IN THE FIRST TIER TRIBUNAL **Claim No: CA/2021/0013**

GENERAL REGULATORY CHAMBER

(CHARITY)

B E T W E E N:-

Mermaids **(Appellant)**

-and-

The Charity Commission for England and Wales **(First Respondent)**

The Trustees of LGB Alliance **(Second Respondent)**

Witness Statement of Eileen Gallagher

I, Eileen Gallagher, of LGB Alliance, Kemp House 152-160 City Road London EC1V 2NX, shall say as follows:

My Background

(1) I am the Chair of Trustees at LGB Alliance. My background is in media, script writing and creative business. I was the Managing Director of London Weekend Television and in 1999 I formed my own Production Company, Shed Media, floated it on the AIM stock market and finally sold it to Warner Brothers.

(2) I am the former Chair of PACT, the trade association for independent film and TV producers. I was involved in the changes to the 2003 Communications Act, that led to the creation of the media regulator, Ofcom. I also chaired the media training charity, TRC, for three years and sat on the Commonwealth Games Board (Glasgow 2014) and was responsible for the opening and closing ceremonies and cultural programme. I was proud to be awarded an OBE for my services to broadcasting in 2010.

Why I Became Involved with LGB Alliance

(3) It would have been very easy for me not to have taken a role with LGB Alliance. I don't need to be the Chair of a charity to raise my profile or further my career. I don't need to make new business connections, and I certainly don't need to seek out the limelight. But I became involved because I simply could not stay quiet.

(4) Around 2019 I watched with great dismay the rise of a new homophobia that meant being lesbian, gay or bisexual – stating that same-sex attraction was real – came to be considered bigotry

(5) Organisations that had existed to support us began to say, instead, that gender mattered more than sex. Women, like me, were told that to reject a male bodied person as a partner would be transphobic and unkind

(6) Even worse, young boys and girls who don't fit into a rigidly masculine or feminine stereotype were being asked to consider whether they might actually have been born in the wrong body. I think that it is wrong to suggest to a child who may not conform to gender stereotypes that their body needs to be fixed in some way. I was a tree climbing tomboy myself, I shudder to think how my gender non-conformity might be treated if I were a young teenager today.

(7) I wasn't one of the early fighters for LGB freedom like Bev Jackson and Kate Harris who both have decades of activism behind them, but I certainly benefitted from their efforts in my life. It was true to say that until recently, the UK was one of the best places in the world to be gay. But by 2019, there was no charity catering specifically for the needs of the millions of lesbian, gay and bisexual people in the UK. There was clearly a need for one to exist. That's why LGB Alliance was formed and it's why I stepped up.

The Work of LGB Alliance

(8) LGB Alliance currently consists of six Trustees / Directors, one Managing Director, two freelance Administrative Assistants, one freelance Fundraising Co-ordinator, four voluntary management team members, one voluntary Press Officer and up to 14 volunteers who assist with our social media, shop, website, research, events and fundraising.

(9) LGB Alliance is barely two years old, we had been a charity for a less than a year when I wrote this statement. We were entirely volunteer-run until recently when we appointed a Managing Director to help us in the more efficient delivery of services for LGB people. In only two years, I'm proud to say that we've delivered a great deal. I have set out some of this below, and referred to paragraphs of our Charitable Objects where relevant [**Exhibit EG17]**

The National Conference

(10) We ran a national Conference in October 2021 attended by politicians from the left, right and centre. These included Joanna Cherry QC MP (SNP), Neale Hanvey MP (Alba Party), Rosie Duffield MP (Labour), Jackie Doyle-Price MP and Peter Bottomley MP (Conservative) and by well-known academics, journalists, lawyers and media commentators. The conference was very well attended. Some 500 of our supporters attended to hear panel discussions about issues of interest to LGB people, visit stalls, gather information and hear about our work. We sold 431 tickets plus guest and complimentary tickets for low income supporters. The analytics from Event Bright set out our ticket sales. **[Exhibit EG1] (Charitable Objects Paragraphs 2.1.2, 2.1.4, 2.2.5, 2.2.6, 2.2.9, 2.2.10 and 2.2.11).**

(11) We offered free tickets to those who would not otherwise have been able to attend and released footage of all of the talks on our YouTube channel. Those videos have been viewed by more than 40,000 people, proving there is significant interest in our work. [**Exhibit EG2, page 2 onwards**].

