



Gender Identity Research and Education Society

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NHS STANDARD CONTRACT FOR GENDER IDENTITY DEVELOPMENT SERVICE FOR CHILDREN AND ADOLESCENTS

SERVICE SPECIFICATION

19 April 2016

GIRES Response

Recommendation

The document should be amended extensively and then subjected to a further consultation with stakeholders before it is implemented. Amendments are necessary to the following:

- Terminology
- Prevalence data
- Biological nature of gender identity development
- Criteria for cross-sex hormones
- Data relating to desistance
- Effect of early transition
- Apparent advocacy of reparative therapy
- Rigid application of age and time restrictions relating to physical interventions
- Client autonomy and choice, relating to physical examinations and lead worker
- Punishment inflicted on those who obtain medication outside
- Assessment process
- Introduction of triage and fast track in appropriate cases
- Expertise in caring for clients on the autistic spectrum
- Resources allocated to pre-pubertal children
- Transfer to adult services

Detailed Comments on the document

Page 2 - 1.1

The descriptions of '*gender identity*' and '*gender dysphoria*' are somewhat clumsy and do not make clear the differences between gender and sex.

'Gender identification is diversifying' is probably not correct. Identities have very likely always been varied but people felt obliged to live according to binary roles. We are now seeing identities that were previously hidden.

We suggest:

Gender identity refers to a person's sense of fitting into social categories of boys/men; women/girls. These are binary identities, but identities may also be non-binary, that is somewhere on a spectrum between the two, or outside that spectrum, known as non-gender. More of these widely diverse identities are now emerging, and many will be needing the support of medical services.

Gender dysphoria describes the unease experienced when the gender identity is not aligned with the sex assigned at birth; the gender role and expression typically associated with that sex are also sources of unease.

Prevalence

Epidemiology

There is little point in referring to earlier estimates when we now have more up to date information.

Conway 2008 does not appear in the list of references and, in any case, the figures supposedly derived from her work are very out of date. The up-to-date studies by Kuyper et al. and Van Caenegem et al 2015 are below.

The Netherlands

Kuyper, L., & Wijzen, C. (2014). Gender identities and gender dysphoria in the Netherlands. Archives of Sexual Behavior, 43, 377–385 Found that in The Netherlands:

Those assigned **female**, who identified as men (gender incongruent) = **0.8%**; or identified as non-binary (gender ambivalent) = **3.2%** (*therefore non-binary 4 times greater than gender incongruent population*);

Those assigned **male**, who identified as women = **1.1%**; or identified as non-binary = **4.6%** (*4 times greater than gender incongruent population*)

The combined gender non-conforming population = (0.8 + 3.2) + (1.1 + 4.6) x ½ = 4.85%

Belgium

Van Caenegem, E., Wierckx, K., Elaut, E., Buysse, A., Dewaele, A., Van Nieuwerburgh, F, T'Sjoen, G. (2015). Prevalence of gender nonconformity in Flanders, Belgium. *Archives of Sexual Behavior*, 44(5), 1281–1287. (World Health Organization).

found that in Belgium:

Those assigned **female**, who identified as men = **0.6%**; or identified as non-binary = **1.9%** (**3 x greater than gender incongruent population**)

Those assigned **male**, who identified as women = **0.7%**; or identified as non-binary = **2.2%** (**3 x greater than gender incongruent population**)

The combined gender non-conforming population = (0.6 + 1.9) + (0.7 + 2.2) x ½ = 2.7%

UK

There appears to be no acknowledgement of the data published by Fiona Glen and Karen Hurrell in the Technical note: Measuring Gender Identity (2012) www.equalityhumanrights.com/sites/default/files/documents/technical_note_final.pdf **1% had the gender reassignment characteristic .**

(n=10,000 but with the warning that this cannot necessarily be extrapolated to the whole population)

Page 3

Evidence Base

~~“Evidence for a biomedical causal model also remains limited”~~ The references given are dated, and unhelpful. Swaab’s stance on this is being misrepresented here. He is completely committed to the brain science interpretation of gender variant outcomes.

