Response ID ANON-4VB5-H7EZ-Y

Submitted to Interim service specification for specialist gender dysphoria services for children and young people – public consultation
Submitted on 2022-12-02 14:51:53

About you

1 Are you responding on behalf of an organisation?

Yes

If yes, please tell us which organisation you are responding on behalf of::
Christian Concern

2 In what capacity are you responding?

Other (please describe below)

If you select other, please describe further:
Organisation which has supported the rights of people not to use compelled speech in relation to pronouns, and supported people who wish to detransition.

Your views

3 To what extent do you agree with the four substantive changes to the service specification listed in the supporting documents?

Disagree

Share any further comments about this::

We welcome the fact that psychosocial and psychological support and intervention is to be the primary intervention for children and young people. In reality this should be the only suitable intervention for all children and young people referred. The reason is that affirmative treatment is harmful for children and teenagers.
Whilst we welcome the proposal to have multidisciplinary teams in principle, we note that the new specification includes 'gender dysphoria specialists', with 'experts in mental health' added at the end after emphasising 'experts in paediatric medicine, autism, neurodisability'. This signals a downgrading of the importance of mainstream psychotherapists and psychologists, as well as complete removal of social workers from these teams. This is a serious problem that needs to be addressed.
The fact that the setting for the Multi-Disciplinary Teams must be in an established tertiary paediatric unit means that the inclusion of paediatric endocrinologists is assumed from the outset. This raises questions about how open this particular consultation question is on the composition of the clinical teams. It is vital to consider carefully the reason for the inclusion of paediatric endocrinologists in the Multi-Disciplinary Teams. Assessing the psychology of what is going on with the children is the paramount factor. Our concern is that the inclusion of endocrinologists will lead to an over facilitation and prescribing of puberty blockers and cross-sex hormones. As is now well established, the prescribing of such hormonal treatments is experimental contrary to medicine. The Hayes Directory reviewed all the relevant literature for the hormonal different treatments in 2014 giving them the lowest possible rating, stating that the research findings were "too sparse" and "limited" to suggest conclusions. See: Hayes, Inc., "Hormone Therapy for the Treatment of Gender Dysphoria," Hayes Medical Technology Directory (2014).

The harm of affirmative treatment

There is overwhelming scientific evidence that treatment affirming the fantasised gender of minors, is harmful. We refer to the expert witness evidence given by Professor Paul McHugh, University Distinguished Service Professor of Psychiatry at the Johns Hopkins University School of Medicine, in the legal case brought by Christian Concern's sister organisation, the Christian Legal Centre, on behalf of parents Nigel and Sally Rowe. Professor Paul McHugh explains at length why the affirmative model of treatment for gender dysphoria in children has no scientific basis, and why it is positively harmful for children. It should be discarded altogether.
https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Rowes-JR-McHugh-20210915.pdf
Likewise we refer to the expert witness evidence given by Dr Quentin Van Meter, currently professor of Paediatrics at Emory University and Morehouse Schools of Medicine.
https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Rowes-JR-Van-Meter-20210915.pdf
Dr Van Meter provided a 2012 study of extensive psychological evaluation and subsequent focused counselling of over 500 patients. This proves that gender incongruence can be resolved by counselling in the vast majority of patients as they go through puberty.
Kenneth J. Zucker PhD, Hayley Wood PhD, Devita Singh MA & Susan J. Bradley MD (2012) A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder, Journal of Homosexuality, 59:3, 369-397, DOI: 10.1080/00918369.2012.653309 To link to this article: https://doi.org/10.1080/00918369.2012.653309
The most current version of the Diagnostics and Statistical Manual (DSM), also included in Dr Van Meter's expert witness statement, documents the extensive work of Dr Kenneth Zucker in this field. This proves that there are high levels of desistance by late adolescents provided that counselling is ongoing, and that it has as its goal resolving gender incongruence.
Diagnostics and Statistical Manual of Mental Disorders, 5th edition
https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Rowes-JR-Van-Meter-20210915.pdf [pp.193-202]
The paper 'Gender Dysphoria in Children' by the American College of Pediatricians is an extensive review of scientific literature and shows there is 'unquestionable proof of harm' to children by exposing them to affirmative therapy and hormonal and surgical procedures.

https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Rowes-JR-Van-Meter-20210915.pdf [pp.203-216]
Dr. Quentin Van Meter also provided his professional medical opinion on the permanent physical harm to children of puberty blockers and cross-sex hormones, and the harmful psychological and physical effects of gender transitioning on children.
https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Rowes-JR-Van-Meter-20210915.pdf [pp.4-10]

