Response submitted to NHS consultation on the proposed Interim Service Specification

Specialist Service for Children and Young People with Gender Dysphoria (Phase 1 Providers)

December 2022

Contents

Introduction

About Our Duty

Founded in 2018, Our Duty supports and advocates on behalf of parents of children who have been led to believe that they are transgender.

As the only UK based parent organisation to reject the medical imitation of the opposite sex as treatment for adolescent transgender ideation, we advocate for changes to medical practice which would ensure that children and young people are not at any risk of such interventions. Instead, we advocate for interventions that are geared towards the alleviation and prevention of transgender ideation. We call for more research into the range and efficacy of such approaches.

International in scope, Our Duty has over 900 members in over a dozen countries.

Our mission is primarily the safeguarding of adolescents.

Our Duty challenged the practices at The Tavistock and Portman NHS Foundation Trust in Autumn 2019[1] holding the board to account.

We advocate the repeal of the Gender Recognition Act 2004 and the redrafting of 'gender reassignment' in the Equality Act 2010 so that it protects those not conforming to traditional sex-based stereotypes without incurring the unintended consequences which arise when 'gender' is enshrined in law.

We oppose opposite sex imitation interventions for reasons of transgender ideation and seek the abolition of "gender clinics".

Regret, desistance and detransition are real. It is reasonable and right to seek cessation of transgender ideation. It is reasonable and right to seek to prevent transgender ideation.

[1] https://www.thetimes.co.uk/article/parents-battle-state-sponsored-sterilisation-of-trans-children-mb55fxt60

How we have approached this response

In our response, we focus on analysing the adolescent safeguarding implications of the proposals in the Interim Service Specification.

Our definition of adolescent is a person of age between the onset of puberty and 25 years.

We consider transgender ideation and suicidal ideation to be similar presentations. Consequently, we have an expectation that health services seek prevention, desistance, and avoidance of adverse outcomes.

The answer to the question:

“Do the proposed Interim Service Specifications meet the requirement for children and adolescents to be safe from the risk of unnecessary medical harm resulting from transgender ideation?”

is “No.”.

This is a simple test. We can apply it consistently to all developments and announcements.

There is much to welcome in the proposed Interim Service Specification. In the interests of brevity and clarity we have chosen to omit many of our responses which would merely agree with the proposals.

General observations

Before addressing the specific consultation questions, we have some general comments about the NHS proposals:

Objectives

Effective healthcare service delivery is all about healthy outcomes.

The proposed Interim Service Specification would be greatly improved by having its healthy outcomes clearly defined. Each proposal can then be justified and judged against these outcomes.

Hitherto, so-called ‘gender’ services have been delivered with a focus on short-term relief of the distress associated with ‘gender dysphoria’ (patient want).

Future services need to be delivered with a focus on the long-term health and wellbeing of the patient (patient need).

Our goals are aligned with those of The Cass Review – patients presenting with transgender ideation must “receive a high standard of NHS care that meets their needs and is safe, holistic and effective”[2].

Our suggestions for healthy outcomes for an outcome-driven model of service are:

- Desistance from transgender ideation
- Identification and resolution of underlying factors contributing to transgender ideation.

[2] Independent review of gender identity services for children and young people: Interim report (2022) https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf

Structure

The proposed Interim Service Specification does not have a structure that is clear and easy to analyse. In places, it seems disjointed and ill-organised. A diagrammatic representation of boundaries and pathways would be a useful addition and might serve to illuminate productive navigation of the specification.

While it is noted that the proposed Interim Service[3] will screen referrals offering what appears to be an appropriate level of 'gatekeeping', the expectations for the scope and quality of the services to be delivered locally, requires a proper specification.

Standards of care and of data collection need to apply for patients presenting with transgender ideation in the Primary Care setting. Such patients might be referred to the new 'Phase 1 Service' or they might not. However, they do need to be treated as if they had entered a standardised service for transgender ideation from the moment transgender ideation is recognised by a General Practitioner.

Service Name

The service name is given as *"Specialist Service for Children and Young People with Gender Dysphoria (Phase 1 Providers)"*

This name is inappropriate because it presumes every child or young person entering the service has '*gender dysphoria*'. Despite the attempt in DSM-5 to provide criteria to allow a diagnosis of 'gender dysphoria', it should be clear to any medical professional that the criteria are subjective and heterogeneous, and the extent and degree of heterogeneity are unknown.