There are many studies now indicating biological correlations in the development of gender identity/dysphoria. The Lancet is about to publish a short paper on this (Diamond and Reed), as part of a wider coverage of gender incongruence. We suggest that rather than attempting to cover all the references that properly relate to the underpinning science, a recent published Review is used, which contains the statement that:

“Although no studies to date demonstrate the mechanism, multiple studies have reported associations with gender identity that support it being a biologic

phenomenon.[...] Current data suggest a biologic etiology for transgender identity."(Saraswat et al. 2015)

"Evidence Supporting the Biological Nature of Gender Identity" (2015) Aruna Saraswat, Jamie D.Weinand, Joshua D. Safer, Endocrine Practice Vol 21 No. 2

Regarding age for interventions with cross-sex hormones

We have dealt with this matter more extensively in our submission concerning the Policy Proposition, to which we refer NHS England's commissioners.

It should be noted that both the World Professional Association for Transgender Health and the Endocrine Society are currently amending their respective standards and guidelines. The latter's recommendation and suggestion concerning the eligibility for cross-sex hormones may be amended.

As well as noting that "boys and girls enter puberty at different stages", the varying development rates of different ethnic groups should be taken into account in the formulation of individual care plans.

Rosenthal has been grossly misrepresented in the Evidence Review upon which the Policy Proposition was based. Among the statements he actually made was:

"not only could delaying such treatment [cross sex hormones] until that age (16) be detrimental to bone health, but keeping someone [on blockers] in a pre-pubertal state until this age would isolate the individual further from the age-matched peers, with potentially negative consequences for emotional wellbeing".

Cross-sex hormones are acknowledged to be effective in treating gender dysphoria (which hormone-blockers are not).

"...body image difficulties persisted through puberty suppression (...) and remitted after the administration of CSH and GRS..." (De Vries et al 2014)

N.b Cross-sex hormones are partially reversible.

Delaying treatment causes '**psychological torture**' (Kreukels and Cohen-Kettenis) "Puberty suppression in gender identity disorder: the Amsterdam experience", *Nat. Rev. Endocrinol.* 7, 466–472 (2011); published online 17 May 2011)

Another significant statement was made by De Vries et al (2014):

“The age criterion of 16 years for the start of CSH may be problematic especially for transwomen, as growth in height continues as long as cross-sex steroids are not provided (causing the growth plates to close). Therefore, psychological maturity and the capacity to give full informed consent may surface as the required criteria for puberty suppression and CSH in cases that meet other eligibility criteria.”

1.2. Persistence/Desistence

Page 4

The language used to describe these issues, even though in common use, is inappropriate. Children and young people may show behavioural traits that lead adults (parents, clinicians) to draw the conclusion that the child is gender dysphoric, when in fact the child is gender *non-conforming* for other reasons, including the possible outcome of an LGB identity. These children are not ‘desisting’, their GD does not disappear, they have never experienced it. They are just being themselves and have been misinterpreted or misdiagnosed. This usually becomes clear at the onset of puberty, well-before the issue of cross-sex hormones is raised.

The Kreukels and Cohen-Kettenis article (*Nat. Rev. Endocrinol.* 7, 466–472 2011) noted that in the early days, when psychotherapy was the only treatment offered to children and adolescents: *“despite many years of psychotherapy, the gender dysphoria of most adolescents with GID does not often abate”*.

The statement: “in most children, GD will disappear before, or early in, puberty” should be rewritten as follows.

It is not always possible to know whether gender non-conforming behaviours in a child are actually a reflection of gender dysphoria, or whether they are related to some other possible outcome, such as being gay, lesbian or bisexual. Usually, at the onset of puberty, the outcome becomes clearer to the child, and therefore to the relevant adults, including clinicians if they are already involved. Hence the requirement to experience the onset of Tanner Stage 2 which helps to inform the child as well as families and clinicians whether or not medical intervention is appropriate. According to the Dutch, the initiation of hormone-blockers, where this step is taken, provides a further opportunity for ‘diagnosis’. Usually, this is well before the likely commencement of treatment with cross-sex hormones.

The argument that the possibility of ‘desistance’ exists, is neither a relevant nor a rational excuse for withholding cross-sex hormones. ‘Desistance’ should be

completely detached from decisions about cross-sex hormones, which should be made on an individual basis in accordance with reasonable readiness criteria excluding age.

The paragraphs citing percentages of drop-outs, non-attenders etc is confusing and therefore unhelpful. **We suggest that independent research should be conducted to ascertain why 17% never attended, 17.8% dropped out and 2% opted for private therapy. The figures may derive from dissatisfaction with the GIDS. In any case, they may indicate a substantial waste of scarce and expensive resources.**

The figures given: “In about 20% of cases GD had decreased and in 20% GD was noted to have desisted” are uninformative without an analysis of the Tanner stage at which these events occurred.