(12) We ended the day by turning the event into a disco, with a DJ, dancefloor and lighting. A trivial detail you might think, but the absence of the spaces where lesbian, gay and bisexual people can meet means there are no book shops or cafes and very few bars catering for LGB people and our community is becoming increasingly isolated. Astonishingly, London has a population of 9 million and now has just one small venue for lesbians. In the mid noughties there were I think at least a dozen lesbian bars in London, but now there is only one. They have been lost because although it used to be possible to have single sex lesbian bars, it is now seen as transphobic. It's not the purpose of LGB Alliance to rebuild the lesbian bar scene, but this is demonstrative of how aspects of LGB society

have been lost, which was one of the catalysts for our foundation. The opportunity for people to meet, dance and have fun at our conference was immensely meaningful and many people wrote to us, tweeted and told us in person that our Conference was the highlight of their year. Examples of the feedback we received from attendees is at [**Exhibit EG2]** and examples of tweets that were sent is at [**Exhibit EG3**].

Friends of LGB Alliance

(13) We launched a community building initiative, Friends of LGB Alliance. It's a way for people to connect over shared interests – from baking to ballroom dancing – to establish new friendship groups and, if they choose, to fundraise at the same time. Our starter pack is filled with ideas and tips about setting up events [**Exhibit EG4**]. Our desire to rebuild the kind of supportive, local communities of friends that are so important for a rich and fulfilling life is a key thrust of our work and the Friends' communities will be integral to our future growth (**Charitable Object paragraphs 2.1.2, 2.1.4, 2.2.10 and 2.2.11)**.

Webinars

(14) We developed a series of webinars on subjects as diverse as tackling a rise in international homophobia, financial planning for LGB people and understanding gender dysphoria [**Exhibit EG5**.] and produced an informative election special. **(Charitable Objects paragraphs 2.1.1, 2.1.2, 2.1.4, 2.2.2, 2.2.3, 2.2.5, 2.2.6, 2.2.8, 2.2.9, 2.2.10, 2.2.11, 2.2.12)**

Quizzes

(15) In the depths of lockdown, when we all needed cheering up, we put together a panel of comedians for a pub quiz that people could play along with at home [**Exhibit EG6.]** (**Charitable Object paragraph 2.2.3)**

Newsletter

(16) We send our 4,487 subscribers a regular newsletter to keep them connected with our work and we invite them to comment on our progress and make suggestions as to areas where we could do more. We believe that good communication with

our supporters is the best way to be able to really speak to their needs and to provide meaningful help [**Exhibit EG7**.**] (Charitable Object Paragraphs 2.1.1, 2.1.2, 2.1.4, 2.2.2, 2.2.3, 2.2.5, 2.2.7, 2.2.8, 2.2.9, 2.2.10, 2.2.11, 2.2.12)**.

Party Conference

(17) We ran a stand at the 2021 Conservative Party Conference [**Exhibit EG8**]. It was hard work but extremely rewarding to be able to represent the views of many LGB people to a new audience who were interested to hear about our position. No other organisation that exclusively represents LGB people was present. Attendees were responsive and it was also good to make friendly contact with representatives from the LGBT+ group, The LGBT+ Conservatives were on stand 28 and we chatted to their representatives. We have a photograph of Malcolm Clark taken with one of their members, who is a transwoman [**Exhibit EG8 internal page 7]**. There was no bad feeling or intemperate words exchanged at all, and it was very friendly and respectful (**Charitable Object Paragraphs 2.1.1 – 2, 2.1.4, 2.2.5, 2.2.6-7, 2.2.9-12)**.

(18) I always find that meeting people face to face helps dispel the myth put around by some of our detractors that we are in anyway disrespectful or neglectful of the rights of others. We are proponents of respectful free speech and it's an approach that continues to win us friends.

Arts

(19) LGB people have long contributed to a rich arts scene in the UK and we very much want to support that. Our LGB Film Fund is a fully scoped project that will provide small grants of £5K or £10K to young filmmakers who are LGB and want to make a film with LGB themes or characters. Our promotional material for the Film Fund are at [**Exhibit EG9**]. We are currently seeking a funder for that project **(Charitable Object Paragraphs 2.1.1-2, 2.2.5, 2.2.9-12).**.

(20) We are also seeking funding for our film project 'Queens on the Queen' to celebrate the Diamond Jubilee. The premise for this series of interviews is probably obvious and will certainly be great fun. A full description of the project is set out in our bid document at [**Exhibit EG10**].