[3] Proposed Interim Service Specification, paragraphs 8.1-8.2

The DSM-5 definition merely provides parameters for the categorisation of a feeling. Albeit one that might be accompanied by significant distress. Nevertheless, with '*gender dysphoria*' having been seen as a diagnosis by some, it creates an illusion that it is an actual condition based in psychopathology and thus must be treated.[4]

For the adolescent cohort (with which we are primarily concerned), many of those claiming to have '*gender dysphoria*' are merely following a script. This is a known phenomenon that has been reported[5].

The feelings and possible distress associated with gender dysphoria might serve as a differentiator required to enter the proposed Interim Service, however, its precursor, transgender ideation, is that which requires attention in a Primary Care setting.

It is for these reasons that we prefer to use '*transgender ideation*', at least for the adolescent cohort. Alternatively, the word transgender can be dropped altogether (or replaced with 'unhealthy').

Naming the service *"Specialist Service for Children and Young People with* ***Transgender Ideation*** *(Phase 1 Providers)"* would clarify the ideological nature of gender ideation and de-pathologise it, while providing a more optimistic, accurate framing to remove the presumption that presenting patients *have* 'gender dysphoria' (or even 'gender incongruence'). Such a simple change has the potential to deliver huge benefits because both patients and professionals will be approaching a case from a more appropriate starting point.

[4] Davy and Toze (2018), What Is Gender Dysphoria? A Critical Systematic Narrative Review, https://www.liebertpub.com/doi/10.1089/trgh.2018.0014

[5] Horan (2019), Patients 'coached to fast-track sex change treatment' https://www.independent.ie/irish-news/health/patients-coached-to-fast-track-sex-change-treatment-38543409.html

Language

There are significant issues with the language used in the proposed Interim Service Specification. A full list of the language in the proposed Interim Service Specification which we see as problematic is presented in **Appendix A**.

Where possible the word 'gender' must not be used because it is not objective and means different things to those with different ideologies.

Crucially, making the service 'all about gender' will cement the associated concepts into patients and practitioners consciousnesses. The phenomenon this proposed Service aims to manage is primarily one of unhealthy ideation.

Of particular note are the following:

Paragraph 5.2

"The Service will provide multidisciplinary assessment and care to children and young people and their families who will benefit from clinical support around the development of their gender identity, and interventions in response to a diagnosis of gender dysphoria, and consultation and support to local professionals."

The first instance of problematic language in this paragraph is "*the development of their gender identity*".

'Gender identity' is a highly controversial concept without no medical consensus[6]. This is a quasi-religious political construct used by advocates of an ideology to promote it as if it were fact.

People do not have an innate gender identity. Those who adopt one are likely to be adherents to gender identity ideology including persons with entrenched transgender ideation.

It is certainly the case that nobody needs *'development of their gender identity'*. Anyone with a 'gender identity' would benefit from losing it. Therefore 'Gender identity' must not appear in this specification.

[6] Griffin, L., Clyde, K., Byng, R., & Bewley, S. (2021). Sex, gender and gender identity: A re-evaluation of the evidence. BJPsych Bulletin, 45(5), 291-299. doi:10.1192/bjb.2020.73 https://doi.org/10.1192/bjb.2020.73

The second instance is '*diagnosis of gender dysphoria*' and reference is made to the section on **Service Name**, above. In the context of this paragraph, which appears to be outlining possible interventions for that which is diagnosable. We note that this aspect is covered in the following paragraph referring to the 'range of co-presentations that may typically present…'.

We suggest the following alternative wording for paragraph 5.2:

"*The Service will provide multidisciplinary assessment and care to children and young people and their families who will benefit from clinical support around the resolution of their transgender ideation, and interventions in response to diagnoses of co-presentations, and consultation and support to local professionals.*"

Paragraph 5.3

We would remove the word 'typically' and advise practitioners that while many co-presentations and comorbidities are readily identifiable from a list of the typical, the possibility of an atypical contributory factor cannot be ruled out.

The political construct 'gender identity' is used (it must not appear in this specification).

Paragraph 6.1 Terminology

The political construct 'gender identity' is used (it must not appear in this specification).