Page 5

1.3 Social transition

Social transition for young children has become much more possible in recent years. Children in the UK are protected by the Human Rights Act. They have the right to autonomy regarding their gender identity and expression. Schools have become more accommodating (although not universally so). Whether or not the child continues to seek medical intervention around the time of the onset of puberty, or not, it is surely crucially important for a child’s mental health and self-esteem, for them to understand that their parents, carers, and families would support them, no matter who or what they were. It should always be made clear to the child and the family that a return to the original gender presentation is perfectly acceptable.

The conclusion drawn from the 2011 paper by Steensma and Cohen-Kettenis that “early social transition does not equate with an adult transgender identity” does not seem secure. The paper was based on interviews with only twenty five adolescents diagnosed with a Gender Identity Disorder, whose ages were (M age 15.88, range 14-18).

Moreover, the statement that the authors advise parent to encourage “activities that are associated with the child’s natal gender” appears to be **tantamount to recommending reparative therapy**. The General Medical Council has stated that, with regard to sexual orientation, this form of therapy is “**unethical and potentially harmful**”

<http://www.gmc-uk.org/news/26043.asp>

With regard to gender identity, reparative therapy is highly controversial, as evidenced in the events surrounding the closure of the Gender Identity Development Service in Toronto, Canada.

<http://nymag.com/scienceofus/2016/02/fight-over-trans-kids-got-a-researcher-fired.html>

The Legislative Assembly of Ontario, Canada, introduced a law in 2015 which stated that **“any services that seek to change the sexual orientation or gender identity of a person are not insured services”**.

http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=3197

See also: Annual Review of Critical Psychology: The governance of gender non-conforming children: a dangerous enclosure, Jake Pyne, McMaster School of Social Work, Toronto, Canada 2014

<http://www.discourseunit.com/arcp11/5-governance.pdf>

See also: Mental Health of Transgender Children Who Are Supported in Their Identities (2015) Kristina R. Olson, PhD, Lily Durwood, BA, Madeleine DeMeules, BA, Katie A. McLaughlin, PhD (*Department of Psychology, University of Washington, Seattle, Washington*)

<http://pediatrics.aappublications.org/content/pediatrics/137/3/1.44.full.pdf?...>

“Socially transitioned transgender children who are supported in their gender identity have developmentally normative levels of depression and only minimal elevations in anxiety, suggesting that psychopathology is not inevitable within this group. Especially striking is the comparison with reports of children with GID; socially transitioned transgender children have notably lower rates of internalizing psychopathology than previously reported among children with GID living as their natal sex.” (Olson et al, 2015)

1.4 Associated difficulties

Page 6

It seems from the figures quoted that UK young people have a higher rate of mental health issues than do the Dutch

The UK 2002 data on reduced risk indicate the potential for the service to make a significant difference to the lives of these young people, provided they treat them in a timely manner. If they do not, the result is, as mentioned in the Kreukel & Cohen-Kettenis paper, ‘psychological torture’.

The statistics quoted, from different service providers, show a wide variety of satisfaction rates, but with little analysis why. Are the high rates of depression and self-harming linked to delays in providing appropriate medical interventions? There is little analysis of the meaning of all the statistics on p6

1.5 Autistic spectrum

It seems unlikely that the Finnish would have twice as many ASD as the UK in the gender variant population, but that is not a reason for believing the UK figure is an underestimate. Anecdotally, young people who have been successfully treated, are often described as having no residual ASD. The symptoms have disappeared once the dysphoria has been treated. That is obviously not always the case, but it is something that long-term follow-up should address.

Page 7

1.6 Physical treatments

“the research evidence for the effectiveness of any particular treatment offered is still limited”. Why start with a statement that contradicts the Dutch and other findings?

It is reassuring to see the quoted evidence from the Dutch on “improved psychological functioning”.

Could the “continuing high rates of anger and anxiety in trans men” be the effect of testosterone medication?

Have the authors of the service specs taken account of the Dutch in vivo MRI scans on their cohorts of young people? There appear to be no MRI scans of the UK young people.

