Response ID ANON-6GAQ-ZA61-H

Submitted to **Gender Identity Services for Adults**
Submitted on **2017-09-09 15:49:09**

General overview

1 In what capacity are you responding?

In what capacity are you responding?:
Other

If you have selected 'Other', please specify::
On behalf of Transgender Trend, an organisation of parents of trans-identified children.

2 In what region are you based?

In what region are you based?:
England - South East

3 The proposed service specifications aim to address inconsistency in care quality, differing levels of access, and out-dated service models.

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for Non-Surgical services achieves this? - Principles (section 2.2):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for Non-Surgical services achieves this? - Duties on providers (section 2.3):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for Non-Surgical services achieves this? - Staffing, structure and governance (section 2.4):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for Non-Surgical services achieves this? - New referrals and transfers of care (sections 2.6 – 2.8):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for Non-Surgical services achieves this? - Assessment process (sections 2.9 – 2.10):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for Non-Surgical services achieves this? - Role of named professional and lead clinician (sections 2.11 – 2.12):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for Non-Surgical services achieves this? - Interventions that are delivered by the Gender Identity Clinic (section 2.17):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for Non-Surgical services achieves this? - Interventions that are delivered by other providers (section 2.18):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for Non-Surgical services achieves this? - Population covered and population needs (sections 3.1 – 3.2):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for Non-Surgical services achieves this? - Outcomes (section 4):
To some extent