The proposed interim service specification seeks to differentiate between 'gender incongruence' – the feeling that one is not of one's sex (which we prefer to call transgender ideation) and 'gender dysphoria' – when transgender ideation results in 'clinically significant levels of distress'.

Our experience is that transgender ideation is best resolved when 'nipped in the bud' and so interventions are most effective before clinically significant distress arises. Thus, **the ideation is a more significant diagnostic tool than the distress**.

Any attempt to provide care contingent on the level of distress risks failing the patient and leaving interventions too late to have meaningful impact on what can become a deeply embedded mindset.

Paragraph 6.2.1 Minimum Population Size

Having just provided **Terminology** in 6.1.2 the service specification immediately introduces a new term *'gender variance'*, this term is not defined and yet *'inconsistent terminology'* is cited as a problem for data integrity in the following sentence!

Cohort Differentiation

There is a blurring of the clear differences in the cohorts of children and young people presenting with transgender ideation. Prepubescent children, (almost entirely boys) are mentioned as if that cohort had much in common with the adolescent cohort (majority girls).

While both cohorts share rumination on the idea of being the opposite sex, and have the idea validated by much of society (via gender ideology capture of mainstream media and the societal trend to socially affirm) there are also differences. These include:

- the origination of the ideation (where the child got the idea from),
- how it is promulgated (e.g. at school, on the internet),

The failure to include young people aged 18-25 – who are very much part of the adolescent cohort – in this proposed service specification adds to the impression that those drafting this service specification have little understanding of the real nature and challenge of transgender ideation in adolescence.

Paragraph 6.1 Population Covered

The defined patient cohort in the specification is children and young people up to their 18th birthday. **We strongly urge the NHS to extend the upper age cut-off to 25** which is both developmentally appropriate and in line with NHS Long-Term Plan for Adolescent Mental Health Services (which is due to be implemented by 2025)[7].

[7] NHS Mental Health Implementation Plan 2019/20 – 2023/24 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

Transfer into the adult services would be less of a problem if the adult services did not offer opposite sex imitation treatments. NHS England can redesignate such treatments as cosmetic and elective to reduce the risk of patients choosing to harm themselves in this way when they lack the maturity to give fully informed consent.

Paragraph 7.3 Audit and Evaluation

Continuous data collection, reporting and audit is likely to provide clearer understanding of the relevant patient cohorts. This data collection needs to continue throughout a patient's journey through NHS services for transgender ideation and beyond. All data that can be used to support a much-needed longitudinal study into adolescent transgender ideation is of very high importance. This project needs to be established from the outset that sub-cohorts (e.g., the homosexual, the autistic) will be of interest.

Paragraph 8.2 Transition to adult services and discharge

It is inappropriate to move a patient from the adolescent service into the adult service. Their presentation and healthcare needs do not magically disappear when they reach 17 years of age. The current adult provision is entirely centred on medical interventions to imitate the opposite sex. The question has to be asked as to whether these cosmetic, elective services should be available from the National Health Service. The relevant question for the justification of this part of the proposed service is 'what has changed in the patient's healthcare needs?'. They still belong in the adolescent cohort, and that cohort requires a single service, not one arbitrarily bisected by age.

Risks to Effective Service Delivery

Current Service Environment

The current provision of services for children and young people with transgender ideation outside of the remit of the proposed Interim Service Specification constitutes a risk to the delivery of healthy outcomes for these patients. We call for a consistent integrated approach for all children and adolescents, not just those referred to the new 'Phase 1 Service'. 'Local Professional Networks' with expertise in transgender ideation simply do not exist. While we are aware of some practitioners in CAMHS and CYPMHS who understand the issues, our experience is that such professionals are very much in the minority. If we are to assume that the improved gatekeeping will lead to more patients being seen locally (as is implied by the proposed Interim Service Specification), then these services will also need specification and establishment. Existing services that do deal with these patient cohorts are inappropriate (see **Ideological Capture of NHS**).

We are unaware of appropriate psychoeducation resources to help children and young people with transgender ideation. We are keen to see these developed rapidly, to a high quality standard, and at sufficient scale.

"A co-ordinated transfer to appropriate local adult services will be needed where complex presentations continue".

There are no *appropriate* local adult services[8]. Even if there were, the proposed transfer age of 18 is inappropriately premature.