Childhood transition should not be allowed under any circumstances

In light of this extensive peer-reviewed scientific evidence, we strongly disagree with how the Interim Service Specification clearly allows pre-pubertal children to transition, and assumes uncritically that they have adopted this mindset all by themselves (page 14).
As well as going against the scientific evidence that proves affirmative treatment is unquestionably harmful to children, this puts a radical legal interpretation of children's rights above parental rights. This has been witnessed on previous occasions as based on a misinterpretation of the UN Convention on the Rights of the Child.
https://christianconcern.com/comment/the-abusers-behind-gender-identity-for-children/
'Watchful waiting' here will have the impact of being merely window-dressing for continuing this approach, as it puts the child as the primary decision-maker.
As a result, we are deeply concerned and lack confidence in the statement that the Multi-Disciplinary Teams as a whole will have competencies and expertise in childhood and adolescent development, paediatric medicine and child safeguarding (Section 8.3: 'Essential Staff Groups'). Christian Concern has seen safeguarding used by activists against Christian parents who ask social services for help with a child who is suffering from gender dysphoria. It has been used to threaten parents and to insist that they recognise a child's acquired gender identity.
Likewise, 'expertise in sex development' is incompatible with 'endocrine intervention', given that sex development in puberty is a natural stage of life, not a disease or a developmental disorder. Endocrine intervention can harm sex development, often irreversibly. The current NHS page on gender dysphoria explains this with the following statement:
"From the age of 16, teenagers who've been on hormone blockers for at least 12 months may be given cross-sex hormones, also known as gender-affirming hormones.
"These hormones cause some irreversible changes, such as:
• breast development (caused by taking oestrogen)
• breaking or deepening of the voice (caused by taking testosterone)
"Long-term cross-sex hormone treatment may cause temporary or even permanent infertility."
https://www.nhs.uk/conditions/gender-dysphoria/treatment/

Who will be the gender dysphoria specialists?

There is also a need for clarification as to who will count as gender dysphoria specialists in the teams, and a need to consider long-term historical evidence in relation to this.
Not long ago, a significant number of clinicians resigned from the GIDS after whistleblowing over inadequate work practices. The split in approach to treatment is traceable to the merger of the Tavistock and Portman clinics in the early 2000s, as Portman clinicians are on record as preferring talking therapy to physical gender reassignment treatments for both children and adults. Mainstream, explorative and critical talking therapy for gender confusion, which above all aids children to live in harmony with their biological sex, has been marginalised due to all mental health professional bodies signing the MOU on Conversion Therapy. The fact that the mental health professional bodies and NHS England remain signatories of the MOU means that there will be a strong bias towards gender dysphoria specialists who are inclined to prefer affirmative treatments. Clinicians are afraid of being accused of engaging in 'conversion therapy' if they do not adhere to an affirmative approach.
Former Tavistock clinician Marcus Evans has argued that the MOU on Conversion Therapy has prevented clinicians' ability to provide adequate therapy for children referred to the GIDS.
https://www.cambridge.org/core/services/aop-cambridge-core/content/view/F4B7F5CAFC0D0BE9FF3C7886BA6E904B/S2056469420000728a.pdf/div-class-title-free
Second and related to this, the historical data from the opening of the GIDS in 1989 shows that underlying issues of the children referred to the GIDS have tended to be psychological and social, not medical. In the first cohort it was noted that there was a high prevalence of children from single-parent families. There were also many children from a south Asian background, a fact that has never received any analysis.
A study of the first 124 children referred to the Child and Adolescent GIDS in London between 1989 and 2001 found that 26.8% of the children had spent time in care, 48% of the children had spent time living with a single parent, and 41.7% of the children had experienced loss of one or both parents through death or separation.
'Children and Adolescents Referred to a Specialist Gender Identity Development Service: Clinical Features and Demographic Characteristics', International Journal of Transgenderism 6(1), 2002
This is clearly an atypical sample of children compared to the general population.
On Census Day in 2001 there were 1,758 children under 18 in local authority children's homes in England. There were 1,185 children under 18 in other children's homes in England. This comes to a total of 2943 children out of 890, 685 children in England under 18. (All figures for the Census come from the website http://www.nomisweb.co.uk)
Only 0.33% children in England were in a care home on Census Day in 2001. By contrast, 26.8% of children referred to GIDS between 1989 and March 2001 had been in the care system at some point. Thus, children from the care system were 81 times more likely to have been referred. Of course, this isn't a perfect comparison as the GIDS figures are cumulative, whilst the Census figures are a snapshot of the total number of children on one day.
Likewise, nearly half (48%) of children referred to GIDS by 2001 had lived with a single parent. On Census Day there were 1,311,974 lone parent households with dependent children in England and Wales. There were just over 7 million households with dependent children. This means that children from single parent families were roughly three times more likely to be referred to GIDS. Most single parent families then were headed by mothers.
It should come as no surprise that half of children referred to GIDS had lived only with their mother. Psychiatric research conducted in the UK by the distinguished psychiatrist J. R. B. Ball as far back as 1965 shows that male-to-female transsexuals were much more likely than the general population to have the mother as the dominant parent, and to be closer to their mothers.
J. R. B. Ball, Transsexualism: A descriptive and comparative study to attempt to establish possible aetiological factors. MD thesis, University of Newcastle-Upon-Tyne, 1965.

