
- The lack of evidence is clear throughout the specification, with only one flawed citation in the entire document used to justify the statement that 'in most prepubertal children, gender incongruence does not persist into adolescence' (p. 13).
- This is taken from The Endocrine Society's Clinical Practice Guidelines, which in turn is based on outdated studies from the 20th century largely concerned with problematising 'deviant gender role behaviour'. More recent studies refute this claim, including a 2022 longitudinal study of 317 participants which found that an average of 5 years after initial social transition, 94% of children retained a trans identity.
- Olson's 2022 study further states that "detransitioning" is infrequent. 'More commonly, transgender youth who socially transitioned at early ages continued to identify that way.'
- The longest and largest study to date on the continuation of gender-affirming hormones in transgender people starting puberty suppression in adolescence to date found that '(98%) of people who had started gender-affirming medical treatment in adolescence continued to use gender-affirming hormones at follow-up
- Research from 2022 with 30 parents of prepubertal trans children found that 'Parents, in turn, observed profound and sustained improvements in mental health, well-being, educational attainment, and happiness once their children had socially transitioned.'

- One study found that 60% of trans male and 53% of trans female clients knew their gender identity before the age of 5; as Vincent states, this demonstrates two important things: 'many people who do transition had a strong sense of their genders from a young age,' and that 'just because someone didn't express gender difference in childhood, this is not evidence that they are not trans.'

Question 5 – To what extent do you agree with the approach to the management of patients accessing prescriptions from unregulated sources?

Proposal:

- A reinforcement: people accessing hormone blockers or hormones from unregulated sources or unregulated providers (such as via the internet) will not be managed or monitored by the NHS, i.e., shared care – this is currently the case.
- What's new: if the new service is made aware of access to unregulated medications, they 'will advise the GP to initiate local safeguarding protocols.'

What you might want to raise:

- That there is a conflation between 'unregulated' sources and private providers. Private healthcare providers are regulated, as are providers from other countries. Will those with prescriptions from regulated private providers or from international providers be refused access and face safeguarding protocols?
- That accessing regulated private healthcare, especially given the 3+ year waiting time, should not be treated as a safeguarding concern. Safeguarding referrals should be done on the basis of risk of harm to the child. Accessing regulated private care or internationally regulated care is not evidence of risk of harm. It is unclear how the proposal in any way meets the requirements of child centred safeguarding set out in Working Together to Safeguard Children (2018).
- This approach may be experienced as coercive: the NHS does not, and will not under this service specification, offer a care pathway that meets time limits set out in the NHS constitution. For children and families waiting for years to have a first meeting with a clinician, this approach to 'safeguarding' may be experienced as a threat: that if they seek care through any other route they will be punished, whether or not that care is clinically indicated for the child.
- That this provision will prevent some patients and their families from seeking other support from GPs, for fear of being reported to Local Authority safeguarding teams. This contradicts the harm reduction approach of the NHS (Domain 5 of NHS outcomes, as stated within the specification), and the General Medical Council's ethical guidance.

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?

What you might want to raise:

- That WPATH Standards of Care 8 includes an extended discussion around the evidence base for the use of puberty blockers (GnRHa), whereas this service specification presents the use of blockers as experimental, and restricts them to children and young people who agree to participate in a research project;
- That this version makes no reference to local endocrine services or fertility preservation;
- That this version does not explain access or prescription protocols for cross-sex hormones;
- That the previous version of this specification refers to regular reviews, which appears absent from this version;
- That there is no acknowledgement that not all parents, carers, schools, and local authorities will be supportive. WPATH Standards of Care 8 does acknowledge this, and states that sometimes it's not appropriate to include parents/carers in decision making.
- There is no longer reference to public and patient involvement in innovation and service development. Embedding the patient voice into any new service is critical.
- The mandatory enrolment onto a research protocol in order to access puberty blockers is out of line with best practice recommendations regarding ethical research into trans healthcare: it is advised that 'any provision of transgender healthcare is also available in a manner that is explicitly independent of research participation', as informed consent must be 'without coercion or undue influence.' It appears this will not be the case within this specification.

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

What you might want to raise:

- The EHIA states that 'The interim service specification sets out more clearly that the clinical approach in regard to prepubertal children will reflect evidence that in most cases gender incongruence does not persist into adolescence'. No evidence is given to support this, and in fact there is a significant body of evidence to suggest the opposite (see above);
- On the impact of those with the protected characteristic of 'gender reassignment', the EHIA presents an inaccurate interpretation of the Equality Act 2010, stating that: 'Children and young people who are on the waiting list for GIDS, or who may be referred to a Phase 1 service in the future, or who are receiving an assessment by GIDS and who are without a diagnosis of gender dysphoria, do not share the protected characteristic of 'gender reassignment' as a class or cohort of patients. They cannot be treated as "proposing to undergo" a process (or part of a process) for the "purpose of reassigning" their sex "by changing physiological or other attributes of sex".
- It is beyond any reasonable doubt that within the cohort of patients referred to GIDS is a subset who do meet the definition of 'gender reassignment'. In fact, this is acknowledged in the interim service specification itself, where it concedes that children and young people may have socially transitioned prior to accessing assessment and treatment at GIDs (largely as a consequence of the substantial waiting times). Therefore the EHIA should account for how

the interim service will avoid discrimination in access to care for this subpopulation of children and young people.

- On disability, the EHIA should include an assessment of how the service will avoid discriminating in access to gender affirming healthcare for people with the protected characteristic of disability. In particular, given the focus on neurodiverse children and young people in the service specification, it is important to demonstrate how this will ensure the provision of better and more holistic care, rather than simply introducing barriers to treatment for children and young people who are diagnosed both as having gender incongruence and neuro developmental conditions.
- That limiting referral routes could exclude children and young people with unsupportive families, as well as children accommodated away from the family home, and no provisions have been made for this.
- The EHIA states that 'there is evidence that transgender people from BAME groups are more likely to face discrimination on the basis of their race and gender' but does not describe what it will do about this or to mitigate against this.
- The EHIA states that it has not consulted on how to address or reduce inequalities; this is concerning as the NHS has access to various groups to consult with on this. This suggests that little care has been taken to ensure that individuals accessing the service will not experience discrimination, inequalities, or worse health outcomes.

Response from Transgender Trend

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

The team covers a comprehensive area of relevant disciplines. Expertise and knowledge is crucial in the following areas:

- Understanding of adolescent feelings of confusion and anxiety in the development/recognition of their sexual orientation and how this may relate to the over-representation of same-sex attracted young people (gay, lesbian and bisexual) referred to gender services, including the effects of homophobic bullying.
- Knowledge of the difference between the watchful waiting and gender affirmative approaches and the statistics concerning outcomes of both approaches in terms of sexual orientation, mental health and resolution of gender dysphoria.
- Knowledge of the changed sex ratio in referrals to gender clinics, the change in age of onset of gender related distress from prepubertal to post-pubertal and the predomination and vast increase in the number of teenage girls experiencing a sudden onset of gender dysphoria during or after puberty.
- An up-to-date knowledge of patterns in the development of mental health issues during adolescence and the differences between boys and girls, e.g., differences in experience of the physical changes of puberty and how they might influence an adolescent's self-perception, self-confidence and self-acceptance.

- Knowledge of the cultural factors affecting teenage girls and teenage boys differently, including social responses to pubertal changes e.g., sexual harassment of girls, online influences e.g., online porn, and social media pressures e.g., 'Instagram culture' of idealised female sexuality and YouTube videos glamorising medical transition for teenage girls.
- Familiarity with studies of detransitioners and the reasons young people may regret medical transition.
- Experience with family dysfunction and ability to recognise potential abuse, e.g., Munchausen by proxy or child sexual abuse.
- Expertise in female health issues specifically affecting girls, including mental health problems in adolescence such as body dysmorphia, anorexia, eating disorders and self-harm.
- Safeguarding and protection of children must be the first principle of care.
- A thorough knowledge of the Equality Act, the protected characteristics, Public Sector Equality Duty and legal obligations pertaining to equality law.

B. Clinical leadership

We agree in the sense that a medical doctor is more likely to follow the Hippocratic Oath 'first, do no harm', is less likely to be ideologically captured, and is comprehensively trained in diagnosis and treatment of the physical human body. Where any medical intervention may be proposed, a medical professional should be the clinical lead. It is important that the lead is not a 'gender specialist' who subscribes to ideological 'gender identity' beliefs, in denial of the material reality of sexed bodies.