[8] Jordan (2021) What the media missed about the Care Quality Commission's Tavistock report https://thecritic.co.uk/what-the-media-missed-about-the-care-quality-commissions-tavistock-report/

Context

Adolescent transgender ideation is primarily a cultural phenomenon (patients presenting with it are victims of indoctrination). Consequently, ending this phenomenon will ultimately be achieved via cultural change of which the NHS must take a leading role. This is because any Government sponsored action which young, confused, vulnerable people can interpret as legitimising their harmful and irrational ideation will have catastrophic consequences.

Transgender ideation is most often a consequence of social contagion[9]

Ideological Capture of the NHS

Local Services

It is the experience of members of Our Duty in the United Kingdom that local CAMHS and CYPMHS services are not safe. This is because a significant proportion of staff seem to subscribe to the ideology behind 'gender identity'.

This situation is worsened by gender identity ideology being embedded in the training and development of staff in these services.

The result of this is that staff at these adolescent mental health services are prone to socially affirm transgender ideation.

It is often said that local adolescent mental health services will refer a child or young person on to so-called 'gender identity' services to reduce their workload.

Many staff in these services have transgender ideation themselves and so have a conflict of interest between helping patients and their own need for validation of their social identity as a medical attribute.

These three factors are indicative of an urgent requirement for fundamental overhaul of child and adolescent mental health services in the United Kingdom.

[9] Lisa Marchiano (2017) Outbreak: On Transgender Teens and Psychic Epidemics, Psychological Perspectives, 60:3, 345-366, DOI: 10.1080/00332925.2017.1350804
https://www.tandfonline.com/doi/pdf/10.1080/00332925.2017.1350804

Examples of local CAMHS services that show clear evidence of ideological capture are:

On the Sussex Partnership CAMHS website, parents and carers are signposted to Mermaids and Allsorts Youth (two organisations ideologically promoting transgenderism in children and adolescents). The page also includes a video from a practitioner promoting 'pronouns' (i.e. social affirmation).

In Bedford, the new 'Evergreen' in-patient facility received 'gender identity' training in October from a team sporting rainbow lanyards and at least one with 'they/them' pronouns.

See **Appendix B.**

Historical Inertia

The NHS Consultation Guide for this proposed Interim Service Specification[10] includes the following paragraph:

"The Tavistock and Portman NHS Foundation Trust and the endocrine teams based at University College London Hospitals NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust will play a vital role in supporting both Phase 1 services as they establish the new services building on their extensive experience of working with this patient group."

This is not mentioned in the main proposal document.

Our Duty has maintained that the so-called 'gender' services at the Tavistock and Portman NHS Foundation Trust are unsafe for patients presenting with transgender ideation since its foundation. Recognition of this fact by The Cass Review Interim Report[11] is the reason for its planned closure. The danger that this NHS Trust presents to patients comes not from the building in which it is housed. The name of its services containing 'gender identity' constitutes some danger in that it confers legitimacy on 'gender identity' as medical attribute. The

[10] NHS England Public consultation - Interim service specification for specialist gender dysphoria services for children and young people https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/user_uploads/b1937-ii-interim-service-specification-for-specialist-gender-dysphoria-services-for-children-and-young-people-22.pdf

[11] Independent review of gender identity services for children and young people: Interim report (2022) https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf

main danger to patients, however, is from the staff employed there. Their *'extensive experience of working with this patient group'* has resulted in significant harm to a great many patients. This has been described by many as a scandal. There is also a disturbing, homophobic undercurrent in the prevailing ideology[12].

It would seem entirely inappropriate to have medics with ideological 'gender' experience in their employment history charged with implementing an objective service which must eschew 'gender' as a human attribute to stand any chance of delivering healthy outcomes for its patients.

Child and Adolescent Safeguarding

Paragraph 7.1 Service Aims

'Provide advice in respect of and, referral to endocrine (hormone) intervention services.'

Our Duty would like to see the elimination of any risk of children and young people receiving hormone intervention for reasons of transgender ideation. The harms are well documented and as per the report from NICE the evidence of any benefit is poor.[13]

Paragraph 8.1 Future Service Model

'It is important that the opportunity is taken to gather further evidence on the safety, potential benefits and harms of Gonadotropin-Releasing Hormone Analogues in children and young people with gender dysphoria.'