Reports on LGB Issues

(21) Much of our work is of a more serious nature. We have created a report, based on interviews and a range of new data, on the experiences of LGB staff working for the NHS, Europe's largest employer. A draft of this report is at [**Exhibit EG11**]. In addition to uploading the report to our website, we will be using it to seek to engage with Government to drive improvements in working conditions for LGB people (**Charitable Objects Paragraph 2.1.1-4, 2.2.1-7, 2.2.9-12)**.

(22) This is the first of a series of reports we will produce that will build to provide a useful reference library for people seeking high quality information on subjects which are important to LGB people.

Representation, Debate and Making the LGB Voice Heard

(23) We have made over 30 Submissions to consultations on a range of issues, central to the protection of the rights of LGB people. Each submission typically represented a considerable number of hours of work and involved more than one volunteer to ensure the quality and rigour of the response. A copy of our submission to the Law Commission Consultation on Online Communication is at [**Exhibit EG12**] (**Charitable Objects Paragraph 2.1.1-2, 2.1.4, 2.2.5-12)**.

(24) Our campaigns have focused on issues that have an impact on LGB people. The most recent, Gay Teens Aren't Sick, sought to ask questions of the pharmaceutical industry. There has been an increase in children being referred to gender clinics from 50 in 2009 to 2,500 in 2020 [**Exhibit EG13**, **paragraph 3.10, internal page 32**] which is a 4,900% increase. A further 4,600 are on the waiting list. Information on the NHS Gender Identity Services website shows that the vast majority of those children describe themselves as same-sex attracted [**Exhibit EG14** under the heading 'Sexuality of young people coming to GIDS' **page 3**]. We have launched a major campaign to persuade the manufacturers of drugs such as puberty blockers to engage with us. We are asking why it is predominantly gay children who are being medicated in this way and challenging them to reveal what evidence they have as to their safety for long term use.

Helpline for LGB People

(25) Our most ambitious project yet is now underway. We are planning, scoping and costing a helpline and online support service for young LGB people. It will be delivered from premises in London initially with a team of paid staff supported by volunteers. The first centre will be a model for later duplicates to be established in hubs around the country. We want to avoid being London-centric and always consider how a more regional approach can feed into our broader, community-building objectives. We have assembled a team that includes a professional fundraising consultant, a policy and regulatory expert, a qualified therapist, experienced charity phone line volunteers and a safeguarding lead. We have held a number of meetings, in person and online, to explore how we can best provide appropriate support. Further details regarding the helpline including the projected costs are in the draft plan **[Exhibit EG18].**

(26) We estimate that we will be able to support up to 20,000 people a year via the Helpline and web-based chat. That number will be refined during the scoping exercise. At this point that we will be seeking in the region of £250,000 to establish and run a high quality service for LGB people. Our National Lottery Funding bid for initial scoping has been successful with the award of a £9,000 grant. **[Exhibit EG19]** (**Charitable Objects Paragraph 2.1.1-1, 2.1.4, 2.2.1-12)**. Due to the attacks on us since our inception, we are necessarily having to keep details of this relatively confidential at the current time because of the risk that our opponents would try to stop it being set up.

Counselling and Advice

(27) Perhaps the most meaningful but least high profile thing we do is answer letters and emails from our supporters, many of whom get in touch because they are in distress. We are contacted by LGB people at work who feel marginalised because of their sexuality and ask for advice on issues ranging from compulsory pronoun usage to coming out to their colleagues. Young people at university tell us they are afraid to speak out about same-sex attraction for fear of being considered bigoted. Parents get in touch because they are worried that their children are not hearing balanced views about the difference between sex and gender **[Exhibit EG15]**. (**Charitable Objects Paragraph 2.1.1, 2.2.1, 2.2.3, 2.2.11-12)**.

(28) But very often too, we receive letters and emails that don't seek our help but relay to us examples of our supporters overcoming difficulties associated with being LGB. Personally, I find these particularly important as they remind us why it's so important we continue to work so hard [**Exhibit EG16**]:

> *Hello All, A quick email from my real email address, and my real name to let you know the impact you have had in less than a year.*
>
> *I first sent you a donation not long after your inception from another email and with no name. I was so paranoid I rang afterwards and asked you to check no records would be kept.*
>
> *Yet yesterday - less than a year later - I attended a work meeting wearing one of your hoodies. (I'd love to say this went down well, but it was not entirely without consequence. I've since been 'invited' to a meeting to 'discuss' my views on sex and gender, which I expect will be a reprimand.)*
>
> *However, I'm also very happy to attend this 'discussion', because the issues are ones that I believe need to be discussed more and more openly. The best way to bleach bad ideas in the light.*
>
> *But most strikingly of all, these are no longer views I am frightened to own or share, and thanks in no small part thanks to you all.*
>
> *So huge thanks and best wishes from me,*

(29) Every single one of our volunteers is driven by the desire to make life better for lesbian, gay and bisexual people. It's often not easy, and we have extremely vocal opponents, as evidenced by this litigation.

