NHS England: Public Consultation - Interim service specification for specialist gender dysphoria services for children and young people

1. In what capacity are you responding? (Patient / Parent / Clinician / Service Provider / **Other**; If you have selected 'Other', please specify.)

Senior Researcher

2. Are you responding on behalf of an organisation? (**yes** / no; If you have selected "yes", which organisation are you responding on behalf of?)

Christian Medical Fellowship

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

A. Composition of the clinical team

(**Agree** / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

We support the proposed changes to the service specification and endorse the interim Cass Report advice that "a fundamentally different service model is needed which is more in line with other paediatric provision." We welcome the language that suggests a substantial reform of the existing service specification is needed, that "must include support for any other clinical presentations that they [children and young people needing support around their gender identity] may have."

The new specification recognises the high incidence of co-existing mental health /neurodevelopmental complexities in many of these children, that require careful exploration.

B. Clinical leadership

(**Agree** / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

We note that the previous service specification was cast in ideological language and concepts, reflecting the influence of transgender lobby groups. We very much hope that the new service will treat gender confusion and dysphoria in children in ways that align with other paediatric provision.

We commend the intention to create a strong partnership between established paediatric units and mental health services, where care plans are based on a standardised approach to assessment and diagnosis, in an environment of continuing data collection and analysis, research, and robust clinical governance and safeguarding procedures.

The previous specification made room for treatments to be given without a sufficient evidence base. Young lives have been harmed, sometimes permanently, as the result of an overly 'affirmative' gender ideology. We welcome the news that, under the new service specification, children will only be referred through medical health professionals and that puberty blockade will only be prescribed within a formal research programme.

We remain concerned about the influence that the 'gender affirming' ideology has in education and social services. We welcome the new specification's recognition that social transitioning is an active intervention that should never occur in schools without careful consultation with clinical professionals and parents/carers. The new specifications make clear that teachers/schools should not be promoting social transitioning. We would further contend that school lesson plans and library books that reflect the trans ideology, suggesting to the youngest minds that 'you can be born in the wrong body' or that 'you can be who you want to be,' are misleading and should be withdrawn.

Curiosity about gender and identity is normal among young children. We welcome the new specification's recognition that gender uncertainty is most commonly a transient phase in childhood, and that a large majority of gender confused children will emerge from puberty with a gender identity congruent with their natal sex.

The Equality and Health Inequalities Impact Assessment makes clear that children referred to GIDS do not constitute a cohort of people with the protected characteristic of 'gender reassignment' (under the 2010 Equalities Act). Studies in neurodevelopment suggest that our brains continue to develop and change until our mid-20s. To assume that a child's sense of identity is sufficiently formed and stable for him/her to give fully informed consent to life-changing treatment by the age of 16 is clearly 'unsafe.' We welcome the new specification's recognition of the complexity of the issues concerned, and that each child should be assessed carefully by a Multidisciplinary Team. Schools should not pre-empt the outcome of The Service by 'affirming' what cannot be safely assumed.

C. Collaboration with referrers and local services

(Agree / **Partially Agree** / Neither Agree nor Disagree / Partially

Disagree / Disagree; comments)

We welcome the emphasis on individual assessments and care plans, but question whether the capacity to deliver a personalised pathway for each child referred is/will be in place in time. Clearly, Phase 1 will inherit a long waiting-list and the current referral rate is running at over 5,000 per year. Only two Phase 1 services are being considered initially.

It is not clear from the consultation documents what will be the access criteria for The Service. What is clear is that not all those children who do meet the access criteria will be seen directly by The Service. In such cases, The Service will provide consultation and support for local professionals in formulating individualised care planning.

We welcome the intention to collaborate in this way but think that a more detailed picture outlining resources and capacity, as part of the final draft of the new specifications, might increase confidence and reassure those who fear that this could turn out to be more a bureaucratic exercise than a clinical one.

D. Referral sources

(Agree / **Partially Agree** / Neither Agree nor Disagree / Partially

Disagree / Disagree; comments)

We welcome the proposal that referrals may be made by GPs and NHS professionals. Given 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', we suggest that the wording in italics under 4. 'Referral sources – substantive change' be amended to read '...that referrals **must** be made by GPs and NHS professionals.'

CMF is concerned about those adolescents aged 17. At present, the referral rate drops around 17, presumably because this group of young people are waiting for referral to adult services. The adult services suffer from the same ideological 'gender affirmative' approach as the Tavistock GIDS, lacking a whole-person perspective and failing to adequately assess and treat co-existent mental health issues, including autism. We believe there is an urgent need for a transition pathway that will continue the level of care provided in child and adolescent services. Ideally, this should continue until young people reach their mid-twenties and their brains reach full development. As things stand, the approach proposed in the new specification will not be replicated in adult services, with inevitably harmful consequences.

A further concern relates to the Sandyford clinic in Glasgow. We understand that there has been no independent review of GIDS provision in Scotland. There is clearly a risk that NHS England and NHS Scotland will be out of step with each other following the implementation of the new specification in England and Wales. We appeal that political differences be set aside such that gender dysphoric children in Scotland can benefit in the same way as those south of the Border.

4. To what extent do you agree that the interim service specification

provides sufficient clarity about approaches towards social transition?

(Agree / **Partially Agree** / Neither Agree nor Disagree / Partially Disagree /

Disagree; comments)

We agree that the interim findings of the Cass Report should shape policy in this area and wholeheartedly support the 'wait and see' stance towards gender uncertain pre-pubertal children. We are concerned that the current trend of encouraging gender affirming social transition in primary schools will lead many children, who otherwise would have emerged from puberty with a gender identity in line with their biological sex, to transition psychologically as well as socially such that by puberty they already think of themselves as trans and start down a path of puberty blockade leading, in almost every case, to treatment with trans-sex hormones from their mid-teens onwards.

The consultation document makes clear that the current evidence base is insufficient to predict the long-term outcomes of complete gender-role transition during early childhood. We agree that social transition represents active intervention and applaud the decision to pull back from what has been an irresponsible experiment on young children.

In our view, the advice regarding post-pubertal adolescents should also address the fears instilled in many parents and carers that gender incongruent children are at a high risk of suicide. 'Better a live son than a dead daughter.' The evidence base for such fearmongering is flimsy at best, and certainly

does not support gender transition at an age when those areas of the brain that mediate our sense of identity are neurodevelopmentally immature.

We would argue, on the basis of what is already known about neurodevelopment, that a gender incongruent adolescent is not able 'to fully comprehend the implications of affirming a social transition,' and that distress or social impairment would have to be uncommonly severe to warrant their social transition, given the lack of evidence of long-term outcomes.

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

(**Agree** / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

We welcome the clarity of the approach outlined.

Is the UK considering legislation to render unlawful the supply of GnRHa and masculinising / feminising hormone drugs by unregulated bodies?

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?

(comments)

Version 2 of the Memorandum of Understanding on Conversion Therapy (MOU2), to which NHS England is a signatory, obliges psychotherapeutic practitioners to adopt an 'affirmation' approach for all young people with gender dysphoria. It would appear that professional bodies in the UK have been captured by the activists' ideology. We suggest the MOU2 is incompatible with the new service specification and respectfully request that NHS England reconsider its position.

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?

(**Agree** / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)