However, the danger is that the service will be seen as a predominantly medical service, therefore it is especially important that the wider clinical team has expertise in a comprehensive area of disciplines.

C. Collaboration with referrers and local services

Local services such as CAMHS have been undermined and therapists compromised by political pressures in this area, specifically by the risk of the charge of 'conversion therapy' if they provide standard levels of care to an adolescent who announces they are 'transgender.' If collaboration is going to be effective, the clinical team must provide reassurance to local services that a normal level of explorative therapy is expected, in line with all other child and adolescent services.

If NHS professionals are to be confident of providing a normal standard of care for gender dysphoric adolescents the NHS should remove itself as a signatory of the Memorandum of Understanding on Conversion Therapy as long as it includes 'gender identity.' Allowing for therapeutic exploration only in the case of service users who are 'questioning their gender identity' automatically excludes the majority of adolescents who are certain they are 'transgender', along with young children who have been told by trusted adults that they are 'trans.' Inclusion of 'gender identity' in the MOU has had a chilling effect on therapists, as evidenced in the Cass interim report, and is incompatible with the Cass report recommendations and this interim service specification. The most recent version of the MOU is an ideological campaign document controlled by activists[12] and in order to support employees the NHS needs to show clearly that it is not an ideological body, but a health service.

The NHS must acknowledge the fear that has been created in this area and the highly charged political controversy, and must not be complicit in the silencing of clinical professionals. NHS England must show the way in not being cowed or diverted by political activists.

D. Referral sources

Referrals should never have been accepted from social services, schools, colleges of further education or 'voluntary organisations' which included political lobby groups, none of which are qualified to refer children to GIDS and have typically been trained by ideological and political organisations.

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

Whereas the interim service specification acknowledges that prepubertal gender incongruence rarely persists into adolescence, it does not specify that outcome research was conducted under a 'watchful waiting' approach (i.e., with no social transition). As the current cohort of largely adolescent referrals has been treated under a 'gender affirmative' approach, we have no idea whether gender incongruence/dysphoria would persist into adulthood for this cohort under a 'watchful waiting' approach. As this is a new phenomenon there is not yet outcome evidence for this group of adolescents and if there was it would be evidence of outcomes under a gender affirmative approach and therefore incomparable with earlier studies on younger children.

It is therefore imperative that the same level of caution around social transition should be applied to adolescents, especially in light of the fact that this age group has typically experienced online/peer pressure to identify themselves as 'transgender' and is of the age where medical intervention may be instigated.

It is this generation of teenage girls in particular who have been led to believe that medical transition will solve all their problems and have been coached online about what to say to the gender clinician in order to access hormones. No previous generation has been subject to such pressure to self-diagnose according to the beliefs of other people who are not clinically trained, and to believe there is one medical solution. This generation of adolescents believes they are literally the opposite sex to the same extent as prepubertal children do when they are affirmed and socially transitioned by adults.

The NHS should clearly distinguish between 'affirmation' as standard therapeutic practice (i.e., a patient is 'affirmed' as how they present as a first step to exploring underlying meanings and understanding) and 'affirmation' as it is understood and promoted by gender activists (i.e.. a girl is 'affirmed' in her belief that she is really a boy or a boy is affirmed in his belief that he is a girl, as a fact which requires no further examination). The service specification should clarify that 'gender affirmation' is the first step to social transition.

We know from existing research that around 80% of prepubertal children desist from a cross-sex identity without affirmation and social transition, and become resolved and happy with their biological sex without having been harmed. The only research to draw on in the case of the current cohort of adolescents who have been affirmed and socially transitioned is the testimony of detransitioners, who desist after having been medically harmed by the NHS. This is reason enough to exercise the same level of caution about affirmation and social transition for the adolescent age group.

The results of a study this year [13] on outcomes for young children who were affirmed and socially transitioned shows the stark contrast with the approach of 'watchful waiting.' The study 'Gender Identity 5 Years after Social Transition' found that 94% of these children persisted in a cross-sex identity and 3.5% identified as 'non-binary', i.e., no sex at all or a mixture of both sexes. Only 2.5% desisted. The powerful influence on children of affirmation and social transition, informed by gender identity ideology, is clearly demonstrated in this study and it should not be assumed that this does not apply to teenagers. Such powerful psychological intervention cannot be dismissed as harmless and 'reversible' just because it is not medical transition. Rather, it should be seen as the first step on an almost-inevitable medical pathway.

The service specification should define clearly what 'social transition' means. It may sound benign, but in reality it means telling a child that they are really the opposite sex. The NHS cannot collude in telling lies to children about the fundamental reality of their sex, which cannot be changed. The NHS also cannot be party to the deception of children that medical intervention can change their sex. NHS paediatric services must be based on biological reality and must not seek to mislead children or encourage them to dismiss material reality and replace it with magical thinking.

Social transition is fundamentally incompatible with exploratory therapeutic support for children and adolescents experiencing distress. The NHS must not engage in psychological propaganda and indoctrination of children into a belief system with no basis in reality. The NHS is not a political lobby group and should not operate according to ideological concepts promoted by such groups.

To socially transition a child is to impose an adult belief on them and cement the child's belief that it is reality, with no consideration of the psychological consequences to the child. It would be a dereliction of duty of the NHS not to make this clear to parents. Any adult in a position of authority over a child has a duty to be truthful about reality. Acceptance of reality is a foundation of good mental health; the role of the NHS is to help a child manage a reality which may be painful to them, not to pretend that that reality does not exist.

The NHS must also consider that 'social transition' is a demand on other people to collude in the pretence that a girl is a boy, or a boy is a girl. This is an infringement of other people's rights to freedom of belief and expression with a particularly harmful effect on children in schools. If a school looks to the NHS for guidance in this area, information must be very clear. The psychological impact of being coerced to deny a fundamental reality is already evident in the confusion and distress expressed by some children in schools; the long-term psychological impact on this generation is as yet unknown.

The NHS is a health service. Fostering a mind-body split in children through 'social transition' is the antithesis of good mental health practice. The consequences for the NHS in the future are not yet known but must be considered in light of the increasing number of young people who regret medical intervention, the effects of which they must live with for the rest of their lives.

The service specification states “Young people and their families will be supported in making difficult decisions regarding the expression of a gender role that is consistent with their gender identity, including the timing of changes to gender role and possible social transition“ (p.15) without explaining what a ‘gender role’ is and how it is different for girls or boys.

This idea can only be based on stereotypes, for example a girl’s role is to be passive and nurturing, a boy’s role is to be active and competitive. It feeds into what may be the beliefs of conservative parents with rigid ideas about how their son or daughter should act and behave, and should not be reinforced by the NHS.

The service specification should make clear that freedom of expression is encouraged without tying certain behaviour, interests or appearance to one sex or the other. Social roles should be open to both sexes equally and the NHS should not be promoting or encouraging sexist ideas about what is appropriate behaviour for girls or for boys.

The only other way a boy, for example, can change ‘social role’ is by using the girls’ toilets and changing rooms and participating in girls’ sports, all of which are separated by sex, not gender. This would not only infringe on girls’ rights to separate facilities and sports, creating a safeguarding risk, it also makes clear that ‘social transition’ in effect means changing sex. A child should not be encouraged to believe they are of the opposite sex and other children (in a school for example) cannot be expected to collude in this belief.

The NHS should be clear about what message ‘affirmation’ sends to a teenage girl who hates her body and rejects her female self. To tell her that she is correct in her belief about herself, to confirm her self-hatred and self-rejection as valid is unprecedented as a treatment by the health service. ‘I’m transgender’ stated by an adolescent translates as ‘I hate my body and I hate myself.’ Affirmation and social transition is an approach that confirms she is right to feel this way.

The clinical team must include psychologists and psychiatrists who understand the full implications of affirmation and social transition on the minds of young children[14] and adolescents.

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

Access to hormones from unregulated providers online is a growing problem, exacerbated by online and lobby group influence on adolescents to believe they need medical intervention immediately or they will regret it later. The NHS must not support the use of unregulated groups in any way and it is right that children and their families are strongly discouraged from using such services. The NHS is right to refuse clinical responsibility for management of endocrine interventions accessed through unregulated services. To collude would be to undermine the credibility of the NHS, by supporting a practice that puts young people at risk.