[12] The Times (2019) It feels like conversion therapy for gay children, say clinicians https://www.thetimes.co.uk/article/it-feels-like-conversion-therapy-for-gay-children-say-clinicians-pvsckdvq2

[13] National Institute for Health and Care Excellence (2020). Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_Gender-affirming-hormones_For-upload_Final.pdf

Our Duty would like to see the elimination of any risk of children and young people receiving Gonadotropin-Releasing Hormone Analogues for reasons of transgender ideation or as part of medical experiments on children. The harms are well documented and as per the report from NICE the evidence of any benefit is poor[14].

Paragraph 8.2 Direct work with adolescents and their families

'Medical interventions will not be considered at least until puberty has been reached (Tanner Stage 2).'

Our Duty would like to see the elimination of any risk of children and young people receiving medical interventions for reasons of transgender ideation. We are unaware of any research that uses randomised controlled trials and comprehensive longitudinal outcome studies demonstrating opposite sex imitation to be beneficial. This sentence appears to be upholding the approach suggested by the now discredited 'Dutch Protocol'[15].

[14] National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_GnRH-analogues_For-upload_Final.pdf

[15] Michael Biggs (2022) The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence, Journal of Sex & Marital Therapy, DOI: 10.1080/0092623X.2022.2121238

Responses to the Consultation Questions

1. In what capacity are you responding?

(Patient / Parent / Clinician / Service Provider / Other; If you have selected 'Other', please specify.)

Other

Support and advocacy for parents of children with transgender ideation.

2. Are you responding on behalf of an organisation?

(yes / no; If you have selected "yes", which organisation are you responding on behalf of?)

Yes

Our Duty International Ltd

3. To what extent do you agree with the four substantive changes to the service specification?

A. Composition of the clinical team

(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

Partially Agree

"*gender dysphoria specialists*" are included in the list of proposed team members. There is a risk here of perpetuating gender identity ideology within the new service. These team members need a different name, and might include transgender ideation specialists, body dysmorphia specialists, and rumination specialists.

We do not believe that endocrinologists are needed in the clinical team. Access to endocrinologists might be appropriate during the 'screening and triage' phase.

It is possible that a child or young person might have developed transgender ideation because they have a pre-existing hormone imbalance causing them dissatisfaction with their body as it undergoes puberty. This might be a due to a Difference of Sexual Development (DSD) or it might be due to Body Dysmorphic Disorder (BDD). In such circumstances endocrine intervention might be appropriate but only for the reason to better align the patient's body with the stereotypical morphology for their sex. The patient is unlikely to desire such intervention while suffering from transgender ideation, however, such an intervention might contribute to a resolution of their transgender ideation by treating the underlying cause. In such a scenario, the parent's role is crucial.

B. Clinical leadership

(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

Partially Agree

The Clinical Lead for each Phase 1 Service MUST have a scientific (as opposed to ideological) view of transgender ideation. i.e. they must understand that sex is binary and immutable and that adolescent transgender ideation tends to be:

- a maladaptive coping mechanism,
- acquired through peer contagion, frequently online,
- arrived at after much rumination,
- influenced by copious misinformation.

We recognise that this recruitment criterion is discriminatory, however it should pass the objective justification test of a 'proportionate means of achieving a legitimate aim'. Protecting children and young people from the harms of gender identity ideology is the aim.

C. Collaboration with referrers and local services

(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

Partially Agree

Referring GPs who do not have sufficient knowledge in this domain might refer patients to the service for the wrong reasons. There are activist GPs who will likely refer everyone, GPs who believe in Gender Identity Ideology (especially since GLADD is pushing it to be taught in Medical Schools) who will likely refer everyone, and some GPs who understand the issues and will likely prefer to refer nobody, instead preferring the underlying conditions to be dealt with locally and with zero risk of a medical pathway.

Local services need to be built anew from scratch.

Existing services, particularly CAMHS / CYPMHS have been ideologically captured by the gender identity movement. There cannot be anybody who believes that someone can **be transgender** (as a diagnosable medical condition distinct from a social affinity) involved in the clinical care of somebody who thinks that they are transgender.

D. Referral sources

(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

Partially Agree

Referral sources need to be limited to those practitioners who have qualified to refer. Qualification should by necessity involve screening out those who believe in gender identity ideology.