Please provide comment in support of your answers:
2.2 If not a mental health condition, NHS England needs to specify what kind of condition gender dysphoria is: is it physical/biological? If the condition is not specified, how is a diagnosis made and appropriate treatment formulated?
2.3 Providers should have an obligation to young patients to research all viewpoints on 'gender,' including ones which fundamentally disagree with the belief that your 'gender identity' is what makes you a boy or a girl and not your biological sex. Young people should not be denied access to knowledge and left vulnerable to the influence of only one political lobby group. Are young people told, for example, that it is impossible to actually change sex, or that the 'born in the wrong body' idea has no medical or scientific basis? Providers need to be knowledgeable about issues such as social contagion, rates of desistance, cross-sex identity as a predictor of future gay/lesbian sexual orientation, and the unprecedented sudden-onset gender dysphoria affecting predominantly teenage girls (for which there is no known etiology or explanation).
2.4 As above; further, 'professional development' should not be delivered by non-medical political lobbying groups such as GIRES who promote sexist and discredited 'pink and blue brain' theories and the idea that young people can be 'trapped in the wrong body' as literal fact. Professional training needs to include input from professionals in child/adolescent psychology and development. Speech and Language therapy needs to be routine in the assessment of all young people's ability to really understand the words they are using and the ideas about themselves which may have been learned from social media. ASD young people in particular need expert assessment.
2.5 The NHS care pathway for young people should involve more therapeutic support; medical intervention should not be an established first-choice pathway. Support for underlying co-morbidities needs to be prioritised: past trauma, family dynamics, a troubled background, a history of mental health issues and depression, all need to be explored therapeutically. It is not ethical to simply agree with a child/young person's self-diagnosis without exploration of the issues which may have led to it, especially when effects of treatment are irreversible, long-term effects are unknown, and sterilisation is likely. Sterilisation is a human rights violation and is therefore only acceptable as a side-effect of life-saving treatment. Young people are being influenced by transgender organisations to believe that their choice is transition or suicide: this message is wholly irresponsible; however, NHS representatives themselves have repeated the mantra "to do nothing is not a safe option" on TV. This non evidence-based idea needs to be challenged, not reinforced. The options should not only be either 'do nothing' or 'set a young person on a medical intervention pathway for life.'
2.6 -2.8 Children should not be referred to adult services at age 16. 'Adult' means 18+ The brain is not fully developed until the mid-twenties. Until then, the brain is primed for risk-taking and instant reward-seeking; the ability to weigh up future consequences or make considered decisions is not yet fully developed. Teenagers (especially girls) are vulnerable to online grooming and indoctrination, and susceptible to strongly-held passions about social justice causes. Teenagers are also exploring their identities and fiercely defend those they adopt, believing they will last forever. Vulnerable young people are seeking acceptance within a 'tribe' which trans support groups provide. Children cannot make fully-informed decisions about treatment when the professionals themselves have no idea of the long-term effects. Young people need dedicated services staffed by professionals who understand child and teenage psychology and development.
2.9 - 2.10 As above, the same level of assessment needs to be applied in the case of older teens newly entering the service.
2.11 - 2.12 It is suggested in Appendix G that less frequent contact with a Named Professional may be adequate for an individual who is "less distressed by dysphoria" but is waiting for completion of "multi-stage surgical intervention." If a young person is not suffering serious distress, why are they on a surgical, irreversible pathway? What are the alternatives offered to young people to help them manage their dysphoria other than extreme physical intervention?
2.17 The statement on 'conversion therapy' is incoherent and open to misinterpretation. It leaves counsellors and therapists in a position where they may be afraid to do anything except 'affirm' a young person's gender identity, as any deeper exploration of issues may lay them open to the charge of 'conversion therapy.' This is already happening, parents report that they cannot find a therapist who will support their child to explore their feelings, but will just accept the child's word at face value. 'Affirmation' of a young person's gender identity is not a neutral position, it is one which presupposes that the young person's feelings about themselves are correct and immutable. It is not the job of a therapist to just agree with the client. When a person has a self-identity which contradicts physical reality therapists should not be obliged to simply reinforce the person's beliefs, which in the case of young people especially, are subject to change. Therapists should not operate as facilitators of an ideology, but provide a neutral safe space to support individuals to come to a deeper self-understanding.
2.18 It is unethical to remove any healthy organs of 17 year-olds, particularly when this will result in sterility. NHS England needs to explain the rationale for performing such life-changing irreversible surgery on teenagers in the absence of long-term evidence that it is effective in alleviating gender dysphoria, and without full prior use of non-invasive methods such as counselling and therapeutic support. There is no indication here that NHS England has considered any other reasons for a cross-sex identity other than that the young person is 'trans' and in the absence of that acknowledgment, the number of young people who subsequently regret their medical transition and feel that their lives are ruined, will inevitably increase.
3.1 NHS England suggests here that 'gender dysphoria' can result from a mismatch between 'gender identity' and 'visible sex characteristics' suggesting that the physical body (male or female) must match an internal abstract sense of 'gender' (masculine or feminine). "The social role typically associated with those characteristics" is an accurate definition of the word 'gender' - should the NHS be facilitating the idea that young people need to physically alter their bodies to cosmetically appear to be the opposite sex in order to escape social gender roles they reject? In reality we are all 'non-binary' in terms of gender (nobody is 100% 'feminine' or 100% 'masculine' according to society's definition of those words). NHS England recognises the unprecedented increase in referral numbers but fails to acknowledge the possibility of social contagion nor the fact that children are being taught in schools that it's their 'identity' which makes them a boy or a girl and not their biological sex. It is worrying that NHS England seems to have accepted this idea without question when healthcare depends on a knowledge of a person's biological sex, even for transgender people.

4 The proposed service specifications aim to address inconsistency in care quality, differing levels of access, and out-dated service models.

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for surgical services achieves this? - Principles (section 2.2):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for surgical services achieves this? - Duties on providers (section 2.3):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for surgical services achieves this? - Staffing, structure and governance (section 2.4 & 2.8):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for surgical services achieves this? - Referral for surgical intervention (section 2.6):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for surgical services achieves this? - Role of the specialist surgeon and surgical team (section 2.7):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for surgical services achieves this? - Assessment process (sections 2.9 – 2.10):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for surgical services achieves this? - Patient dissatisfaction with technical outcome of surgery; and discharge arrangements (section 2.17 & 2.19):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for surgical services achieves this? - Population covered and population needs (sections 3.1 – 3.2):
To some extent

The proposed service specifications aim to address inconsistent clinical protocols, inequitable access arrangements and out-dated approaches to service delivery. To what extent to you think these sections of the specification for surgical services achieves this? - Outcomes (section 4):
To some extent