Page 8

The mean time of 9 months achieved by the Dutch from starting assessments to starting blockers is stated to be 9 months. That is substantially shorter than achieved in the GIDS. Moreover, there are obviously many cases in which the time in The Netherlands was less than that. This indicates a flexibility in the Dutch approach that appears to be lacking in the GIDS.

It would have been helpful to see data for Tanner stage in the above study.

The evidence from Boston is that “those who do not receive counselling have a higher risk of behavioural and emotional problems and psychiatric diagnoses”. There is no indication in Figure 1 on page 15 that the GIDS provides or procures any counselling. However, on page 12 the service includes therapeutic exploration.

The tragic death of a young person is not really a useful anecdote in this context. All surgeries carry risk, but unless you give the figures to show how many have had surgery, sometimes several surgeries and survived, mentioning one death is not meaningful. It seems like a deliberate scare tactic.

Page 9

Recognition of treatment on a “case by case basis” contrasts with the rigid application of age and time requirements within the GIDS.

2.1 NHS outcomes framework

Domain 1

(in addition) Preventing premature death would be overcome by providing cross-sex hormones to overcome the misery of gender dysphoria; providing safe prescriptions for young people who have resorted to the Internet (sometimes funding this through risky sexual behaviours). Adults are able to access ‘bridging prescriptions’; adolescents should also be able to.

Domain 2

(in addition) long-term effects of delayed treatment. “Refusing timely interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization.... Withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.”

Domain 3

Psychological support is important but if the current reluctance to provide timely cross-sex hormones continues, young people will not recover from dips in their mental health but will continue to deteriorate.

Page 10

Domain 4

The client should have a choice in Lead Worker, and be able to change if they wish. Clinicians, family and carers should not overrule the client's choice.

At the moment the decisions regarding medical intervention are not balanced. The client and families are disempowered in this situation. They have no power to disagree with the clinicians, and if they take unilateral action because they are not satisfied with the client's treatment, they are punished, by being refused treatment or discharged.

The list that follows does not hold good for many young clients. These points only apply once the client is able to access treatment – GnRHa or CSH. Being involved in service developments has not proved effective in changing policy from the inflexible age limit on CSH.

Only those attending the young person's Stakeholder Group have a say, and there is little evidence of clinicians listening to the anger felt by young people who are Gillick competent but unable to access CSH in a timely manner

Page 11

Domain 5

Harm occasioned by delaying hormone-blockers and/or CSH is avoidable. Bridging prescriptions could be introduced as for adults so that Internet users have a proper alternative. Those who seek treatment abroad should not be excluded from endocrine services under the Tavistock

At the moment, when clients or their families do not comply with "agreed standards", they are punished. These are not standards that they have agreed.

P11

Objectives

Interface with CAMHS is still not able to overcome the resistance and ignorance of many CAHMS providers. Knowledge within CAMHS is very variable.

Page 12

It is **most welcome** that the GIDS is committed to "recognising that the needs of each individual will be different" and will deliver "tailored treatment packages". In previous

discussions with stakeholders, the GIDS has resisted the provision of individualised packages of care on a case by case basis.

The GIDS is described as providing: “therapeutic exploration of gender identity. This approach will ensure that clients have adequate time to fully assimilate the effects of each stage of physical intervention, together with the different options for gender expression”. It should be made clear that this process should not be used as a means of delaying physical intervention or of engaging in reparative therapy.

Page 13

The GIDS intends to provide an assessment report and care plan after three to six meetings. This will not be suitable for some individuals, especially if there is a long delay between appointments.

The greatest complaint from clients and families is the delay in providing physiological interventions. This led to the recommendation by the Parliamentary Women and Equalities Select Committee that “consideration be given to reducing the amount of time required for the assessment that service-users must undergo before puberty-blockers and cross-sex hormones can be prescribed”. When a client has already passed Tanner 2, the process of assessment should be speeded up. The ongoing changes to the body lead to self-harm, depression and suicidality.

We have urged the GIDS to adopt a triage method of assessing the urgency of individual cases and providing fast track access to physical treatment when needed. The triage process could be conducted via telephone and e-mail before the first appointment. Some clients should be seen in less than 18 weeks.

Another complaint is the tools used for making these assessments.

Page 15

The multi-disciplinary team (MDT) should include clinicians who are expert in communicating with clients on the autistic spectrum.