(30) I am very proud to Chair the Board of Trustees for LGB Alliance. I have sat on many boards and managed thousands of people over the course of my career but I can honestly say I have never met such a collection of kind, committed and intelligent people who give hours, days and weeks of their time for free to help people they don't know.

(31) Since retiring from full time work in December 2013 I have turned down many invitations to chair prestigious, high-profile arts organisations preferring to keep out of the public eye. When Kate Harris and Bev Jackson asked if I would chair LGB Alliance I knew it would be challenging and demanding and indeed it has turned into a near full-time job but I couldn't in all conscience refuse to do it. I believe the work the Alliance does is too important.

(32) Our voice is a unique one (among charities) for lesbian, gay and bisexual people. To the best of our knowledge there is no other charity that does what we do.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.



18 March 2022

Signature Date

eventbrite

View • Event Ended • More

Tickets

Publish

Dashboard

Order Options

Payments & Tax

Marketing

Manage Attendees

Reports

Event Reports

Analytics

Apps

Analytics

See where your sales are coming from, in real time

Updates every minute

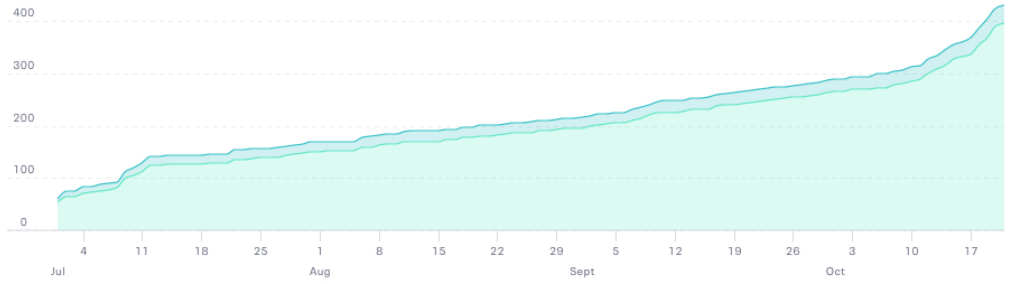
Sales Cha... | All time | Daily D...

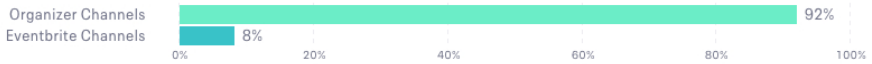
Related To
LGB Alliance Conferen...

Group By
Sales Channel

Quantity sold

Total | Daily





Summary for 1 Jul, 2021 - 21 Oct, 2021

Name	Quantity	Gross Sales	Total Fees	Net Sales
Eventbrite Channels	35	£1,791.00	£158.16	£1,632.84
Organizer Channels	396	£22,044.00	£1,937.04	£20,106.96
Total	431	£23,835.00	£2,095.20	£21,739.80

Date ↓	Quantity	Gross Sales	Total Fees	Net Sales
21 Oct 2021	431	£23,835.00	£2,095.20	£21,739.80
20 Oct 2021	425	£23,512.00	£2,067.04	£21,444.96
19 Oct 2021	404	£22,416.00	£1,972.67	£20,443.33
Total	431	£23,835.00	£2,095.20	£21,739.80

VIEW MORE

Export Chart | Export Data

Learn more about analytics

© 2022 Eventbrite

About • Blog • Help • Careers • Press • Investors • Security • Developers • Terms • Privacy • Accessibility • Cookies •

United Kingdom

1. Excellent speakers (especially, for me Alison Bailey and Lucy Masoud), highly relevant topics, all very informative and well-presented. 5 stars for everyone, including the organisers.

2. The speakers were excellent, there was a broad range and there were some impressive very knowledgeable speakers (eg on law and human rights) as well as people speaking more from personal experience - all valid and much appreciated.

3. The range of speakers, hearing from different people from so many different backgrounds and experience, hearing spoken out loud what so many have been forced to say in secret. It was empowering and Allison Bailey brought me to my feet with tears in my eyes. Wow.

