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NHS England consultation on the future of adult GIDS

Question 3.

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

To what extent do you think these sections of the specification for **Non-Surgical services** achieve this? **(Fully / To some extent / Not at all)**

Principles (section 2.2) - Not at all

This is because we disagree that gender dysphoria is 'not a mental health problem'. It clearly is. There exists over a century of psychiatric literature on the subject in different languages, and it is irresponsible to ignore the wisdom accumulated therein. Consistency in care quality requires that the NHS formally recognises gender dysphoria as a mental health problem rather than pretending that it isn't.

Duties on providers (section 2.3) - To some extent

We agree with the need to provide a service that meets the needs of the population. The question is how to evaluate what those needs are. In addition, taking in the views of individuals should require taking in the views of people who regret prior gender reassignment surgery and/or cross-sex hormone treatment and any other physical gender reassignment treatment, and who wish to reverse the effects so far as is possible. Currently the NHS does not offer such treatment on a regular basis. We call on the NHS to make concrete plans for this to happen as soon as possible and to train doctors especially for this field.

We are suspicious of the idea that providers will 'work with specialised services for adolescents' to ensure a transfer to adult services. The NHS needs to state openly how much critical input from and dialogue with mainstream psychiatry and psychology there is in the case of older adolescents. We do not think this duty can be met until and unless the GIDS for children and adolescents at the Tavistock and Portman NHS Trust publish the database that they are currently building of evidence regarding young people who have detransitioned or chosen not to go forward with gender reassignment.

We want to know exactly which ‘other expert centres’ the NHS has in mind at national and international levels. Why does the NHS feel the need to have close links with centres outside of the UK?

We certainly agree that awareness of best practice in diagnosis of gender dysphoria should be increased. However, the problem seems to be over-enthusiasm in diagnosing people with gender dysphoria. NHS England should move to the treatment protocol that has been used by NHS Wales since 2006, whereby all patients who consider themselves to be suffering from gender dysphoria in any way must be referred by their GP to the local psychiatric team at the local NHS board or trust first. The psychiatric team then should be required to make formal diagnostic assessments of the patient to see if they have any pre-existing but unknown psychiatric conditions which could be the root cause of delusions or fantasies of belonging or wishing to belong to the opposite sex/gender, or which could form part of the conditions that have proven to be fertile soil for these to develop.

The repeated use of the term ‘trans people’ in relation to health needs in this document is problematic as it presupposes that everybody presenting themselves with any gender incongruence or gender dysphoria to the NHS considers themselves to be ‘trans’ or ‘transgender’. This would not necessarily be the case.

We believe that the NHS should collaborate in research projects to increase the evidence base for understanding people who desist from the path of gender reassignment, whose gender incongruence and/or gender dysphoria wanes or fluctuates, and those who after undergoing sexual transformation surgery come to question or regret that decision and who wish to return to living as members of their sex.

The NHS should start to publicise national and local organisations which provide a more critical perspective on gender identity issues. These have started to spring up as families and individuals have become alarmed at the uncritical acceptance of self-identification as transgender has increased massively in recent years. The NHS should no longer uncritically publicise pro-transgender organisations that seek to provide support for families of people with gender dysphoria, as these organisations have tended to manipulate families into accepting gender reassignment with all the drastic and often traumatic disruption to family and kinship relationships that this has entailed.

Staffing, structure and governance (section 2.4) - Disagree

All nominated Senior Clinical Leads should be required to have significant experience in general psychiatry and to have worked in settings other than Gender Clinics. We also want to see the NHS recruit forensic psychiatrists to this role given their expertise in the most demanding conditions which are frequently indicated as co-morbid with gender dysphoria and gender identity disorders.

The NHS should make arrangements including training to ensure that all staff have psychological sensitivity towards people suffering from gender dysphoria, towards those who consider this to be possible but who do not receive a diagnosis, and towards those who regret transitioning. The stigma needs to be removed from detransitioning.