A clinician has made the excuse that it takes longer to assess gender dysphoria in a client who is on the Autistic Spectrum. Since there appears to be a raised incidence of ASD in this field, clinicians with this specialism should be part of the team. ASD should not be an excuse for delaying treatment for gender dysphoria.

Page 16

The flow diagram should be amended as follows:

- Insert Triage box immediately following “Referral Received by GIDS”
- Include a fast track option for urgent cases through the rest of the diagram
- Reduce minimum number of meetings in Assessment Phase to 2 for fast track cases
- Shorten 3 monthly timescale for fast track cases

Page 17

The flow diagram should show maximum time of two weeks for first follow-up appointment

The flow diagram states that decision on cross-sex hormones will be made at age 16 +/- one or two months or post one year on blocker. This means that a client provided with the blocker at Tanner stage 2 is eligible for cross-sex hormones one year later. That is a very welcome proposal.

Page 19

Tier 1 professionals should be referred to the NHS e-learning at:

<http://www.nlmscontent.nesc.nhs.uk/sabp/gv/>

Page 20

Despite frequent mention of ‘case-by-case-basis’, this does not appear to be happening on the ground.

Although puberty blockers are not offered before Tanner 2, the necessary assessments should have been undertaken in good time, so that this intervention is not delayed.

To help the GIDS meet the currently overwhelming demand, the amount of effort applied to pre-pubertal children might be reduced. It is questionable whether or not it is necessary to see them and their carers every two to three months. Perhaps follow up appointments could be deferred until the client enters the first stage of puberty.

Page 21

The proposal here is for a minimum of two assessment sessions prior to referral to the endocrine clinic. That is welcome. The flow diagram, which states a minimum of three should be altered accordingly.

Adjusting the time intervals between sessions on a case by case basis, as proposed, is very necessary.

Page 22

We welcome the following statement: “Exploratory work recognises the right of young people to self-define their gender identity and to make decisions about their own life and treatment, taking their developmental stage and competence into account.”

Page 24

Regarding Informed consent, this section includes the words:

“age does not determine capacity to give consent”

However, using age as the measure of readiness and eligibility is irrational and not supported by any evidence.

How can it then be ethical to withhold treatment, causing great distress (WPATH), from young people who need to be on hormone blockers rapidly, because they are already at Tanner 3-4 and who have the capacity to consent;

Potential Benefits of cross sex hormones (CSH) for those who are already on blockers, who move on to CSH:

- a) Their gender dysphoria is finally being treated and abates;**
- b) Their pubertal development starts to catch up with their peers as they develop the secondary sex characteristics that align with their gender identity; the effects are partially reversible, and;**
- c) Their mental health improves**
- d) Their ability to focus on school work improves**
- e) Their relationships improve**
- f) They are less likely to indulge in risky behaviours**

Potential disadvantages of withholding CSH from adolescents:

- a) Their gender dysphoria is not being treated; CSHs are the treatment for gender dysphoria (which blockers are not) and**
- b) They fall behind their peer group in terms of pubertal development, and**
- c) Their mental health deteriorates, they experience suicidality, anger and other manifestations of distress. Adult trans people still talk retrospectively about their distress at this age.**
 - their self esteem plummets,**
 - they may self-medicate,**
 - they may self-harm,**
 - they may be suicidal,**
 - their relationships with their families may deteriorate,**
 - their trust in the clinicians may disappear,**
 - their school work may suffer, or they may drop out.**

Potential advantages of withholding CSH

- a) fertility may be affected, and prior gamete storage may be undertaken. N.B trans boys whose periods have been established can become pregnant at a later date, but pre surgery to remove ovaries and uterus, by stopping estradiol and allowing menses to restart. Specialist advice should be offered. It may be necessary to explain to young people that there is a very small chance that any child they have may also experience atypical gender identity development**
- b) The young person may find that CSH do not feel right for them. It is extremely rare for this to occur at this stage. Any ‘uncertainty’ about ‘persistence’ is not an argument for withholding CSH, because those that have already experienced the onset of puberty have usually dropped out. Even if they have spent only a limited period on GnRHs they will drop out, well before CSH are considered. This is regarded by the Dutch as a ‘diagnostic’ window.**

Therefore it is extremely rare for CSH to be started and then have the young person decide they want to stop. If that happens, their phenotypic puberty will restart.