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?

The statement “being mindful that this may be a transient phase, particularly for prepubertal children“ (p. 2) should be amended to align with the information (p. 13): “in ***most*** prepubertal children, gender incongruence does not persist into adolescence.“

The wording should be changed, for accuracy, to “this is most likely to be a transient phase for prepubertal children and that there is no evidence to suggest that this would be any different for adolescents who develop gender dysphoria during or after puberty.“

The service specification states: “the main objective is to alleviate distress associated with gender dysphoria and promote the individual’s global functioning and wellbeing“ (p. 2). These are psychological/mental health objectives and the NHS needs to make clear that cosmetic medical alteration of the body is not evidenced as a treatment for psychological problems.

The NHS needs to do more in education of parents, schools and charities on the potential harms of affirmation and social transition for both young children and adolescents, and provide clear information that this is an experimental approach with no evidence to show that it is safe. It was developed by activists, not clinical professionals, and has replaced the ‘watchful waiting’ approach without any evidence to show that this established model of care was harmful.

The NHS should provide accurate information about the harms of breast binders for girls and not condone their use as part of ‘social transition.’

Parents and schools need to know that sudden onset of gender dysphoria in teenage girls during or after puberty is historically unprecedented; that this is a very recent phenomenon, about which we have virtually no research or evidence, as indicated in the Cass interim report.

The NHS should also add accurate information for parents to dispel the myth promoted by activists that a child is more likely to commit suicide if not ‘affirmed’ and supported to medically transition.

The NHS needs to make clear that gender non-conformity is normal and healthy, and should not be pathologised by labels such as ‘transgender’ and ‘non-binary’, terms inevitably based on gender stereotypes that have emerged through political activism based on an ideology of ‘gender identity.’ Parents and schools need accurate information: that there is no scientific basis for the concept of innate gender identity (for example ‘a girl’s brain in a boy’s body’) and that these are not clinical terms, nor a clinical diagnosis.

There is no mention of services for detransitioners or any support for those who regret medical transition in the service specification. This is an issue the NHS must address urgently, as currently there is no provision of services for this group.

The NHS must re-examine the current age cut-off for child and adolescent services, and the transfer to adult services which leaves a very vulnerable cohort of older teens and young adults without the same standard of care outlined in this service specification.

In the statement: "…service design and improvement is co-produced with experts by experience and promotes equality, diversity and inclusion" (p. 19) it is not clear who the 'experts by experience' are. The group should not be comprised only of people who call themselves 'transgender' or parent activists of 'trans kids.' A middle-aged male cross-dresser, for example, can have no experience of the issues teenage girls face. It is critical that the group does not comprise only those who believe in gender identity ideology, but also those who reject it, including parents, detransitioners and adults (including gay and lesbian adults) who outgrew childhood and adolescent feelings of discomfort and distress about their sex.

The term 'equality, diversity and inclusion' likewise must include people with different beliefs. 'Inclusive' policies based on 'gender identity' (not a protected characteristic) can lead to exclusion of girls and women based on 'sex' (a protected characteristic). 'Inclusion' can lead to inequality as well as being a safeguarding risk for girls in facilities where they need privacy from the opposite sex, and the NHS needs to be especially aware of this in a service catering mainly to vulnerable teenage girls, some of whom will have been sexually abused.

In the phrase "Understanding of the differences in sexual identity and gender identity, and expression" (p. 24) 'sexual identity' should be changed to 'sexual orientation.' Sexual orientation is a fact, not an 'identity' and wording it this way conflates two very different things.

In the statement "Understanding of the role of education services in supporting children and young people with gender incongruence (supporting full access to the curriculum and pastoral support including, vulnerable children policies; toilet and changing room policies; pupils with special education needs and, addressing, exclusion, bullying and harassment)" (p. 25) the NHS should not be advising schools to allow boys who 'identify' as girls to use girls' toilets and changing-rooms.

'Exclusion' based on sex is lawful policy to protect the privacy, comfort and boundaries of both sexes, and the safety of girls. The NHS cannot propose policies that create a demeaning or degrading environment for girls in schools. When the issue is the safeguarding of children, 'privacy, boundaries and consent' are the key words which must be placed above 'equality, diversity and inclusion' when it comes to sex-segregated facilities.

The service specification must acknowledge that the most likely outcome for prepubertal children who have a cross-sex identity is same-sex sexual orientation in adulthood, and that the majority of adolescents referred to gender clinics are lesbian, gay or bisexual.

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?

The 'gender affirmative' model, which did not meet normal standards of care in NHS child and adolescent services, resulted in indirect discrimination against several groups:

Age: the gender affirmative model is not developmentally appropriate treatment for children who have not yet developed an understanding of reality v fantasy, and adolescents whose identity development is in flux and liable to change. A principle tenet of safeguarding is that developmentally inappropriate expectations should not be imposed on children; this can be viewed as a form of emotional abuse.

Sex, Sexual Orientation and Disability: teenage girls, same-sex attracted young people and neurodiverse children and children with mental health problems, including gender dysphoria, are disproportionately disadvantaged by an unsafe system as they are disproportionately represented at gender clinics, as are children from the care system.

However, the NHS misunderstands the protected characteristic ‘gender reassignment.’ Although at the time this was written (Equality Act 2010) it may not have been envisaged as applying to children, the protected characteristic does not depend on a medical diagnosis of gender dysphoria, or on having taken any steps to ‘transition.’ It applies to ‘transsexual persons’ which suggests adults, but there is no age restriction. This protected characteristic, however, does not mean that a protected person must be treated as the opposite sex, only that they must not be discriminated against on the basis of this characteristic.

Whereas the previous NHS service specification in 2016 treated children protected by this characteristic unfavourably in comparison with other children with psychological/mental health problems, the new interim service specification treats them equally with other groups of children accessing NHS services.

The interim service specification, in addressing previous failings in order to establish a normal standard of care in line with other paediatric services, ends the failure of safeguarding and protection of these vulnerable groups. All children of all protected characteristics will benefit from a proper service of care. Health inequalities previously existed between the cohort of children accessing gender clinics and children accessing all other NHS health services and this health inequality has been rectified by the new service specification.

The EIA however, fails to consider other protected characteristics in its inadequate advice about social transition. Equality Impact Assessments must be tied to, and made in relation to, all advice in the service specification. The social transition of a child in school introduces compelled speech and imposes on the rights to freedom of belief of all teachers and children attending the school, under the protected characteristic ‘religion and belief.’ If school policies are introduced such as mixed-sex toilets, changing-rooms and sport, this would impact the rights of girls under the protected characteristic ‘sex.’ Coerced use of ‘preferred pronouns’ would disproportionately impact neurodiverse or learning disabled children under the protected characteristic ‘disability.’ Social transition of gay and lesbian children, who are more typically likely to be gender non-conforming, could be seen as a version of gay conversion therapy and therefore unfavourable treatment of same-sex attracted children under the protected characteristic ‘sexual orientation.’

The NHS must consider the rights of all protected groups in all the recommendations in the service specification, and not create inequalities for other groups outside the clinic through its advice.

Response from Christian Concern

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

A. Composition of the clinical team

We disagree with this proposal overall, because despite there being some improvements in the Interim Service Specification, some of the key problems already found in the GIDS are set to continue.

Psychosocial and psychological support and intervention is proposed to be the primary intervention for children and young people. In reality this should be the *only* suitable intervention for all children and young people referred. The reason is that affirmative treatment is harmful for children and teenagers. The evidence for its harmfulness is set out in the expert witness cited in our legal case supporting Nigel and Sally Rowe, which is referred to in our full response.

Multidisciplinary teams

This is good in principle, but there are serious problems with the details.

While we welcome the proposal to have multidisciplinary teams in principle, we note that the new specification includes ‘gender dysphoria specialists’, with ‘experts in mental health’ added at the end after emphasising ‘experts in paediatric medicine, autism, neurodisability’. This signals a downgrading of the importance of mainstream psychotherapists and psychologists, as well as complete removal of social workers from these teams. This is a serious problem that needs to be addressed.

We do not think that paediatric endocrinologists should be part of these Multidisciplinary Teams, as the only reason for their inclusion is to facilitate administration of puberty blockers and cross-sex hormones. These are experimental treatments that are contrary to medicine.