Under the new 'Dutch protocol' used by the GIDS from 2011 onwards, no information has been recorded about the family background of the children

referred. Clearly this has to do with a change of outlook with the Dutch approach, which favours 'watchful waiting' and the offer of referral for administration of puberty-blockers and cross-sex hormones, being adopted at the GIDS from 2011 onwards.
For a detailed history of the adoption of the Dutch protocol in the United Kingdom, see Michael Biggs (2022): The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence, Journal of Sex & Marital Therapy. See especially p. 7.
The following are standard accounts of the Dutch protocol by its own proponents.
Annelou L. C. de Vries MD PhD & Peggy T. Cohen-Kettenis PhD (2012) Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach, Journal of Homosexuality, 59:3, 301-320, DOI: 10.1080/00918369.2012.653300
Henriette A Delemarre-van de Waal and Peggy T Cohen-Kettenis, Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects, European Journal of Endocrinology (2006) 155 S131–S137.
Unfortunately, the change of clinical outlook has clearly not addressed the underlying psychological and social problems first recorded by Domenico Di Ceglie and his colleagues. It has merely served to marginalise them.

Concerns about anorexia among gender confused children ignored by consultation

As the consultation document says, children on the autistic spectrum do represent a significant minority of referrals. It is a problem that the significance of anorexia among children referred is never mentioned in the consultation. It is however discussed at length by Marcus Evans and Susan Evans in their book on gender dysphoria.
• Susan Evans and Marcus Evans, 'Early Development in the context of the family', in Susan Evans and Marcus Evans, Gender Dysphoria: A Therapeutic Model for Working with Children, Adolescents and Young Adults. Bicester: Phoenix Publishing House, 2021.
In light of this we recommend that the reference to 'experts in mental health' once again specify psychiatrists, psychotherapists and family therapists as members of the clinical teams.

Exclusion of social workers from multidisciplinary teams not justified

The proposed new specifications exclude social workers completely from the multidisciplinary teams. No evidence is provided to justify their exclusion. This will merely reproduce the inadequate state of affairs recorded by the CQC at the GIDS in its 2021 report. On page 13 of that report it said this:
"The teams did not always have good working links with primary care, social services, and other teams external to the organisation. The service did have good relationships and regular meetings with the endocrinology departments that provided medical interventions."
https://api.cqc.org.uk/public/v1/reports/7ecf93b7-2b14-45ea-a317-53b6f4804c24?20210120085141
Removing social workers altogether from the multidisciplinary teams will only weaken good working links between the new gender hubs and social services.
We recommend the reinclusion of social workers in the new multidisciplinary teams.

Interim Cass Report ignored evidence from psychotherapy

This consultation relies heavily upon the Interim Cass Report and the work of the Cass Review as a whole as an evidence base. This is a serious problem because the Interim Cass Report did not discuss any evidence from the field of psychotherapy. The Cass Report occasionally cites recent evidence from gender identity clinics for children, but not systematically so. It promises a literature report in the near future. Normally a literature report is the first task completed in a research project, so as not to duplicate previous work. This must then lead to a real concern that the older evidence on family dysfunction as a key background factor in gender dysphoria in children has not been properly considered or even wilfully avoided.
The recommendation that 'experts in paediatric medicine' should be part of the new multidisciplinary team in reality only refers to paediatric endocrinologists, in line with the Interim Cass Report. The Interim Cass Report did not have any other branch of paediatric medicine in mind. Section 5.30 of the Interim Cass Report recommended paediatric endocrinologists and mental health staff should be seen as 'equal partners'.
Interim Cass Report recommendation no. 12 goes as far as saying that
"Paediatric endocrinologists should become active partners in the decision making process leading up to referral for hormone treatment by participating in the multidisciplinary team meeting where children being considered for hormone treatment are discussed."