This seems ill-informed. It would be better to provide an up-to-date picture, especially as The Lancet is about to publish on this matter. The WHO is changing the ICD entry for adults, having been advised to **“abandon the psychopathological model for a model that reflects current scientific evidence...”**

Multiple studies have reported associations with gender identity that support it being a biologic phenomenon.[...] Current data suggest a biologic etiology for transgender identity."(Saraswat et al. 2015)

"Evidence Supporting the Biological Nature of Gender Identity" (2015) Aruna Saraswat, Jamie D.Weinand, Joshua D. Safer, Endocrine Practice Vol 21 No. 2

3.2.4

Should include **‘those that enter the service at Tanner stages 3-4 will be fast tracked to start hormone-blockers, bearing in mind that their pubertal changes may be causing them great anxiety. This will provide part of the diagnostic evidence to inform future interventions.**

Page 25

Physical examinations can be extremely difficult for young trans people so this needs an exceptionally sensitive approach. The reasons for such an examination must be clearly explained to the young person. If a choice of clinician is possible, that should be offered.

There should be a reference to the RCGP e-learning which has an additional module for children and adolescents:

<http://gires.org.uk/gender-variance>

See: https://www.engage.england.nhs.uk/consultation/clinical-commissioning-wave8/user_uploads/gids-serv-spec-upd.pdf

Page 26

As described more fully in our submission concerning the Policy Proposition, the wording with regard to the research study should be amended as follows:

When ethically approved, the service will undertake a research study to assess the physical and psychosocial impact and outcomes of offering cross sex hormones based on readiness criteria that have been developed in consultation with stakeholders. Actually, it would be sufficient simply to start offering CSH based on readiness criteria and then collect data on the cohort that receive them.

The section on privately obtained medication should be revised as follow:

Policy regarding physical interventions obtained elsewhere:

- **Young people may have accessed mental health and/or endocrinology services within, or outside, the NHS before or after referral to its specialised Gender Identity Development Service for children and adolescents (GIDS). Young people, with or without the support of their parents or guardians may have acquired puberty-suspending, or masculinising/feminising medication via alternative medical providers overseas, or from the Internet. The GIDS may provide medical care for these young people but only on an exclusive basis.**
- **The GIDS will, with the consent of the young person or parent/guardian, review and evaluate the records of any prior mental health assessments or treatments, liaising as necessary with any previous provider, to obtain the results of baseline examinations and laboratory tests.**
- **Where medication has been prescribed by an alternative provider, the GIDS will ensure that medication is not interrupted, but assessed for safety and drug interactions and substituted, when indicated, with safer medications or doses in line with any existing or new blood results from the GIDS' own endocrinology service.**
- **Where internet provision has occurred, the GIDS will adopt a harm reduction approach, by continuing medication, adjusting it if necessary following health checks and associated advice from its own endocrinology service.**
- **Young people and their families must be made aware of the risks, contraindications and any irreversible or partly reversible effects of any interventions that they have previously obtained.**

Page 27

Discharge Planning and Transfer

The GIDS does not provide effective smooth and timely discharge. There are examples of chaos. There are also reports of those who come into the service at 16+ having medication withheld on the basis that transfer will happen soon. This can be a period of agony for those in this situation, because the transfer is not rapid and the assessment starts over again. This should not happen. The Good Practice Guidelines (p20) recommend **“that the transfer between adolescent and adult services is**

achieved through liaison between these services so that treatments that have been initiated for adolescents may continue without interruption. Where treatment has not yet been undertaken, it may be started in a timely manner, taking account of the young person's clinical and social history".

Page 28

3.4.1 Referral Management

The Service Specification states: "Where the service identifies that the client is at significant risk, the communication from the service to the GP and local CAMHS will request that the young person is reviewed locally as soon as possible and an appropriate risk management plan put into place. *Referrals will not be accepted in cases when the identified risk is not being managed locally.*

This appears to ignore the ethical principle 'do no harm'. The Tavistock is deliberately leaving a young person who, for whatever reason, is unable to access local support – sometimes due to ignorance or prejudice or both, to flounder around without help or even hope of help from the Tavistock. This is exactly the kind of situation that drives young people to self-medicate, possibly involving risky behaviours in order to earn enough money to pay for Internet hormones. They will be further punished by the Tavistock for having the temerity to do this, but what else can you expect.