The Interim Service Specification clearly allows prepubertal children to transition and assumes uncritically that they have adopted this mindset all by themselves (page 14). This contradicts the scientific evidence against affirmative treatment. The ‘watchful waiting’ alternative is not good enough. It does not have the goal of resolving gender incongruence, rather it allows for waiting until the child has made his or her own mind up about whether or not to change gender. Therefore, the proposed new ‘watchful waiting’ paradigm still allows the child to make all decisions, ignoring parental authority and rights to bring up children as members of their biological sexes.

- We suggest you say that you are opposed to affirmative treatment or a ‘watchful waiting’ approach.
- We also suggest that you say that children and young people should be encouraged in all circumstances to live in line with their biological reality and given all appropriate support to address the real cause(s) of their gender dysphoria.

Who will staff the new gender hubs?

There will have to be new clinical staff, including mental health professionals, in these new Multidisciplinary Teams. The fact that a significant minority of therapists resigned from the GIDS not long ago leads to the question as to whether they would now be treated as eligible for the new posts. It is clear that these therapists believed in talking therapy not physical procedures such as puberty blockers accompanying gender transition.

The key problem here is that NHS England remains a signatory of the professional ban on 'LGBT conversion therapy', the Memorandum of Understanding on Conversion Therapy. This has caused the bias in favour of affirmative therapy at the GIDS.

Dr Marcus Evans, one of the GIDS whistleblowers (a qualified therapist and mental health nurse) has argued that the MOU has prevented clinicians' ability to provide adequate therapy for children referred to the GIDS.

- We suggest you say that NHS England should withdraw from the Memorandum of Understanding on Conversion Therapy so that clinicians do not feel obligated to affirm a child's self-defined gender identity. They should also be willing to re-employ those therapists who resigned and/or whistle-blew about what was happening in GIDS.

Concerns about anorexia among gender confused children ignored by consultation

The consultation document is selective in addressing possible underlying problems among children with gender confusion. For example, children known to be on the autistic spectrum are overrepresented among referrals. However, it is a problem that the significance of anorexia among children referred is never mentioned in the consultation. It is however discussed at length by Marcus Evans and Susan Evans in their book on gender dysphoria ('Early Development in the context of the family', in *Dysphoria: A Therapeutic Model for Working with Children, Adolescents and Young Adults*. Bicester: Phoenix Publishing House, 2021).

- We suggest you say that the Interim Service Specification needs to be changed so that the reference to 'experts in mental health' once again specifies psychiatrists, psychotherapists and family therapists as members of the clinical teams.

Social workers should be reincluded in Multidisciplinary clinical teams

The proposed new specifications exclude social workers completely from the multidisciplinary teams. No evidence is provided to justify their exclusion. As the historical evidence suggests, many children referred to GIDS had emotional and behavioural problems. Therefore, social workers should be re-included in the new multidisciplinary teams.

For therapists and psychiatrists, indeed all medical and mental health professionals, to be free to work to the highest standard in such teams, NHS England must leave the Memorandum of Understanding on Conversion Therapy Coalition, and the Department of Health must withdraw the Memorandum of Understanding on Conversion Therapy.

- We suggest you say that social workers should be included in the multidisciplinary team and that NHS England must withdraw from the MOU on Conversion Therapy.

B. Clinical leadership

We disagree with the proposal that the new lead should be a medical doctor, as medical conditions are very rarely the underlying issues involved in gender dysphoria. It is highly significant that the Cass Review has not shown any medical problems underlying referrals.
We would like to see leadership rotated between members of the different professions represented. However, for this to work well, NHS England would have to leave the MOU Coalition, as this has clearly been responsible for undermining clinicians' ability to treat gender dysphoria in children and teenagers.

- We suggest you say that the leadership of the teams should be rotated between members of the different professions represented.

C. Collaboration with referrers and local services

We agree in principle with this. However, see our response to 'D. Referral sources' in the next question below. We disagree with narrowing the referral base to only GPs and NHS staff, given that this excludes psychotherapists and other mental health professionals from outside the NHS. This restricts the range of competent referrers without justification. This amounts to a closed shop for mental health professionals who are members of organisations that are in the MOU Coalition.

D. Referral sources

Unjustified exclusion of private practice psychotherapists and counsellors

This draft Interim Service Specification does not allow referrals from psychotherapists and counsellors outside the NHS. In effect this creates not only a monopoly but a closed shop of mental health professionals entirely dependent on the state, and subservient to the MOU Coalition. This almost guarantees that professionals and clients' freedom to discuss the problems involved in gender confusion will be restricted, which would be an unjustifiable restriction on free speech in the workplace.

- We suggest you say that referrals should be allowed from psychotherapists and counsellors outside the NHS.
- We suggest you say that a requirement of making a referral should be that the referrer knows the patient well and has become familiar with them over a minimum of six months with repeated contact.
- We agree that referrals from non-medical sources such as schools and voluntary groups should not be allowed.

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

Contrary to what the consultation says, it is incorrect to assume that ‘social transitioning’ is ‘necessary for the alleviation of […] distress’. To assume this is to cave in to emotional manipulation. It is also incorrect to say that it can be necessary to prevent ‘significant impairment in social functioning’. In reality social transitioning is itself both a sign and instance of significant impairment in social functioning as a member of one’s actual sex. It makes little sense to state that a ‘young person’ (whose age is not delimited) can ‘fully comprehend the implications of affirming a social transition.’

The recent judicial review of the GIDS only considered whether teenagers could comprehend the effects of physical gender reassignment. The question of whether teenagers can fully comprehend the implications of social transition has never seriously been posed by clinicians or publicly debated. The reason for this is evidently that all mental health professional bodies have signed the MOU on Conversion Therapy, which has proven to have a chilling effect on freedom of speech in the mental health profession.

- We suggest you say that you disagree with the view that social transition is an appropriate treatment for children suffering from gender dysphoria.
- Social transition makes it much more likely that a child’s gender confusion will persist into adulthood.
- The service should encourage social detransition which will make it much less likely that gender confusion will persist into adulthood.

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

This approach is unethical, as it ensures that the service washes its hands of all legal and clinical responsibility for minors who access dangerous drugs. It is a cynical approach that shows NHS England has given up on any intention to get to know teenage patients and their families, to try to steer them to live in harmony with their biological sexes.

If this were the approach taken towards teenagers taking classified illegal drugs, there would be public outrage and calls for a public inquiry.

- We suggest you say that the NHS should not avoid responsibility for caring for people who have taken un-regulated prescriptions.

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 are pleased that use of puberty blocking drugs is proposed to be limited to the context of a research proposal, but we believe that any prescribing of puberty blockers to children is unethical.

- We suggest you say that we should not be experimenting on children by prescribing them with puberty blockers.

- It is already known that almost all children who use puberty blockers go on to progress with more damaging gender transition treatments, whereas those that do not use puberty blockers are much more likely to see their gender confusion resolve at the onset of puberty.

Response produced by Katy Montgomerie

Question 3A

All new clinical staff should be specialists in trans healthcare and dealing with trans and gender diverse youth, or have been trained in this. It is not good enough to just have an expert in autism or neurodisability, etc who has no experience or expertise working with trans kids.

Adding support for trans kids with other intersecting conditions is very good, however it must not be used as an excuse to deny trans kids healthcare on the flawed premise that autistic kids cannot be trans or that they don't know who they are for example.

A multidisciplinary team being available when necessary is a good thing for those in need of it, but it should not be required for every patient to waste time having to talk to all of these specialists. This should be about providing extra support, not about adding in new gatekeeping or excuses to deny trans children healthcare.

Question 3B

The person overseeing trans healthcare for trans kids in the UK should be a trans person. We wouldn't accept it if the people in charge of women's healthcare from top to bottom were men, women must have a say in their healthcare, and so must trans people.

Moving towards depathologising NHS help for trans kids is good.

Any expert who is in this role must have expertise working with trans people before starting this role. No cis people learning on the job.

Question 3C

Any interim service should be there to support referrals and not just add an extra step of gatekeeping to slow trans kids down from accessing the care they need.

Local support is good in principle, however it is a reality that many trans people have unsupportive or even hostile GPs towards their care. Any change in this regard must acknowledge this and ideally should provide a route around transphobic service providers and should make it so that hostile attitudes towards trans healthcare are not accepted in the NHS.

This local support must be available to new patients and not just those already on the offensively long waiting lists already.