4. Wonderful speakers, all contributed something of value. I felt a wonderful sense of solidarity. I appreciated people being able to ask questions and the range of different speakers there were. They were well organised, informative and well-run

5. The intelligence, thoughtfulness, and the honesty of the speakers. Many, MANY subjects were covered, and there was a huge variety of provenance of views (I mean people from different backgrounds) so we got to hear about many aspects of the issue and discover new points of view.

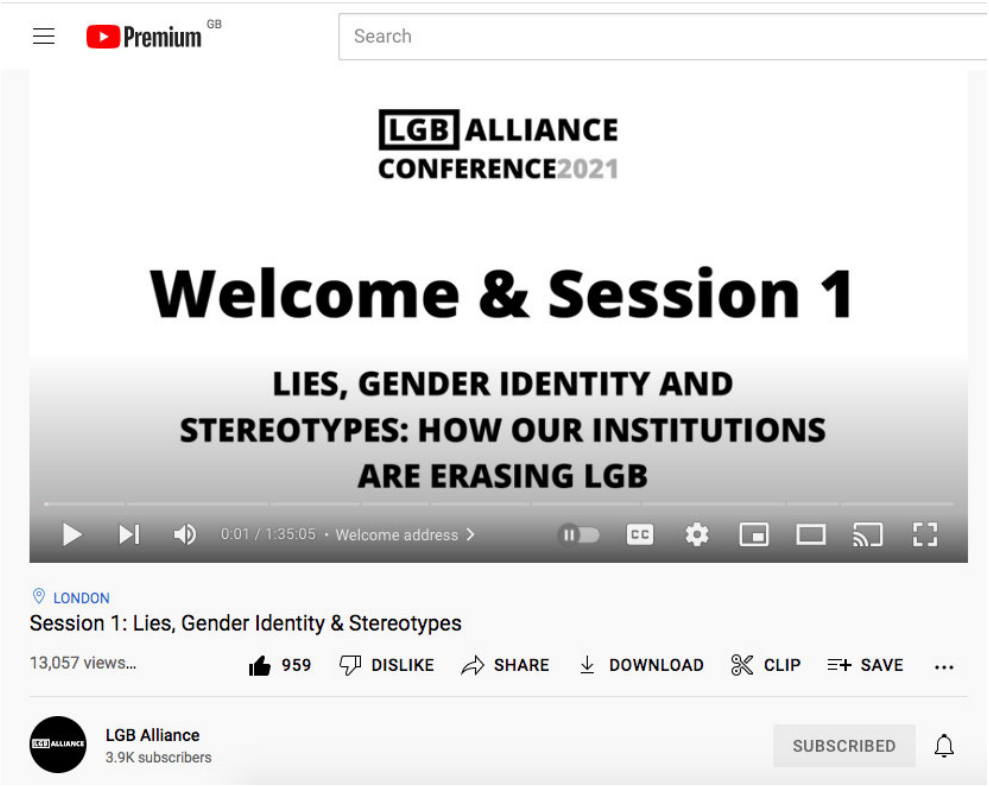
6. I thought this was a hugely welcoming, very well organised and inspiring event. I am so pleased I made the time to go. I met a lot of new people, heard so many stories and the line up of speakers was incredible. I'm glad you had a political mix of speakers and made it clear this isn't a one party issue - LGB rights and women's rights are much bigger than that. The variety of speakers and their backgrounds was first class- law, psychiatry, politics, statistics etc. It gave me hope that with such fantastic brains - and such energy and passion- that the future will be a positive one. Thank you for organising it. I left better informed than when I came in, inspired and energised to push for change. Ps- what a speech from Allison Bailey! The woman is a super hero!

7. Best night out in years! Danced my socks off, everyone joined in, fab music and vibe and loved the dinosaur guest appearance!