Please provide comment in support of your answers:
Broadly the same points as for non-surgical interventions. Specifically, it is worrying to see the NHS use the term 'birth-assigned sex' in 2.1. Biological sex is not 'assigned' but observed and noted. The implication here is that someone arbitrarily decides your sex for you, which is false. Those who identify as 'transsexual' may not be happy to hear from the NHS that this is no longer a preferable term.
'Gender dysphoria' is defined as "a cognitive symptom characterised by persistent concerns, uncertainties, and questions about gender identity" so it is unclear why the condition does not fall under the category of mental health, and no routine mental health support is offered.
2.3. The NHS needs to monitor rates of regret and detransition, through both logging the number of complaints through the NHS England website and through long-term follow-up, as regret typically begins after a honeymoon period which could last a decade or more. Without this information NHS cannot provide an evidence base for the use of medical intervention.

Referrals to gender identity clinics

5 It is proposed that in the future all young people who need to access a specialist gender identity service and who are aged 17 years and above will be referred to an adult Gender Identity Clinic. To what extent do you support or oppose this proposal?

Strongly oppose

6 It is proposed that in the future the specialist Gender Identity Clinics for Adults will not accept referrals of individuals who are not registered with a General Practitioner (GP). To what extent do you support or oppose this proposal?

Strongly Support

7 Please provide comment in support of your answers

Please provide comment in support of your answers:
It is unethical to take this much unnecessary risk with young people's healthy bodies at an age when they can have no idea of what it means to be on a lifetime regime of medication, nor the potential complications, side-effects and impact on health and their lives. This is not minor surgery. Seventeen is way too young to be sure that this is necessary and the right thing to do. There is no consensus even within the trans community itself that this is a good idea, some older trans people are horrified by this medical treatment of children and teenagers. NHS England needs to listen to all viewpoints. Parents are seeing their children go off to University, get involved with the LGBT society and become 'trans,' along with a deterioration in their mental health. This is having a devastating impact on families. It should not be facilitated by the NHS.

Referrals for genital reassignment interventions

8 It is proposed that in the future only a designated specialist Gender Identity Clinic for Adults can refer an individual for specialised genital reassignment surgery (for the purpose of alleviating gender dysphoria). To what extent do you support or oppose this proposal?

Tend to support

9 It is proposed that in the future a decision to refer an individual for specialist genital reassignment surgery must be supported by a Registered Medical Practitioner. To what extent do you support or oppose this proposal?

Strongly Support

10 Please provide comment in support of your answers

Please provide comment in support of your answers:
8. On the proviso that Gender Identity Clinics are cautious, aware of all the social factors encouraging young people into a 'trans' identity, are not unduly influenced by political trans activism or trained by transgender activist organisations, and provide the same duty of care which would be expected for any other individual young person whose belief is causing them distress.
9. If the NHS is funding genital reconstruction surgery, of course the referral must be supported by a Registered Medical Practitioner.

Equalities and health inequalities

11 We want to make sure we understand how different people will be affected by our proposals so that Gender Identity Services are appropriate and accessible to all and meet different people's needs. We have assessed the equality and health inequality impacts of these proposals. Do you think our assessment is accurate?

No

12 Please describe any other equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?

Please describe any other equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?:
The lesbian community is the most affected as more and more young lesbian women are identifying as 'straight' guys. NHS England needs to be more aware of the cultural pressures on young women, in particular lesbian women, and do more to understand the cultural context within which unprecedented numbers of young women are 'transitioning.'

Performing double mastectomies on girls before they reach adulthood without asking questions about why so many girls hate their female bodies so much is a failure of duty of care towards this group. This could be viewed as indirect discrimination towards both lesbians and women - not because they are denied access to services, but because they are too readily believed to be 'trans,' which is contributing to the erasure of lesbians and fails to consider societal lesbophobia and misogyny which can be internalised by young women and provide motivation to 'become straight' or escape womanhood. Unless 'lesbians' and 'women' are monitored as distinct groups which do not include males, indirect discrimination is inevitable.