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

(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

Partially Disagree

There needs to be more explicit discouragement of social transition, and such discouragement must not be restricted to pre-pubertal children but must encompass all adolescents.

Fewer children and young people will present with transgender ideation of the very idea that someone can be transgender (as a diagnosable medical condition distinct from a social affinity) is not promoted in schools and wider society. While ensuring such might be beyond the remit of this proposed Service, it needs to be a point of view that The Service is empowered to promote as part of its remit of prevention.

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

(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

Partially Agree

There needs to be a reporting mechanism such that when an unregulated source is brought to the attention of NHS Practitioners, a regulatory investigation can be launched with a view to closing down that source, and where appropriate prosecuting the persons with ultimate control.

The safeguarding procedure that must be followed needs to entirely focused on protecting the child from any further harm and removing access to medicines from unregulated sources.

Breast binders should be made Prescription Only Medicine (POM).

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?

(comments)

The Interim Service Specification must:

- Better differentiate between prepubescent and adolescent cohorts.
- Recognise that opposite sex imitation is not proper medicine for the treatment of transgender ideation.
- Extend the adolescent cohort to include those up to age 25.

- Be more emphatic in discouraging ‘social affirmation’.
- Remove the possibility of Gonadotropin-Releasing Hormone Analogues (a.k.a. ‘puberty blockers’) being administered to children for reasons of transgender ideation or for medical experiments on children.
- Remove the possibility of wrong-sex hormones being administered to children or adolescents for reasons of transgender ideation.
- Remove the possibility of opposite-sex imitation surgical interventions being administered to children or adolescents for reasons of transgender ideation.
- Not use ideological language.
- Explicitly target desistance from transgender ideation as the desired outcome.
- Develop a pathway that does not entail opposite sex imitation medical treatments for cases where the patient persists with clinically significant distress or impairment in social functioning.
- Include provision for services for desisters and detransitioners (those who had transgender ideation and may have been medicalised and still require ongoing psychological and medical support).
- Demand a cultural change programme in the NHS to remove gender identity ideology from all healthcare settings.

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?

(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

Neither Agree nor Disagree

Appendix A – Instances of Use of Political Language

Paragraph 5.2

This paragraph is discussed at length in the **Language** section of main response.

The first instance of problematic language in this paragraph is "*the development of their gender identity*".

The second instance is '*diagnosis of gender dysphoria*' and reference is made to the section on **Service Name**, in the Language section.

Paragraph 5.3

This paragraph is discussed at length in the **Language** section of main response.

The political construct 'gender identity' is used (it must not appear in this specification).

Paragraphs 5.5, 5.7 and 5.8

We prefer 'transgender ideation' to 'gender incongruence'.

Paragraph 5.9

We prefer 'transgender ideation' to 'gender dysphoria'.

Paragraph 6.1 Population Covered

We prefer 'transgender ideation' to 'gender dysphoria'.

Paragraph 6.1 Terminology

This paragraph is discussed at length in the **Language** section of main response.

The political construct 'gender identity' is used (it must not appear in this specification).

Paragraph 6.2.1 Minimum Population Size

Having just provided **Terminology** in 6.1.2 the service specification immediately introduces a new term ‘gender variance’, this term is not defined and yet ‘inconsistent terminology’ is cited as a problem for data integrity in the following sentence!

Paragraph 6.2.2 Eligible Patient Cohort

We shall discuss **Cohort Differentiation** separately. As for language this paragraph refers to ‘gender dysphoria’.

Paragraph 7.1 Service Aims

Use of ‘gender incongruence’

Paragraph 8.1

Use of ‘gender dysphoria’, ‘gender querying’.

Paragraph 8.2

Use of ‘gender incongruence’.

Use of ‘gender identity’.

‘Their expression of gender identity across different contexts over time and different settings’

Use of ‘gender identification’ without definition.

‘Exploration of parent/carer and family views on the child or young person’s gender identity journey and family support’

Use of ‘gender querying’ without definition.

Use of ‘gender role’ without definition.

Use of ‘gender expression’ without definition.

Paragraph 8.3

Use of ‘gender identity’.