There is a question as to whether experts in paediatric medicine should be in these multidisciplinary teams, given that a) Dame Hilary Cass did not recommend closer involvement by other paediatric specialists and b) because it would appear that the only reason paediatric endocrinologists are recommended as members of the new multidisciplinary teams is for them to actively facilitate decisions FOR children being given puberty-blocking drugs. If this results in puberty being wrongly treated as if it were a developmental disorder it will be wholly unethical.
For therapists and psychiatrists, indeed all medical and mental health professionals, to be free to work to the highest standard in such teams, NHS England should leave the MOU Coalition, and best practice demands that the Department of Health should rescind the Memorandum of Understanding on Conversion Therapy.

Questions about definition of key concepts in the Interim Service Specification
In important ways, the Interim Service Specification returns to the inherent contradiction which was at the heart of GIDS from its inception. Whilst much more attention was given, rightly, to children's psychological, psychiatric and social problems, it nevertheless opened the door to the expectation some children to undergo 'sex-change' procedures as adults.
Domenico Di Ceglie,'Castaway's Corner', 2002
https://www.researchgate.net/publication/310334449_Castaway%27s_Corner
This unwarranted openness to 'sex-change' procedures for teenagers once they turn 18 clashes with the rigorous evidence provided by Dr Kenneth Zucker and cited in the most recent version of the Diagnostic and Statistical Manual for Mental Disorders referred to above, showing that the goal of resolving gender incongruence is necessary if clients are to desist permanently.
Diagnostics and Statistical Manual of Mental Disorders, 5th edition
https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Rowes-JR-Van-Meter-20210915.pdf [pp.193-202]
This leads us to ask what is the meaning of terms used in the Interim Service Specification such as 'promote the individual's global functioning and wellbeing'.
The terms 'gender incongruence' and 'gender dysphoria' are not differentiated by means of peer-reviewed scientific evidence. What exactly is 'clinically

significant levels of distress' in an individual? Suicidal ideation? The Appendix does not say.
The use of the term 'gender variance' in the specification (section 6.2) suggests the influence of transgender activists writing it, as this was a term coined by GIRES over twenty years ago and has been fed into the policy space since then.
https://publications.parliament.uk/pa/cm200809/cmpublic/equality/memos/ucm2102.htm
The term 'cultural sensitivity' to refer to 'children who are gender diverse' echoes the language used by Dominic Davies, the CEO of Pink Therapy, in campaigning for a 'conversion therapy' ban back in 2014. It has led to Pink Therapy offering Continuing Professional Development on Gender, Sexual and Relationship Diversity which has normalised promiscuity, 'open relationships', polyamory and BDSM, all the result of the MOU on Conversion Therapy. This is unethical.
https://pinktherapyblog.com/2014/04/03/curing-the-gays/
See also: Pink Therapy, What does GSRD mean?, January 202, where BDSM is normalised:
"We are using two different understandings of the word Sex: Sex as in sexuality, sexual orientation/identities: lesbian, gay, bi- and pan-sexual and those on the asexual spectrum, celibate and those engaged in BDSM/Kink and Fetish. Sex is also being used to mean: biological sex including intersex and people born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies). In Relationship Diversities: we include people on the aromantic (aro) spectrum, people involved in BDSM/Kink power exchange relationships, sex work relationships, people in multi-partnered relationships (swingers, non-monogamous, polyamorous people, etc.) as well as those in 'monogamish' forms of partnership."
https://web.archive.org/web/20210725083531/https://pinktherapy.org/wp-content/uploads/2021/01/What-does-GSRD-mean-.pdf
Accessed from the Pink Therapy training site
https://web.archive.org/web/20220823205041/https://pinktherapy.org/

Disagree

Share any further comments about this::

We disagree with the proposal that the new lead should be a medical doctor, as medical conditions are very rarely the underlying issues involved in gender dysphoria. It is highly significant that the Cass Review has not shown any medical problems underlying referrals. This in reality corroborates the international picture for gender dysphoria in both children and adults (see the above-mentioned documents of expert witnesses to our legal case, showing that counselling with the goal of resolving gender incongruence, not pseudo-medical treatments, is the key). Medical doctors are mostly not also psychiatrists (although all psychiatrists require medical training), and most are not psychotherapists either.

We would like to see leadership rotated between members of the different professions represented. However, for this to work well, NHS England would have to leave the MOU Coalition, as its insistence on the affirmative approach is ideologically driven and has clearly been responsible for undermining clinicians' ability to treat gender dysphoria in children and teenagers.