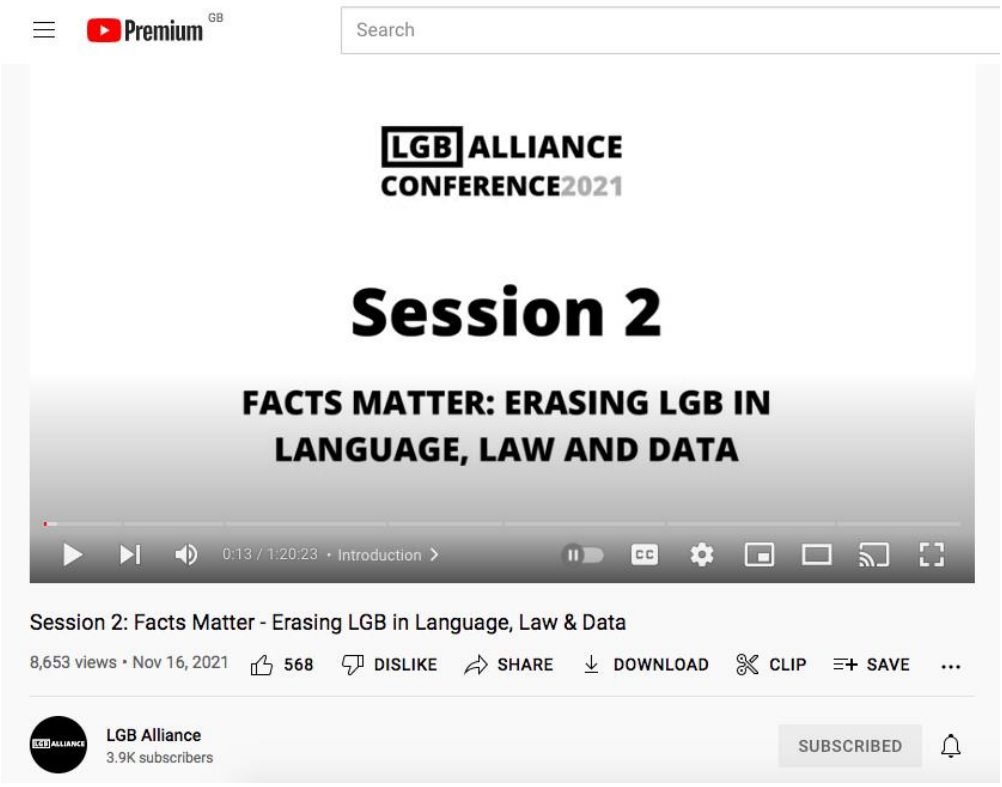
8. Longer disco please!

Conference Sessions on YouTube. Total views to date = 43,399

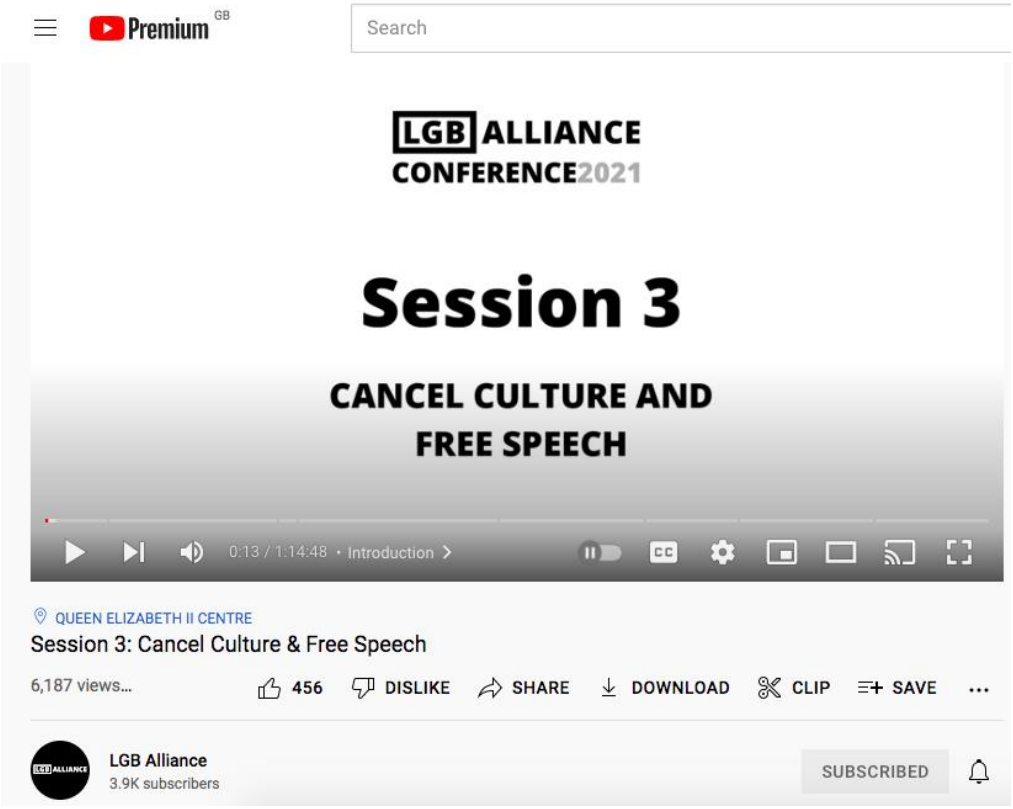
https://www.youtube.com/watch?v=01YzVihxjI0&t=538s