The goal of local services should be to support trans kids in parallel, helping them while they wait for specialist services, not as just an extra step to hold them back from accessing care.

I am well aware that the NHS has completely failed to keep to its own guide of 18-week waiting times when it comes to all trans people, but I think that anyone building a new improved service must commit to these times and make that clear

Question 3D

It is essential that if a patient has an unsupportive or openly hostile GP that they are able to have a route around this. I think it is unreasonable to just assume that a teenager or even a parent will be able to shop around for GPs, there must be other routes. It is naïve and frankly ignorant to assume that every GP has the best intentions for trans people at heart.

Seeing as you acknowledge that only 5% of referrals come from outside the NHS today this move seems pointless as it is clearly not a large burden on the service and is likely just from kids who feel that the person they told is the most supportive adult in their life.

Question 4

Social transition includes some or all of changing clothes, hairstyle, makeup use, name and pronouns. It is beyond ridiculous that the NHS thinks that it can mandate what clothes someone would wear or how they would want to be referred to.

Kids should be allowed to explore who they are and how they want to present without being forced to adhere to outdated gender roles. There is no reason why any child should be forced to wear certain clothes. There is no evidence at all to show that letting a child express themselves is more or less likely to result in them being trans when they hit adolescence.

It is inappropriate for a GP or any healthcare professional to try and dictate how a child or anyone live their lives. To me this seems like an attempt to allow the pushing of conversion therapy onto trans kids. As you well know conversion therapy of all LGBT people is often largely focussed on controlling things such as expression and presentation.

Question 5

Describing HRT and blockers as “unregulated drugs“ is false, these medicines are very regulated in the UK. Describing them like this gives the impression that they are either black market or illegal. This comes across as fearmongering about medicine that cis people are able to access over the counter.

The goal of the NHS should be making it so private healthcare is not needed at all by anyone. If private healthcare options exist it is a sign that the NHS is already failing. In the case of trans healthcare the NHS has been failing so badly for so long for so many people that private options are absolutely essential. This of course excludes those unable to afford them, which is discriminatory, but pressuring or closing down these services will not help anyone and will just force people to buy from the black market or move abroad. There is no reason at all that private services would provide lesser or inadequate care. In fact what we have seen historically is that private options provide care much closer to that of the international guidelines than the disgraceful level of healthcare the NHS has provided trans people.

I personally have had to rely on private healthcare for my own transition for almost every step of the way because the NHS has totally failed trans adults like me, and for trans kids it is currently even worse.

If the NHS wants to create a system without private healthcare options then they should just meet the international guidelines for trans healthcare in a timely fashion.

Question 6

There should be explicit commitment to wipe out conversion practices in all forms.

Forcing all patients to participate in research in order to get healthcare is unethical. It prevents people having autonomy over their own lives and may prevent some people accessing care. Many trans people would be more than happy to voluntarily sign up to being part of studies on trans healthcare, there is no need to treat us as lab mice.

This document makes no reference to NHS fertility services for young trans people. These should be included.

HRT is an essential part of trans healthcare, this document fails to mention them and it is likely that local services will want to prescribe them and they should be given guidance on how to.

This service should be constantly evolving to meet the new best practices and should have constant involvement from patients and the community.

Question 7

The document claims that most prepubescent children grow out of gender dysphoria but does not provide any evidence for this claim.

The document incorrectly describes the Equality Act 2010 protected characteristic of Gender Reassignment. It is hard to read this as not a bad faith attempt to remove legal protections from young trans people. Anyone who proposes to undergo transition has this characteristic.

The equality impact assessment does not address how to mitigate the extra hurdles that disabled trans people and trans people of colour will face in accessing healthcare and support.

This document completely fails to acknowledge the fact that some young trans people may be pregnant. There is no reason why trans people would be less likely than cis people to undergo teen pregnancies.

Response from Gay Men's Network

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

A: Composition of the clinical team

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 NHS England proposes elsewhere in the ISS.

We agree that a multidisciplinary 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 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 GDIS 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.

B: Clinical leadership

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, coordination 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 mechanisms for accountability. It is also consistent 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.

C: Collaboration with referrers and local services

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).

D: Referral Sources

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?

We welcome the acknowledgement in the ISS that gender incongruence in most prepubertal 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?

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 unregulated sources. The NHS should not be a party to young people taking drugs provided to them by unregulated, online 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 of 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 patients' 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 regard 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 psychoeducation 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 prepubertal children, and their families

- We suggest that therapeutic approaches for younger and prepubertal 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 detransitioned. 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 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.

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?

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 "NHS England does not hold relevant data." This cannot be right.

All the available evidence 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 to 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 NHS England 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 NHS England's various responses to its equality duties as follows (taken from NHS England'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 NHS England will have due regard to its own policies. The lack of safeguarding and the risk of homophobia we have referenced throughout this response 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 Care Quality Commission (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 NHS England'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 be clear legal requirements, be embedded into the assessment of risk, as well as the proposed ISS more generally.

TONIC

NHS England

Interim service specification:

Interim specialist service for children and young people with gender incongruence

9 June 2023

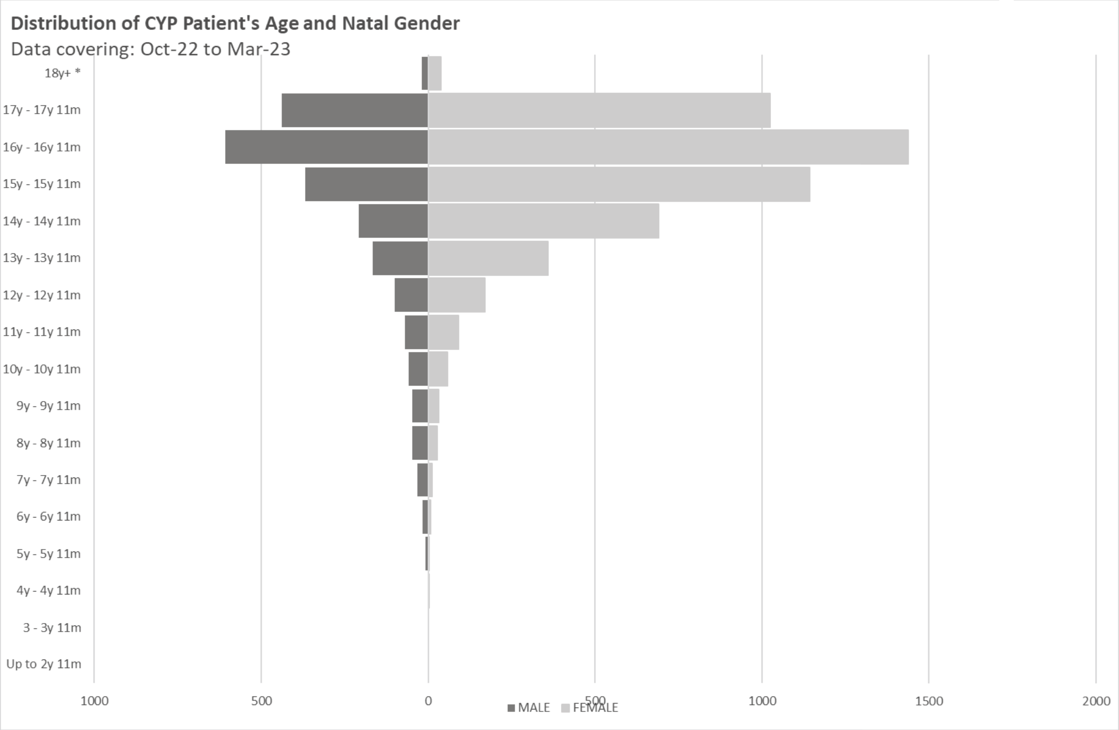
1. Service name	INTERIM SERVICE SPECIFICATION Interim Specialist Service for Children and Young People with Gender Incongruence
2. Service specification number	
3. Date published	8 June 2023
4. Accountable Commissioner	NHS England

5.	**Summary**
	The Service will provide care to children and young people, and their families, who express gender incongruence and who are likely to benefit from clinical support. The Service will adopt a holistic, multi-disciplinary integrated approach to assessing and responding to an individual's needs in view of the range of co-presentations that may typically present in this patient cohort, and the range of complexities relating to gender identity development. The most appropriate clinical pathway in the best interests of the child or young person will be determined through an integrated multidisciplinary team (MDT) approach, fully involving the child or young person and their family. Providers delivering The Service must be an established specialist tertiary paediatric unit with a strong partnership with mental health services; be an established academic centre with a strong track record of research in children and young people; and have robust safeguarding frameworks in place.