Agree

Share any further comments about this::

We agree in principle with this. However, see our response to 'D. Referral sources' in the next question below. We disagree with narrowing the referral base to only GPs and NHS staff, given that this excludes psychotherapists and other mental health professionals from outside the NHS. This restricts the range of competent referrers without justification. This amounts to a closed shop for mental health professionals who are members of organisations that are in the MOU Coalition.

Partially Disagree

Share any further comments about this::

We agree that the current service specification permitting referrals by schools and colleges is far too broad, as these institutions have no formal expertise in mental health, and the delivery of training programmes on this issue has been captured by now many largely discredited (i.e. Mermaids) transgender lobby groups and activists at the local authority level. This has meant that teachers and children at the receiving end of such training and materials have been greatly misled.
However, we note that section 8.4 of the Interim Service Specification says this:
"It is expected that close working will be needed in particular with Children and Young People's Mental Health Services, child health and neurodevelopment services, voluntary community services, education professionals, children's social care and with general practitioners."

Given what we have already said in reply to question 1 about how this Interim Service Specification merely perpetuates the current problems of permitting pre-pubertal child transition, uncritically assuming children have chosen this and not been groomed, we find the expectation that the new service will work with 'voluntary community services and education professionals' highly concerning. This very much allows transgender activist groups such as Mermaids, GIRES, Stonewall and Gender Intelligence, to name but the most well-known, back in through the back door.
It is more difficult to determine how the voluntary sector should be treated, given that psychotherapists and counsellors may work in the voluntary sector, and do see clients suffering from gender confusion.
One of the biggest problems with the proposed new Interim Service Specifications is that they do not allow referrals from psychotherapists and counsellors outside the NHS. In effect they create not only a monopoly of but a closed shop of mental health professionals entirely dependent on the state, and beholden to the MOU Coalition. This almost guarantees that professionals and clients' freedom to discuss the problems involved in gender confusion will be restricted, which would be an unjustifiable restriction on free speech in the workplace.

4 To what extent do you agree that the interim service specification provides sufficient clarity about approaches towards social transition?

Disagree

Please expand further::

We welcome the fact that the ISS warns about the need to watch for 'the risks of an inappropriate gender transition'. At the same time it is a serious problem that this warning is issued in the context of acceptance of pre-pubertal children changing gender. This is inappropriate, given the evidence already cited in response to question 3, namely that affirmative treatment is harmful.
Contrary to what the consultation says, it is incorrect to assume that 'social transitioning' is 'necessary for the alleviation of … distress'. To assume this is to cave into emotionally charged and ideologically driven dogma and not the facts. It also suggests that social transitioning is the only way to alleviate distress, which is not only demonstrably false, it is promoting a form of treatment that many experts in the field (including those cited in this consultation) find harmful.
It is extraordinary for the specification to say that social transitioning can be necessary to prevent 'significant impairment in social functioning'. In reality social transitioning it itself both a sign of and instance of significant impairment in social functioning as a member of one's actual sex.
It makes little sense to state that a 'young person' (whose age is not delimited) can 'fully comprehend the implications of affirming a social transition.' Partly this is because the recent judicial review against the GIDS initially brought by Susan Evans and an anonymous mother of a patient never looked at this question; rather it considered whether teenagers could comprehend the effects of physical gender reassignment.
Bell v Tavistock, [2020] EWHC 3274 (Admin)
https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf
The question of whether teenagers can fully comprehend the implications of social transition has never seriously been posed by clinicians or publicly debated.

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

Disagree

Please expand further::

We certainly agree that patients should be discouraged in the strongest terms from accessing prescriptions from unauthorised sources. However, we are concerned that the proposed guidance means that the NHS washes its hands of all legal and clinical responsibility for minors who access dangerous drugs. If our health services are to show compassion and care for our teenage patients and their families, it is vital to provide a high standard of care and to ensure proper safeguarding.

The most compassionate service will have as its primary goal an aim of steering the young person steer them to live in harmony with their biological sex.

6 Are there any other changes or additions to the interim service specification that should be considered in order to support Phase 1 services to effectively deliver this service?

Please expand further::

Social workers should be included in multidisciplinary teams, as they work with troubled families, and the historical data from 1989 onwards shows that children referred to the GIDS had a high incidence of problems relating to their parents and relatives.

7 To what extent do you agree that the Equality and Health Inequalities Impact Assessment reflects the potential impact on health inequalities which might arise as a result of the proposed changes?

Neither Agree nor Disagree

Please expand further::

The Impact Assessment does not exhibit overt ideological bias. However given our concerns stated about all referrals having to come from GPs or the NHS, there could be future repercussions. The exclusion of mental health professionals in private practice reduces the likelihood of children's problems being assessed adequately, given that NHS England is a signatory to the MOU on Conversion Therapy.