3.4.2 Age of Access

The delay in accessing hormones for those entering the service as a 17 y. o. seems unduly cumbersome. If the young person could be assessed as being ready for hormones (or hormone blockers) at least, they could enter adult services with a recommendation to treat. This would require a better system than currently occurs because adult clinics are imposing a second round of assessments. This is unnecessary

Page 30

3.4.5 Exclusion Criteria

The argument for excluding those with mental health disorders that are not controlled is rather strange:

Mental health disorder → no treatment → because giving treatment → might lead them to be unable to give consent

But the service is not giving them treatment anyway because they have a mental health disorder! This appears to be a circular argument

3.4.6 The criteria for prescribing cross-sex hormones

The list of criteria for cross-sex hormones has not been approved by the CRG for Adult Gender Identity Services and should not be used as a template for readiness for intervention with cross-sex hormones.

It must be made clear that a diagnosis of GD includes those who are non-binary or non-gender

“The client is engaged in or taking steps to secure ‘meaningful’(?) activity such as education or employment.” (does this mean in the affirmed gender role) because if so, this is a more stringent requirement than for adults. That would not be acceptable.

“The client is therapeutically engaged with the service.” (who decides whether the engagement is regarded as therapeutic?)

Support from parents or carers should not be required because this young person will be either Gillick competent, or, more likely, post 16 and competent.

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3.5 Exclusion Criteria

Aspects of these Exclusion Criteria are punitive; clinicians seem ready to knowingly inflict criteria which will do harm, and put young people at risk.

These criteria are not humane or ethical and could be at risk of legal challenge

If a Gillick competent young person has accessed GnRHa from a private source, but cannot continue to do so (money constraints), refusing to continue physiological treatment would inevitably cause harm. Either the treatment would come to an abrupt halt which would create a mental health crisis, which could lead to suicide (attempts) or the young person may embark on risky behaviours to earn money to continue hormones, if necessary, from the Internet.

It seems unlikely that a young person would access GnRHa earlier than Tanner 2, outside the Tavistock, but in view of the intransigence regarding the introduction of CSH on the basis of Gillick competence, it is quite likely that a number of young people will access CSH before 15.10y.

This 'our way or no way' approach seems unethical. It is at variance with medical oath to do no harm

An adult client who accesses treatment elsewhere would be able to switch to the NHS. Adults could have bridging prescriptions which GPs are able to provide, no matter where they had accessed hormones.

Page 32

The statement that NHSE and contracted suppliers will not be liable for any adverse effects where a client sources medication or treatments outside the NHS, may not hold water, if the service is aware of the young person's situation and has been asked for help to continue with GnRHa or CSH (using safer products if necessary) as is the case with the adult population.

No young person should be required to stop medicating until further assessments have been undertaken. This could take months. This no longer happens with adults.

3.7 Response Time

The triage process that we have proposed may indicate that for some clients a wait of 18 weeks is too long.

Page 41

13. Gillick/Fraser

Rather than '16 years or younger', change to 'Children or young people up to the age of 16'

Page 42

17 Natal sex (not gender)

The biological **sex**

Suggest - In those experiencing the discomfort of gender dysphoria, their gender identity is not congruent with the sex assigned at birth. A person assigned male may identify as a girl/woman, and vice versa, or somewhere else on the gender spectrum

Delete the rest of this entry because it's already covered at 9

Page 47

Ensuring that those working with children must wait for a full CRB disclosure...
(Question - should that be DBS?)

Page 50

Appendix 2 – has not yet been accepted and had not been seen by the CRG on March 2016. It seems unlikely that it would have been accepted in its present form

Page 54

It needs to make clear to GPs that they must take on prescribing for young people, in accordance with the GMC's requirements.

http://www.gmc-uk.org/guidance/ethical_guidance/28851.asp

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Assessment process after transfer should only require one appointment, because the Tavistock should have provided a full history etc. Nottingham should not require a third appointment, but the second appointment could include a family member IF the CLIENT WISHES, but NOT OTHERWISE

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A change of role is not necessary in order to access or continue to access CSH

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Appendix 6 Informed consent

Paragraph 3 does not make it clear that Gillick competence goes up to the 16th birthday. It is not people of 16 and under, is just people under 16. At 16 they must be assumed competent

This paragraph needs to be rewritten.

Appendix 7

Age 16 should be amended to “Meets readiness criteria”

Some evidence of presenting coherently with gender identity (this is not required of adults.

Some meaningful activity (this is very vague and, in any case, not required of adults)

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