New referrals and transfers of care (sections 2.6-2.8) – Disagree entirely

As stated above in our response to 2.3, NHS England should move to the treatment protocol that has been used by NHS Wales since 2006, whereby all patients who consider themselves to be suffering from gender dysphoria in any way must be referred by their GP to the local psychiatric team at the local NHS board or trust first. The psychiatric team then should be required to make formal diagnostic assessments of the patient to see if they have any pre-existing but unknown psychiatric conditions which could be the root cause of delusions or fantasies of belonging or wishing to belong to the opposite sex/gender, or which could form part of the conditions that have proven to be fertile soil for these to develop. We agree entirely that self-referrals should not be allowed.

We disagree entirely with the view that a young person may be transferred at the age of 17 to adult services. This would constitute a slippery slope towards lowering the age for surgery. We note that the Gender Recognition Act requires patients be aged 18 or over to undergo surgery. Adolescents' brains are still developing at this age. Also in the teenage years young people are very prone to make rash decisions based on feelings and mood which they may later regret bitterly.

Assessment process (sections 2.9-2.10)

Instead of paragraph 2.9 we propose as already outlined that all individuals who initially present themselves to their GP claiming to suffer from gender dysphoria be referred to the local psychiatric team. We do not consider it appropriate that NHS England proposes to continue the current pathway whereby patients bypass psychiatric diagnosis initially and are first assessed by Gender Identity Clinics. Having compared data for England and Wales, we can see that the current pathway in England has led to over diagnosis of gender dysphoria and gender identity disorders. The question arises as to whether some of these were not in fact misdiagnoses. We say this because Hospital Episode Statistics for NHS England have shown for many years a large number of secondary diagnoses of gender identity disorders. We wonder whether this is due to the deliberate bypassing of psychiatric assessment at the initial stage.

Role of named professional and lead clinician (sections 2.11-2.12) - To some extent

Our agreement with this is conditional upon our stipulation made above in response to Section 2.4.

We are not impressed with the fact that the consultation does not allow disagreement with 2.15 on loss of fertility. We are also unimpressed with section 2.16 which gives away the view that gender dysphoria is an identity not a mental illness, when it is stated that 'personal goals for treatment may evolve as the individual gains more information and new experiences.' The experiences of patients in the grip of sexual and other fantasies and delusions should never be a guide or authority for healthcare.

Interventions that are delivered by the Gender Identity Clinic (section 2.17) - To some extent

With regard to Voice and Communication Therapy, we would like to see the NHS assess whether it would be suitable to offer such therapy for detransitioners. This is because people who have

undergone gender reassignment have done so often due to a sense of severe alienation from others of the same sex, which may have been caused in numerous instances by poor parental role-modelling and poor relationships with peers in childhood and adolescence. Given its extreme sensitivity, such assessment should be conducted in full co-operation with patients and any psychotherapists that they may be visiting as clients. We wish to emphasise that any such therapy should only be brought up after a patient feels comfortable handling more existential psychological issues regarding their gender reassignment.

We would have expected the consultation document to have referred to a publication already available rather than to guidelines which are yet to be published (footnote 2).

It is rather concerning that the Non-Surgical Template says that psychological interventions will not be offered routinely or considered mandatory. We wish psychological therapies to be made available to all who have been referred to Gender Identity Services given that gender dysphoria is a mental health problem as well as a psychological problem in the broader sense. We also call on the NHS to make available psychological therapeutic treatment for all who question or regret their gender reassignment, as this appears not to be available currently. We wish to remind the NHS that a few years ago, the then head of GIDS at Charing Cross Gender Identity Clinic admitted in response to a Freedom of Information Request that the Clinic was aware of a large number of detransitioners, as was the clinic at Nottingham. It is past time for NHS England to address this issue in a consistent and professional manner.

What the NHS disparagingly calls ‘conversion therapy’ is neither illegal in the United Kingdom nor harmful. The assumption that all gender identities are equal is ridiculous nonsense, constituting a capitulation to the vacuous idea that there can be more than two genders and that ‘gender identity’ is a type of experience or self-image or set of behaviours totally divorceable from the sexed body. The implied definition also capitulates to a notion of the absolute right to self-expression which is completely at odds with conventional medical ethics and with the actual needs of mentally disordered individuals. It is especially inappropriate in the case of people diagnosed with gender dysphoria or other gender identity disorders as some are known to have dangerous paraphilias.

