UK — Independent Review of Medical Care of Gender-Confused Youth: Interim Protocols and Results

In 2023, on the basis of the UK's National Health Service Cass Review, the only pediatric gender clinic in the UK, Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (Tavistock), will shut down. It will be replaced with regional hospital-based services. This change resulted from a number of whistle-blowers within the Tavistock who noted that it hid negative outcomes from puberty blockers and complaints that the children were being fast-tracked to transition without exploratory therapy.

The UK's National Health Service released its interim service specifications for specialist gender dysphoria services for children and young people on October 20, 2022:

THE NHS REJECTS THE AMERICAN "GENDER AFFIRMING CARE MODEL"

- Instead of affirming a minor's gender identity as valid, the medical providers MUST perform an in-depth comprehensive mental health assessment led by a broad team of medical experts which must include pediatric, autism, neurodiversity and mental health experts. This is to ensure that the child's complex mental health presentations are addressed.
- The comorbid mental health issues will be the primary focus of the treatment.
- The whole child must be fully assessed, not just the gender incongruence. Causality of gender ideation will be explored.
- Schools, colleges, health and social services staff and non-profits/advocacy groups will no longer be able to refer minors to the GIDS, thus removing some of the ideological basis for referrals.
- Only minors that are referred to the GIDS have the possibility of being medicalized, and not all minors with gender ideation will be referred.

THE NHS RECOGNIZES GENDER DYSPHORIA AND REJECTS WPATH'S "GENDER INCONGRUENCE"

- A "gender dysphoria" diagnosis requires significant distress or functional impairments. "Gender Incongruence" requires only for a person to desire the physical attributes of their internal gender belief.

THE NHS REJECTS SOCIAL TRANSITION OF PREPUBERTAL CHILDREN

- In recognition of social transition as a medical intervention and the possible significant adverse effect of social transition on a child's psychological functioning, the NHS strongly discourages social transition in prepubertal children, and under the rare instances that it is recommended, only in conjunction with an explicit informed consent process.
- The NHS notes that in most cases, gender incongruence/dysphoria resolves with puberty.
- Only where there is "clinically significant distress or significant impairment in social functioning and the young person is able to fully comprehend the implications of affirming a social transition" should social transition occur.

THE NHS ADVOCATES FOR PSYCHOTHERAPY AND PSYCHOEDUCATION AS THE PRIMARY TREATMENT FOR GENDER-CONFUSED MINORS

- Puberty blockers will only be prescribed in a research setting.
- Data will be collected into adulthood.

THE NHS STRONGLY DISCOURAGES PARENTS FROM SEEKING BLACK-MARKET HORMONES

- The NHS will not treat any such patients on hormones obtained outside of the GIDS.
- Those parents permitting the use of illicit hormones will be investigated.

Some of the more salient bases for the new protocols:

- In 2009, there were 50 youth referred; this jumped to 2,500 with 4,600 on the waitlist in 2020. (Section 3.10 of Cass Review)
- During the wait time — typically a delay of 2 years or more, the child's gender identity can become more fixed making psychotherapy more difficult. (Ibid., at section 4.36)
- The reversal of the historic sex ratio of predominately males with gender dysphoria to females is notable, with females presenting with later onset of dysphoria. (Ibid., at section 3.11)
- Children who are in "foster care" are overrepresented. (Ibid.)
- **One-third of children/youth have autism or other types of neurodiversity. (Ibid.)**
- **Over-emphasis on transition is problematic, considering the poor quality evidence of efficacy and safety of Affirmative Care treatments. (Ibid., at section 3.21)**
- **Certainty of stable gender identity is difficult to predict since identity can remain fluid into the mid-20s. (Ibid., at section 3.22)**
- The Tavistock did not keep adequate data on outcomes. (Ibid., at section 3.34)
- Little is known about the long-term outcome of the new cohort of females that transitioned. (Ibid., at section 3.23)
- The Tavistock failed to have a systematic, formal mental health or neurodevelopmental assessment or formal diagnosis of companion metal health issues. (Ibid., at section 3.38)
- **Unknown whether puberty blockers do indeed provide valuable time for children and young people to consider their options, or whether they effectively 'lock in' children and young people to a treatment pathway which culminates in progression to feminising/masculinising hormones by impeding the usual process of sexual orientation and gender identity development. Children placed on puberty blockers have a 96.5% to 98% chance of proceeding to cross-sex hormone treatments. (Puberty blockers cannot be described as a pause button but a scaffolded step.) (Ibid., at section 3.31)**
- The effect of cessation of puberty could retard the development of the brain and further concretize gender confusion. Further study is needed. (Ibid., at sections 3.32 and 3.33)
- **The long-term outcomes of medicalization of children are unknown and there is no established protocol to determine which child would benefit or be harmed by gender interventions. (Ibid., at section 3.34)**
- The lack of quality controls on the treatments is problematic. (Ibid., at section 5.3)
- **The appropriate treatment for gender dysphoric youth is not clear. (Ibid., at section 6.1)**

THE UK RECOGNIZES THAT MEDICALIZING GENDER-CONFUSED CHILDREN IS NOT THE BEST TREATMENT. THE RISKS OUTWEIGH THE BENEFITS.