	The clinical management approach should be open to exploring all developmentally and psychosocially appropriate options for children and young people who are experiencing gender incongruence. The clinical approach should be mindful that this may be a transient phase, particularly for pre-pubertal children, and that there will be a range of pathways to support these children and young people and a range of outcomes. Not all children and young people who present with issues of gender incongruence will require direct interaction with The Service; in many cases the most appropriate care can be provided locally including with additional support and consultation by The Service. A significant proportion of children and young people who are concerned about, or distressed by, issues of gender incongruence experience co-existing mental health, neuro-developmental and/or personal, family or social complexities in their lives. The relationship between these presentations and gender incongruence may not be readily apparent and will often require careful exploration. Where children and young people present with co-existing conditions or presentations, these will normally be addressed by the appropriate local service alongside this Service. The primary intervention for children and young people who are assessed as suitable for The Service is psychosocial (including psychoeducation) and psychological support and intervention; the main objective is to alleviate distress associated with gender incongruence and promote the individual's global functioning and wellbeing. The approach for onward referrals to endocrinology clinics are described in separate NHS England clinical commissioning policies for puberty suppressing hormone treatment and gender affirming hormone treatment.
6.	**Population and/or geography to be served**
6.1	**Population Covered** The defined patient cohort is children and young people up to their 18th birthday who are: • Registered with a General Practitioner in England or who are otherwise the commissioning responsibility of NHS England; AND • Who were under the care of the Gender Identity Development Service at the Tavistock and Portman NHS Foundation Trust; OR • Who were on the NHS waiting list for the Gender Identity Development Service managed by the Tavistock and Portman NHS Foundation Trust; OR

	• Who are referred to The Service because gender incongruence concerns may be present and which exceed the scope and expertise of local services. **Terminology** Gender incongruence of childhood (ICD11 HA61) *"Gender incongruence of childhood is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about two years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis".* Gender Incongruence of Adolescence and Adulthood (ICD11 HA60) *"Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior to the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis".*
6.2	**Minimum population size** Estimates for the proportion of adults or children with gender incongruence vary considerably. This reflects a number of factors such as: variable data reporting by providers; differences in diagnostic thresholds applied and inconsistent terminology; the methodology and diagnostic classification used – population surveys give a much higher estimate than numbers based on service use; and the year and country in which the studies took place. Few studies have taken place in the United Kingdom, and there are no published studies in young children. Published estimates for the proportion of people who are gender diverse range from 0.3% to 0.5% of adults, and around 1.2% of people aged 14-18 years. The number

of referrals is currently likely to be around 1 per 2000 population per year. The current referral profile suggests that the majority of referrals will be of adolescents following the onset of puberty.



Eligible Patient Cohort

The Service will assume a share of the responsibility for: the existing open caseload; and existing national waiting list of children and young people who are waiting to access a specialist gender incongruence service.

New referrals will continue to be made to NHS Arden & GEM Commissioning Support Unit (The CSU) who will hold the national waiting list on behalf of NHS England until referrals may be passed to a new provider in chronological order.

Young people aged 17 years and who are unlikely to be seen by The Service by the time of their 18th birthday may be transferred to the waiting list of an NHS-commissioned Gender Dysphoria Clinic for adults. In such cases, the Gender Dysphoria Clinic will honour the original referral date to the children and young person's service for the purpose of access into the adult service.

7. Service aims and outcomes

7.1 Service aims

Pending the establishment of a new national service specification that will describe all elements of the new regional service, this interim service specification describes a model for delivery that will:

- Tailor an individual care plan following a standardised approach to assessment, formulation and care planning
- Provide psychosocial land clinical interventions for children and young people with gender incongruence, including support for the family
- Provide advice in respect of and, onward referral to endocrine intervention services
- Support local services in meeting the gender incongruence needs of children and young people where appropriate through professional liaison and collaboration
- Through professional liaison and collaboration support local services to meet the wider needs of children and young people (including mental health, neuro-developmental and safeguarding) and in risk mitigation
- Build research capabilities to conduct high quality studies across the clinical pathway
- Build and document the history and nature of gender incongruence to establish evidence-based practice

7.2 Outcomes

NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill-health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm

Service defined outcomes/outputs

- To deliver a plan that maximises capacity, delivers assessments and delivers the full pathway of care.
- To provide continuing high-quality data:
  - Workforce plan including vacancy status reported monthly
  - A monthly SPC Chart on first consultations by region, age, biological sex and aggregated
  - A monthly SPC Chart on work in progress (WIP) by region, age, biological sex and aggregated
  - A monthly SPC Chart on discharges by region, and aggregated
- Evidence of engagement with children, young people and families in design and review of service delivery
- Collection and reporting of children and young people's experience of the service
- Build Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) for routine deployment no later than one year following service initiation

7.3 Audit and evaluation

The Service will take part in continuous data collection, reporting and audit to support the NHS in developing a better understanding of the relevant patient cohorts; and for the purpose of evaluating and enhancing the benefits and value of the service model; and for the purpose of building research capabilities to conduct high quality studies across the clinical pathway.

NHS England will commission a third party to support a Learning Healthcare System working with designated providers to build standardised workflows, apply continuous improvement and to create a standard data set for service evaluation through audit and research.

8. Service description

8.1 Future Service model

The future service model will be developed while this interim service specification is used to initiate the service development. Providers are encouraged to adopt a range of service provision strategies within a structured framework to determine which approaches should be standardised into the workflow.

As a developing area of clinical practice, commissioned providers must actively participate in an ongoing programme of quality improvement to enable continued refinement of models of patient access, assessment, treatment delivery and follow up. This will include:

- Proactive and visible clinical leadership within each service
- Strong links with primary and community care services
- Enhanced data collection, reporting and audit
- Sharing of data and learning between commissioned providers and with national commissioners
- Identification, sharing and rapid adoption of good practice
- Contributing to the prioritisation and focus of national service and quality improvement programmes and initiatives
- Active participation in and delivery of quality improvement initiatives, both at provider level and through a co-ordinated national network approach
- Regular review of service level data at each stage of the pathway and service user feedback, with prompt delivery of any resulting actions for improvement, including where inequalities in access or outcomes are identified

It is important that the opportunity is taken to gather further evidence on the safety, potential benefits and harms of medical interventions.

In addition, well-structured research programmes will be developed through a National Children and Young People’s Gender Incongruence Research Oversight Board to include for example: epidemiology; prediction; the course of gender querying; and outcomes of psychological treatments to reduce distress.

Commissioned centres must:

- Contribute to the identification of study and treatment evaluation priorities through participation in the National Children and Young People’s Gender Incongruence Research Oversight Board
- Deliver research and evaluation programmes within the service and in partnership with other commissioned service providers

- Ensure an enhanced data set is collected from assessment through to follow up to facilitate research and evaluation, including for those whom, following assessment, it is determined would not benefit from intervention by the Service

Providers will build clear relationships with the range of services and skills across all Integrated Care Systems within the regional catchment.

8.2 Current Pathways

Referrals into the service will be through a National Referral Support Service [DN Insert Link to Specification once approved].

The provider will deliver The Service through an integrated MDT. An individualised pathway will be determined in the child or young person's best interests by, among other things, the clarity, persistence and consistency of gender incongruence, the presence and impact of other clinical needs, and family and social context. An individual care plan will be tailored to the specific needs of the individual following careful therapeutic exploration; this plan may require a focus on supporting other clinical needs and risks with networked local services. The care plan will be regularly updated at least every six months while the child or young person remains in the service.

Standardised Assessment

All children and young people who are seen by The Service will receive a standardised comprehensive assessment that will identify and develop a shared formulation of a child or young person's needs based on a comprehensive, holistic assessment including developmental history, history of gender incongruence and associated needs and risks. Assessments should be respectful of the experience of the child or young person and be developmentally informed. Clinicians will meet families with diverse needs and at different stages in thinking about their gender. This could include where: long-standing social transition has already been made; or no social transition has been made, but the child/young person expresses certainty around a different gender identity; or the child/young person expresses uncertainty and confusion around feelings about gender and distress. Families may have unity around the use of names and pronouns, whereas in others, this may be causing conflict and concern.