In any case for the NHS to prohibit any delivery, promotion or referral of individuals to any therapeutic treatment regarded as ‘conversion therapy’ would fly against the actual experience of many individuals who have moved from identification with their own sex (albeit an unhappy one) to coming to consider themselves to be transgender, often due to the power of suggestion. It is clear that the NHS has nothing at all negative to say about change of ‘gender identity’ away from one’s sex towards a transgender identity.

NHS England should realise that the evidence published by ILGA in its global survey of attitudes towards LGBTI in October 2016 is that the vast majority of people in Britain do not believe that transgender people are ‘born that way’. A very large proportion of the population believes that people either became so or chose to be so. A careful reading of accounts by people who have been patients at gender identity clinics will show that a number of them have also held these views. Banning all possibility of therapy that would have the outcome of a change in gender identity would go against the free speech and self-determination of such patients and especially of those who desist from gender identity problems, who regret their gender reassignment and who detransition. The NHS would be failing in its duty of care towards such people by acting in such a restrictive and rigid manner.

Local GPs should not be required to prescribe and administer hormone treatment. Many GPs would have conscientious and scientific objections to this for very good clinical and ethical reasons. NHS England should not put pressure on GPs in this manner.

Interventions that are delivered by other providers (section 2.18) – Disagree entirely

We disagree entirely with the view that mastectomy, 'creation of a male chest' and genital surgery should be available for patients aged 17. The Gender Recognition Act clearly stipulates that only patients aged 18 or over are to be permitted to undergo surgery. Parliament would need to debate whether or not to change the law first. NHS England is acting outside the law in jumping ahead here.

Population covered and population needs (sections 3.1-3.2)

We strongly disagree with the proposal that the Provider will receive referrals of individuals aged 17 for all the reasons already stated. We note that the various 'gender identities' named in this section are not codified in law and as such there is no legal requirement to pandering to them.

We agree entirely with the exclusion of individuals with acute physical or mental health problems. This should screen out a large number of patients. However as stated above the best way to do this would be to change NHS England treatment protocols to be like those of NHS Wales. We also agree entirely that individuals who self-refer or who are not registered with a GP should be excluded.

We do not think it appropriate for this consultation to be dealing with individuals presenting with 'intersex' conditions as this blurs the boundaries between two different issues. We are very suspicious of the exclusion of individuals with Disorders of Sexual Development as this seems to be a covert move towards treating them as a 'third gender' and to deny the fact that in the vast majority of cases, as existing data from the NHS shows, these people belong genetically to one sex or the other.

We find unhelpful the manner in which the Non-Surgical Template slides around different term, from 'gender incongruence' to 'gender dysphoria' to 'gender variance'. We find it rather revealing that the Template admits variations in data quality and consistency regarding prevalence. However, it is very difficult to make any sense of this given the sudden use of 'gender variance', not a clinical term found in the ICD-10 or any editions of the DSM, unlike 'gender dysphoria'. Regarding prevalence, it would seem more prudent to give as the upper limit to the estimated number of people self-identifying as transgender in any way the total number of people ever referred to Gender Identity Clinics in England since John Randell was appointed at Charing Cross in 1950. If the percentage of the English population who were 'gender variant' (arguably a covert way of saying they suffered from gender incongruence and/or gender dysphoria) were as high as 1%, this would mean there were hundreds of thousands of transgender people in England. This is completely implausible. The total number of referrals to Gender Clinics over the last 67 years is much lower than that. In any case available information on referrals suggests that a large number of these have not been given a diagnosis of any kind of gender identity disorder.

It is unhelpful that the Template should have cited an unpublished literature review by Public Health England regarding prevalence. Public Health England should have been required to publish this review before this consultation was opened so that it could be used by respondents.

The Template says that the number of referrals to adult GIDS in England has increased since 2011 and suggests reasons. At no point does it admit that the power of suggestion could be at work, and that the dramatic rise in referrals could be due to social contagion and hysteria. Historic psychiatric literature going back nearly seventy years acknowledges that this has happened several times, notably beginning with the publicity surrounding Christine Jorgensen, and most recently with the global mass media attention given to Bruce/Caitlyn Jenner.