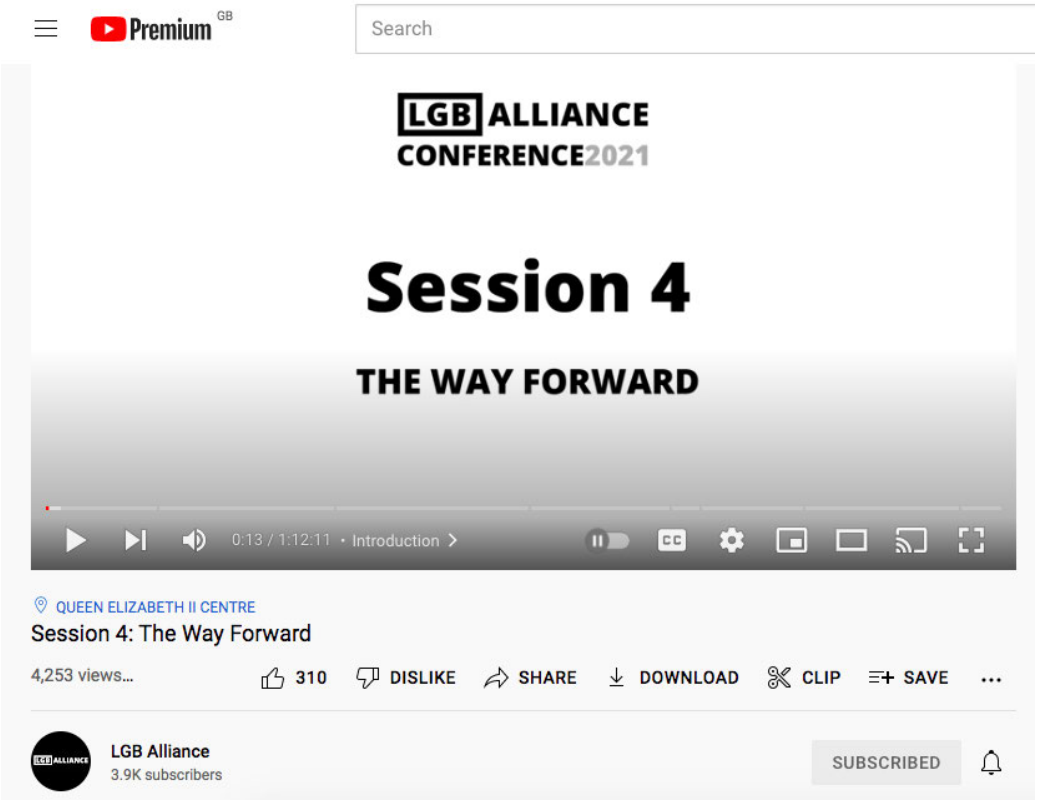
https://www.youtube.com/watch?v=pXQINlDTB0g