The objectives of the process of assessment will be:

- Establish a positive clinical relationship, clinician approach and stance e.g., modelling curiosity, holding balance and neutrality; including sensitivity and flexibility to issues around pronouns, names and language
- Set the context, explain the rationale for a holistic needs assessment and manage expectations
- Seek agreement to understand different areas of the child/young person's life, including wider family/networks
- Identify or confirm significant co-existing conditions or challenges
- Establish next steps in relation to the young person's gender querying / gender incongruence – including the respective contributions from local healthcare (and other multi-agency) services and the nationally commissioned Service
- Identify and signpost to supportive resources for psychoeducation and/or transition pathway options
- Develop an initial, 'working' formulation to guide care planning and next steps

The Service will adopt a holistic, multi-disciplinary integrated approach to assessing and responding to an individual's needs. The most appropriate clinical pathway in the best interests of the child or young person will be determined through an integrated MDT approach, fully involving the child or young person and their family.

There is an increased prevalence of mental health needs in children and young people who present to gender identity services (such as depression; anxiety; risk-taking behaviours) and these children and young people will have spent many years on the waiting list. There is also thought to be an increased prevalence of neurodevelopmental disorders in children and young people on the waiting list. In view of the range of co-presentations that may typically present in this patient cohort the MDT will include expertise for the direct assessment of autism, attention deficit hyperactivity disorder and other forms of neurodiversity.

Initially there will be a focus on understanding the expression of gender incongruence and identifying associated physical and mental health and neurodevelopmental needs; and on identifying and responding to clinical risk, including mental health and safeguarding needs. The Service will identify and initiate action on immediate health and support needs, including in relation to co-existing conditions and, in some cases, safeguarding concerns.

Assessment should seek to understand the holistic needs of the child or young person and their family. This process should determine whether there are any co-occurring and/or contributory elements of the individual's presentation that are affecting their psychosocial wellbeing or functioning and require support as the basis of an individual care plan.

Clinicians should remain open and explore the child or young person's experience and the range of support or treatment options and their implications that may best address their needs, including any specific needs of neurodiverse children and young people.

Assessments will focus on:

- Subjective sense of the child / young person's identity over time
- Their expression of gender identity across different contexts over time and different settings
- Their hopes and expectations and that of their family members/carers and their stance towards the child / young person's gender identification
- Any steps that have been taken along a gender transition
- Developmental needs including cognitive functioning and capacity of the child / young person, and their understanding of gender
- Associated physical mental health and neurodevelopmental needs and their relationship with gender incongruence
- Risk including mental health, safeguarding including risk of vulnerability and exploitation and impact of any unregulated medication
- Psychosocial functioning and impact of the gender incongruence (eg on educational attendance and progress, or experience of bullying or harassment)
- With adolescents – sexual orientation; psychosexual development and any sexual experiences
- Assessment of family functioning and quality of relationships within the family, including children and young people in care (or kinship care or who have been adopted) and the wider community
- Exploration of parent/carer and family views on the child or young person's gender identity journey and family support
- Peer relationships and wider social support
- Family's spiritual, cultural, or religious beliefs

- Protective factors – strengths and resources that the young person and family are able to build on

Outcomes of the process of assessment

- Presentations, pathways and outcomes for this cohort will be individualised in the best interests of the child or young person, who is introduced to the service team and service offer, with a focus on promoting or maintaining the child or young person's overall wellbeing and global functioning.
- A child or young person with mental health or neurodevelopmental needs and / or risk-taking behaviours that require immediate intervention will be supported to access this through professional liaison and care navigation with local services including health, social care and education. The Service should confirm collaborative care arrangements for further assessment and treatment with local services through professional liaison. A significant number of children and young people with very complex needs may also be *Looked After* or may not live with their birth family and may require the active involvement from children's social care and/or expert social work advice.
- Identification of co-existing conditions or needs will lead to an exploration of the relationship between the presentation and gender incongruence through an integrated approach by MDT members.

Support to Local Professionals Following Assessment

The service model will reflect that not all children and young people with gender incongruence will need to be seen directly by The Service or, may only need to be seen for an initial or brief assessment by the Service. The process of assessment will seek to identify children and young people for whom consultation and active support through local professionals is appropriate, 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, the resources available locally, and through a process of clinical prioritisation.

The Role of Formulation

Formulation is a process used by a range of professionals to summarise and integrate a broad range of information gathered in an assessment. A formulation is a set of hypotheses about an individual's difficulties, which links theory and evidence with practice. It is developed collaboratively with the young person and their family, and should inform and guide subsequent support and intervention.

The process of assessment and formulation should conclude with a set of recommendations in relation to a care plan. This will include potential pathways of psychosocial support, recommendations on therapeutic interventions, parent/carer support options as well as wider recommendations for further support that might be accessed from the local professional networks. It should also include clear pathways around discharge where appropriate.

The Service will make a recommendation on the need for further support and information, incorporating the views and wishes of the child, young person and parents/carers and referring professionals, and make recommendations for a specialist explorative assessment in relation to the medical pathway if appropriate.

The outcome of the process of assessment including formulation of needs and risks will be confirmed in writing with the GP and referrer and shared with the family.

Psychoeducation

Psychoeducation material for children and young people, parents/carers and local professionals alike will include information on gender identity development including research evidence and how to support an exploratory approach that allows their child or young person time and opportunity to consider different options in a flexible and non-judgemental context.

Children and young people who are seen by The Service, and their parents/carers, will receive psychoeducational information that is appropriate to their needs. Parents, carers and families, (including siblings) will have the opportunity to access additional resources including facilitated group discussions with peers on a similar pathway.

Social transition as a part of a clinical intervention

Social transition is something that should be led by the young person with family input.

For the purpose of this interim service specification the reference to 'social transition' is intended to refer to the support offered by NHS clinicians to children, young people and their families who have decided that the child or young person will present in public fully 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.

The ability to express individuality – and autonomy 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. However, due to the social and psychological implications that social transition may have, advice about social transition should be seen as informing a significant decision when it forms part of an individual's care.

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 information is needed about long-term outcomes to support decision making. Information and discussion about this with the MDT is an important part of supporting a child or young person in The Service.

At the point of presentation to The Service some children and young people will have already socially transitioned or be in the process of effecting a social transition, while others may be considering this. The Service will support a shared decision-making process - it is important that the risks and benefits of social transition are discussed with the child or young person and family, referencing best available evidence. Decisions will be individual, and the agency to make the decision rests with the young person, along with their family.

The Service's MDT will engage children and young people and their families in an in-depth process of discussion and thinking around the decision of social transition. The MDT will support a consideration of: how this will fit within the broader holistic approach to addressing the child or young person's needs; how the process might proceed; how they will be supported; and how they will be given opportunities to reflect on their lived experience including autonomy to change or cease social transition if the gender incongruence changes or abates. This interim service specification recognises that pre-pubertal children have different needs to older adolescents and that the detail of the different clinical approaches across the age ranges will develop as the services evolve and the evidence becomes available.

Direct work with pre-pubertal children, and their families

The clinical approach in regard to pre-pubertal children will reflect opinion that exploration of gender diversity in childhood is an expected aspect of general human development, and that diverse gender expressions in children cannot be assumed to reflect gender incongruence.

Some children will remain stable in a gender identity they articulate in early life that is discrepant from natal sex and for others it will be a transient phase. While intensity of early gender incongruence in children may be an important predictor of persistence of gender incongruence, gender trajectories in prepubescent children in particular cannot be reliably predicted and may evolve over time.

Generally, the clinical approach will focus on a careful observation of how gender incongruence develops as puberty approaches and is reached. The therapeutic approach for younger and pre-pubertal children is not directed at gender incongruence itself but instead focused on other clinical presentations and needs, or familial/social circumstances that may impact on the child's psychological health and gender incongruence.

The level and timing of intervention will be commensurate to the individual's needs and may range from advice by The Service to the family and professional network where there are no concomitant issues, to more intensive clinical interventions that seek to address other clinical diagnoses delivered by local secondary services with support, advice and consultation by The Service.

Psychological support and interventions provided directly by The Service will focus on children whose presentations are persistent and who have impaired functioning, with the aims of alleviating or preventing the onset of emotional problems, behavioural problems and social relationship problems, improving psychosocial health and global functioning. For younger pre-pubertal children, local services will often be the most appropriate source of continuing direct psychological support and intervention, with or without consultation support from the Specialist Service.