Use of ‘gender expression’

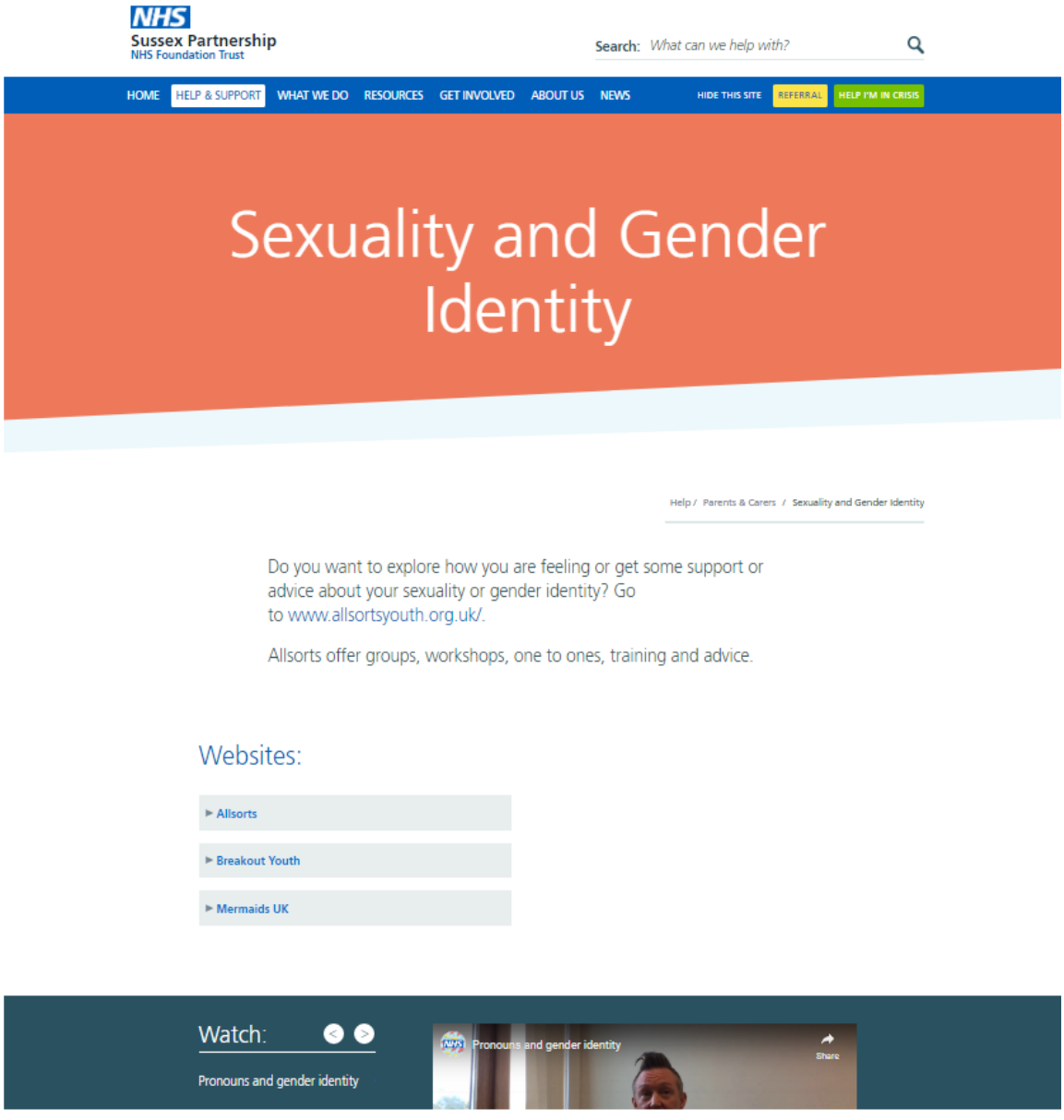
Paragraph 8.6

Use of ‘gender diverse’ without definition.

Appendix B - Evidence of Ideological Capture

Web page from Sussex CAMHS

https://sussexcamhs.nhs.uk/help-support/parents-carers/sexuality-and-gender-identity/



A Twitter Tweet from Bedford CAMHS

https://twitter.com/chameleonpaper/status/1584953253502255104

Contacts

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Questions and comments regarding this publication may be addressed to: info@ourduty.group. We welcome your feedback.

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