Prescribing arrangements

13 We have identified four potential options for prescribing arrangements for hormone treatment and described the positive and negative factors for each. Which of these options for future prescribing arrangements do you prefer?

A: The patient's own general practice remains responsible for prescribing on the recommendation of a Gender Identity Clinic (current arrangements).

14 Please describe any other options for prescribing arrangements for hormone treatment that should be considered?

Please describe any other options for prescribing arrangements for hormone treatment that should be considered?:
This is difficult. NHS England mentions several times the small but increasing group of GPs unwilling to prescribe off-label hormones to young people. This is understandable given that the treatment is untested and the long-term results are unknown. GPs may also feel it is unethical to facilitate the young person's belief that they really are the opposite sex, or can be made into the opposite sex, when this is impossible. 'GPs with a special interest in gender dysphoria' obviously means GPs who are willing to prescribe cross-sex hormones to young people. In no other area is the NHS obliged to provide specialist GPs for the reason that other doctors are unwilling to prescribe for ethical reasons. This is a telling fact.

General comments

15 Do you have any other comments about the proposals?

Do you have any other comments about the proposals?:
The NHS seems to have adopted a political ideology judging by some of the language used in this consultation. To treat young people with 'incongruence between their identity and their body and social role' by surgically altering their healthy bodies to 'fit' their identity and social role suggests that identities and social roles are the fixed realities which biological sex needs to be adapted to fit. 'Sex' is hardly mentioned in fact, as if it has no relevance to whether one is a man or a woman, even though the surgical alteration of sex characteristics is deemed necessary.

There seems to be an assumption that mental health issues/problems are secondary to 'gender dysphoria' or even caused by it, but no acknowledgment that it may be the other way round. How can the NHS categorically state that gender dysphoria is not a mental health issue when body dysmorphic disorder is? This serves to deny patients access to mental health care which may uncover the root cause of their dysphoria and may be sufficient in managing or easing it.

The NHS defines 'gender dysphoria' only 'as a consequence of gender incongruence' but fails to consider that it may be a consequence of underlying mental

health issues and vulnerability to social contagion. The 'higher risk of physical and mental health problems' is not considered as a cause of dysphoria, but as a consequence of not being able to access specialist gender identity services.

It is, however, acknowledged that these health problems may be an 'unintended consequence of medical interventions' which should indicate the need for caution, but the medical transition pathway is presented as the only option for the management of gender dysphoria. 'Psychological interventions' are offered only for 'specific psychological needs' as distinct from the dysphoria. 'Transition' seems to be the inevitable and only solution, and medicalisation a 'need.' 'Gender incongruence' or non-conformity is not, in itself, a problem to be fixed. Surgery to 'change sex' is an extreme 'solution' to the problem of living in a society which does not accept difference.

With no monitoring, we do not know the numbers of young people who regret medical transition, but judging from social media accounts, support forums and organisation online, this is a growing community. Without mandatory psychotherapeutic support, clinicians have no way of separating out those young people who may have been able to manage their dysphoria without the irreversible medical intervention they later come to regret.

The NHS has a duty to serve the whole community, not just one segment. A one-size-fits-all medical pathway fails young people who are troubled, confused, vulnerable, don't 'fit in' and are susceptible to the influence of a powerful trans activist lobby within youth culture, but will grow up to realise they are not 'trans.' There needs to be more awareness of this possibility within NHS gender identity services, which is not apparent in this consultation document.

About you

16 Which age group are you?

Which age group are you?:
50 - 64

17 Which of the following options best describes how you think of yourself?

Which of the following options best describes how you think of yourself?:
In another way

18 Do you consider yourself to have a disability?

Do you consider yourself to have a disability?:
No

19 Please select what you consider your ethnic origin to be. Ethnicity is distinct from nationality.

Please select what you consider your ethnic origin to be. Ethnicity is distinct from nationality.:
Welsh/English/Scottish/Northern Irish/British

20 Please indicate your religion or belief

Please indicate your religion or belief:
No religion

21 Please indicate the option which best describes your sexual orientation

Please indicate the option which best describes your sexual orientation:
Heterosexual