Support will be offered as part of the collaborative care agreement with local services and may be provided by the local and/or specialist service and, could be offered through individual / family work or group work.

In cases where a pre-pubertal child has effected, or is effecting, a social transition (or expresses a wish to effect a social transition) the clinical approach has to be mindful of the risks of an inappropriate gender transition and the difficulties that the child may experience in returning to the original gender role upon entering puberty if the gender incongruence does not persist into adolescence.

However, some children state that they want to make a social transition to their preferred gender role long before puberty, which means that increasing numbers of children may have made a partial or full social transition prior to the first attendance with The Service.

In summary, for pre-pubertal children the clinical approach and advice applied by The Service will be supportive and non-judgemental, balancing on a case-by-case basis a watchful approach overall with a more individualised approach in cases where the child's level of global functioning may be maintained or improved through a carefully observed process of exploration of social transition. Where social transition is occurring or is being considered by the family, The Service will support the family in weighing the potential benefits, challenges and risks.

Direct work with adolescents and their families

Psychological support and interventions provided directly by The Service, including family therapy/work, will focus on alleviating or preventing the onset of emotional problems, behavioural problems and social relationship problems, improving psychosocial health and global functioning, while responding to co-existing needs and conditions.

Clinicians should remain open and explore the young person's experience and the range of support or treatment options and their implications that may best address their needs, including any specific needs of neurodiverse children and young people. The overall aim is to reduce distress in the individual; support the development of positive self-image and self-esteem; promote the individual's global functioning; facilitate understanding and acceptance within the family unit.

Interventions with adolescents should be at a level commensurate with the needs of the individual. More intensive clinical interventions may be needed that seek to address other clinical diagnoses and will be delivered by local secondary services with support, advice and consultation by The Service.

Factors that could influence the complexity and length of the intervention include:

- Unstable or escalating mental health problems
- Ongoing risk issues, and safeguarding issues
- Levels of emotional and cognitive maturity
- Concerns with regard to competency or capacity to understand and consent
- Family conflict about how to proceed

Not all adolescents will want or benefit from social transition. Where social transition is occurring or is being considered by the young person and their family, The Service will support the young person and family in weighing the potential benefits, challenges and risks.

In view of the potentially profound impact of social transition on the young person's life the provision of approaches to support social transition will be considered in cases where expressions of gender incongruence or gender diversity have been persistent; and the young person expresses a clear wish to affirm their gender transition and fully understands the implications of affirming a social transition (informed consent); and where the proposed approach is considered by The Service as necessary for the promotion or maintenance of the young person's overall health, wellbeing and social functioning. In these cases the clinical approach will involve a focus on exploring or supporting (as appropriate to the individual) social transition through psychological support and interventions, family work/therapy and guidance for the local professional network. Young people and their families will be supported in making difficult decisions regarding the expression of a gender role that is consistent with their gender identity, including the timing of changes to gender role and possible social transition.

The Service will aim to maintain a therapeutic relationship with young people and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender incongruence are thoughtfully and recurrently considered. The same reasoning applies if a young person has already socially changed gender role prior to being seen by The Service.

Referrals for assessment for endocrine interventions

Separate but linked NHS England clinical commissioning policies will define the use as part of the NHS commissioned service of i) puberty suppressing hormone treatment; and, ii) masculinising / feminising hormones from around the age of 16 years.

Prescribing from unregulated sources and unregulated providers

Children, young people and their families are strongly discouraged from sourcing puberty suppressing or gender affirming hormones from unregulated sources or from on-line providers that are not regulated by UK regulatory bodies.

If a child or young person has already been started on **puberty suppressing hormones** outside of NHS protocols by the time that they are seen by the NHS, The Service may consider assuming clinical responsibility for prescribing through NHS protocols if The Service's MDT jointly concludes with the related endocrine clinic that this is an appropriate harm reduction measure. In such cases administration of puberty suppressing hormones would need to be stopped for a brief period of time to allow baseline investigations to be undertaken by The Service. If the patient is felt to be appropriate to be restarted on treatment after assessment by The Service treatment may be resumed in accordance with NHS protocols, including the requirement for the patient to be enrolled in the formal research protocol.

If a young person has already been started on **masculinising / feminising hormones** outside of NHS protocols, The Service will consider (jointly with the related endocrine clinic) a continuation of prescribing through NHS protocols as a harm reduction measure where ALL of the following criteria are met:

- Evidence of a comprehensive documented assessment by a multi-disciplinary team that includes a medical practitioner with specialist expertise in gender incongruence in children and adolescents; and
- Evidence of continued psychological support through engagement with the MDT; and
- Administration of puberty suppressing hormones was commenced not before Tanner stage 2; and
- Masculinising / feminising hormones commenced after at least twelve months on puberty suppressing hormones; and
- Masculinising / feminising hormones were commenced not before approximately 16 years of age; and
- Evidence that impact to fertility was discussed with the young person before initiation of the hormones.

Where the Service is not able to accept responsibility for prescribing puberty suppressing hormones or masculinising / feminising hormones the Service will not offer clinical supervision for the management of the endocrine intervention and will not enter into shared care arrangements with a health professional who is making recommendations for prescribing / is prescribing to the child or young person. In such cases The Service will make the child or young person and their family aware of the risks, contraindications and any irreversible or partially reversible effects of the interventions; and will make the GP or local health professional (as appropriate) aware and suggest that the GP or local health professional considers what safeguarding protocols may be appropriate for the individual child or young person's wider circumstances including the extent to which the parents / carers are able to protect or safeguard the child or young person. Safeguarding procedures may be necessary regardless of the endeavours and best intentions of the parents / carers in reducing risk of harm.

Safeguarding protocols should be initiated immediately where the child or young person is at risk of immediate, serious harm.

It would also be important for the GP or local health professional to explore what regulatory bodies may need to be informed if healthcare professionals registered with a UK professional body are prescribing medication contrary to NHS protocols.

Transition to adult services and discharge

The Service may provide support to young people up to their 18th birthday.

The Service will review the needs and progress of the young person in relation to their gender incongruence and the goals of treatment and will step down or discharge their care to local primary care or secondary care services as appropriate.

For young people who have been seen by The Service and who are approaching their 18th birthday The Service will co-ordinate a transition and support plan with the professional network specific to the young person's needs. A transfer may be made to an NHS-commissioned Gender Dysphoria Clinic from 17 years of age where the young person meets the access criteria.

A co-ordinated transfer to appropriate local adult services will be needed where complex presentations continue.

8.3 Essential Staff Groups

The key clinical leadership role will be through a medical consultant with significant experience in the developmental needs of children and adolescents.

The MDT will have (or have access to) the following competencies and experience (see also Appendix A). Practitioners will need access to clinical supervision across a range of clinical areas (e.g., psychological, mental and physical health, safeguarding and gender identity development) to support their roles.

	• Multi-agency working including provision of consultation, liaison and advice for complex cases, and care navigation • Expertise in child safeguarding and assessment and management of risk-taking behaviours • Childhood and adolescent development, including cognitive, social and sexual development; gender identity development and gender expression • Paediatric medicine, including psychological health • Child and adolescent mental health, including expertise in assessment and formulation, delivery of evidence based therapeutic interventions, trauma informed approaches; and family work/family therapy • Cognitive Behavioural Therapy • Neurodevelopment disorders including learning disability and autism spectrum conditions • Gender incongruence • Expertise in sex development, and endocrine intervention • Expertise to support children and young people who may be Looked After or in Special Guardianship or who may be adopted.
8.4	**Essential equipment and/or facilities** The provider must have in place premises that are appropriate to ensure effective delivery of the services described in this service specification; and in an age-appropriate environment that children and young people regard as safe and welcoming. Providers will be mindful that the majority of individuals are likely to be of an age following the onset of puberty.
8.5	**Interdependent Service Components – Links with other NHS services** The Service must be expert in working with a wide variety of agencies. It is expected that close working will be needed in particular with Children and Young People's Mental Health Services, child health and neurodevelopment services, voluntary community services, education professionals, children's social care and with general practitioners. The Service should also be competent in their understanding of and close working with children and young people with social care needs – including adopted children and young people, and children in care, and in working with schools and colleges to facilitate wellbeing and full access for their education.