Outcomes (section 4)

We want NHS England, and the NHS in Wales, Scotland and Northern Ireland, to start recording and publishing annual statistics for the number of people who detransition following initial gender reassignment. We believe there are some indications of this already in the Hospital Episode Statistics. However, as the definition of 'sex' in these statistics has been redefined to be phenotypical as far as transgender people are concerned, they are a mess and clearly prone to serious error. We also therefore call on the NHS to correct all errors in Hospital Episode Statistics regarding diagnosis statistics, Finished Consultant Episodes and Admissions, by getting rid of the phenotypical definition of sex and sticking to the genotypic definition of sex. There is no need for the phenotypical definition given that the verbal descriptions given for sexual transformation surgery specify whether they are male-to-female or female-to-male.

We agree that Clinical Outcomes should include the percentage of referrals received where the diagnosis does not have gender dysphoria. However, this still assumes that the patient experiences gender incongruence. We wish to see figures published for patients who are subsequently not deemed to experience gender incongruence either.

Question 4.

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

To what extent do you think these sections of the specification for Surgical services achieve this?

'Disagree entirely' with all these because we do not agree with gender reassignment surgery as treatment for gender dysphoria (transsexualism).

Principles (section 2.2)

Duties on providers (section 2.3)

Staffing, structure and governance (section 2.4)

Referral for surgical intervention (section 2.6)

Only for detransitioners

Role of specialist surgeon and surgical team (section 2.7)

Assessment process (sections 2.9-2.10)

Patient dissatisfaction with technical outcome of surgery; and discharge arrangements (sections 2.17 & 2.19)

Population covered and population needs (sections 3.1-3.2)

Outcomes (section 4)

Question 5.

It is proposed that in 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

Question 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.

Question 7.

Please provide comment in support of your answers

The Gender Recognition Act stipulates that individuals should be 18 or over to be considered for gender reassignment. As the government consultation on changing the Gender Recognition Act has not yet opened, and as there has been no debate or vote in Parliament on the matter, it is inappropriate for NHS England to jump ahead of the law in this respect. Seventeen-year-olds are not adults. They are too prone to make decisions based on changeable feelings and obsessions. Permitting referral of seventeen-year-olds to adult GIDS would create major social and legal problems for schools and families, as teenagers who would not yet be legally adults would be allowed to make drastic, high risk life changing decisions. This would inevitably result in more social contagion and encourage susceptible younger teenagers who look up to older teens to consider self-identification as transgender as the answer to their problems.

Question 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 oppose

Question 10.

Please provide comment in support of your answers

With regard to question 9, we wish to see the current requirement for two medical opinions to remain as surgeons are neither trained nor qualified to handle psychological matters of the profundity presented by patients with gender dysphoria.

With regard to genital surgery to reverse gender reassignment, patients should gain not only medical opinions but also professional psychological help.

Question 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 health needs. We have assessed the equality and health inequality impacts of these proposals. Do you think our assessment is accurate?

No.

Question 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?

The Equality Impact Assessment neglects some very basic problems.

The proposal to allow 17-year olds to undergo gender reassignment goes against the needs of young people to develop as members of their sex at a particular age. Following these proposals could lead the NHS open to litigation on grounds of sex and age discrimination.

We strongly agree that people with acute physical and mental health problems should not be referred for gender reassignment. However, we wish the NHS to cease to refer all patients who have been diagnosed with any kind of psychiatric problem for gender reassignment.

We do not believe that people with learning disabilities or communication difficulties should be referred for gender reassignment. Their difficulties may only be exacerbated as inevitably they would find it extremely difficult to play the part of a member of their chosen gender, and would also find it very difficult to communicate doubts or regret about gender reassignment. As such we are rather suspicious of the fact that this group of people have not been excluded from gender reassignment.

The paragraph on people with HIV is unclear, though it seems that this is one of the groups most favoured for gender reassignment. NHS England needs to explain to the public why this is, especially given that PrEP is currently supposed to be trialled on male-to-female transgenders who have sex with men in England, Scotland and Wales. We note that correspondence by staff from Charing Cross Hospital Gender Identity Clinic in the British Medical Journal in 1987 alluded to the fact that all patients were screened at the time for HIV and Hepatitis-B, but that they only indicated that 'since 1984 no carriers of Hepatitis-B have undergone gender reassignment surgery'. [BMJ 295, 1987, 17 October 1987, p. 997.] No such reassurances were given about patients who were HIV positive. We call on NHS England to publish all information as to the HIV status of patients who have passed through Gender Clinics in England since 1982.

The paragraph on individuals who misuse substances is unclear. In any case individuals who abuse illegal drugs and alcohol should not undergo gender reassignment. Their addictions will not go away as a result of gender reassignment. Cross-sex hormones will also not deal properly with the dissociation from which drug users may suffer.

NHS England should routinely commission reversal of previous gender reassignment surgery, and should co-operate with the NHS in Wales, Scotland and Northern Ireland in this respect. NHS England should not only offer such surgery and related physiological treatment, it should publicise it through all the normal channels of communication, train surgeons in the field, commission independent research that can be reviewed by medical experts from outside the world of gender identity clinics, and keep and publish annual statistics on the matter.

The Equality Impact Assessment assumes wrongly that the religious demographic profile of people accessing GIDS should be the same as for the last Census. Yet in reality available evidence as cited by the consultation document as well as other evidence suggests that the self-identified transgender population is mostly non-religious. This would partly be due to this population being younger than the average of the UK population. Nevertheless, there is reason to believe that even after controlling for factors such as age, there are philosophical and social reasons for the underrepresentation of people affiliated to most of the major world religions (with the exception of Buddhism) among patients who present themselves to Gender Identity Clinics and/or who identify themselves as transgender. The concept of 'gender identity' is in reality a belief, not a fact. Christianity and other major world religions already have a belief about the non-physical part of the individual person, the soul (or the mind), which is that it is not in itself 'gendered'. This is of necessity as it is incorporeal. Holding to this belief and acting upon it is probably a buffer against gender incongruence spiralling out of control and developing into fully-blown gender dysphoria.

It is possible to show from a recent survey conducted by the polling company Survation in 2016 that the population of the UK is divided as to what gender actually means. In general, older adults are more likely to see gender as meaning 'sex', and thus as binary. Younger adults were more open to the notion that gender can be a range of identities. This means that younger adults distinguish gender identity from biological sex. The discrepancy between these two findings

implies that statements about gender or gender identity can reasonably be considered statements of belief, not fact.

The Equality Impact Assessment statement that there are no equality impacts upon ‘people’ regarding pregnancy and maternity is completely unacceptable as it falsely implies that pregnant women and mothers, all of whom necessarily belong to the female sex, are merely ‘pregnant people’, which is dishonest, and opens the door to the false notion of ‘pregnant men’. NHS England should cease to use such ‘gender-neutral language’. Instead NHS England should return to record all data regarding pregnancy among females who have undergone any degree of gender reassignment according to genotypic sex, for the sake of data quality and data consistency.

Question 14.

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

The NHS should cease to prescribe cross-sex hormones and instead concentrate upon treating patients’ psychiatric and psychological problems in order to enable them to overcome the body and sex dysphoria that often underlies gender dysphoria.

Question 15.

Do you have any other comments about the proposals?

We are glad that NHS England is consulting on the future of adult Gender Identity Services. However, at this point in time the NHS is under severe strain financially and it is simply not possible to continue to justify payment for gender reassignment surgery unless this is reverse surgery. Gender reassignment is not only not clinically necessary, it has been shown to be harmful, e.g. in the case of male-to-female gender reassignment, the risk of Multiple Sclerosis is now known to increase more than six-fold. For female-to-male patients risks of cardiac problems increase, and testosterone of course makes females more aggressive.

NHS England should exclude from gender reassignment all patients who have a criminal record, especially for sexual offences, including offences against minors and possession of child pornography, and violence against the person. It is completely unacceptable that men who have been convicted of rape, sexual assault and abuse against women and girls are then allowed to transition to live legally as ‘women’ and treated on the NHS at taxpayers’ expense. There is evidence that men who are paedophiles and men who ‘identify’ as girls seek out and undergo gender reassignment, and this in order to get too close to girls. NHS England needs to take a clear stance in principle and in practice against all of this, otherwise its reputation will suffer.