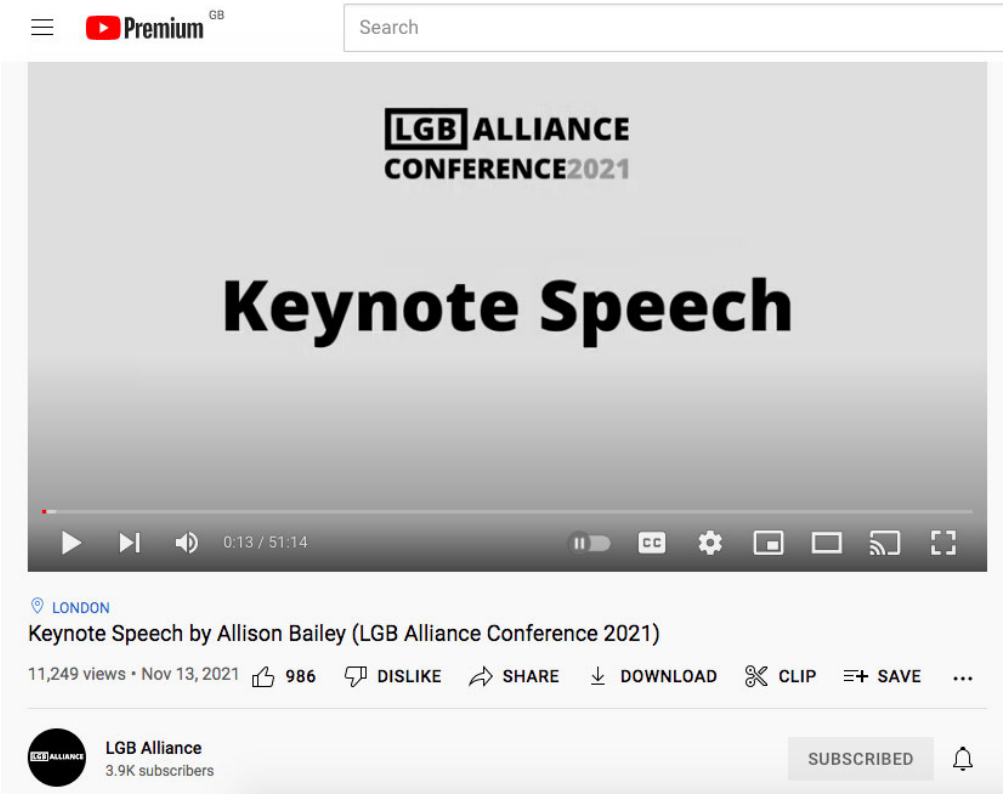
https://www.youtube.com/watch?v=oSk-Atd5HDw



https://www.youtube.com/watch?v=Jl1Frd_QGtc



https://www.youtube.com/watch?v=Otbfv45TRK0&t=10s





James Dreyfus 🇺🇦 ✓
@DreyfusJames

2 day hangover.
TWO FLIPPING DAYS...
A magnificent conference by @ALLIANCELGB , respectful, reasoned debate. Gay men, lesbians, bi, trans & straight...ALL THERE!

Anyone who continues to try & sell you the huge LIE that this is a 'h*te group' is either being wilfully ignorant..1

12:16 PM · Oct 23, 2021 · Twitter for iPhone



Michelle Shipworth
@MShipworth

Replying to @DeirdreReneeNW @ProfAliceS and 4 others

I watched all the LGB Alliance conference speeches & have read huge amounts of the websites of SexMatters & FairPlayForWomen. Genuinely, there is no hate there. I see & hear compassion for all.

11:17 PM · Feb 23, 2022 · Twitter Web App



Dr Viv Pointon, angry woman 🇪🇺💜🤍💚🦕🦙
@VPointon

Replying to @Jebadoo2

I'm so grateful for the LGB Alliance. The conference felt like we'd been reborn.

7:33 PM · Dec 29, 2021 · Twitter for iPad



WomenSpeakScotland
@womenspeakscot1

This was worth waiting for! The final session from @ALLIANCELGB conference in October. Fantastic contributions from @simonjedge @jo_bartosch @JNHanvey @DreyfusJames - just brilliant. #SexNotGender



youtube.com
Session 4: The Way Forward
We've arrived at a point where, after decades of fighting for our rights as people who are same-sex attracted, we are no...

11:57 PM · Dec 18, 2021 · Twitter Web App



David Bridle
@Pomegranate2021

Thoughtful post-@ALLIANCELGB Conference piece for LGN by @RadFem_KatH: “Whilst seemingly harmless, the loss of our spaces in reality means more LGB people feel isolated, and cannot find others with whom they can discuss their experiences or find support…



3:54 PM · Oct 28, 2021 · Twitter Web App



KatieW 🦕🦕🦕🦕🦕🦕🏴
@adarcymraeg

Replying to @BluskyeAllison and @NessNag

Very Happy New Year Allison. Your fab speech at the LGBAlliance conference still rings in my ears, heartwarming and inspirational.xx

11:42 PM · Dec 31, 2021 · Twitter Web App



Ellie Heretic KPSS
@EllieHeretic

Replying to @Jebadoo2 and @treekahlo

I wasn't at the Conference, but I feel so much more optimistic, since.
It was lovely to see you all having a great time.
As a veteran of the fight for Gay Rights,
I feel proud to fight, alongside such intelligent, compassionate, brave, principled people

7:57 AM · Oct 24, 2021 · Twitter for iPad



Mr Alex Bloodfire, Esq 💙🦕🦖 #SayNoToSelfID 🎄🎄
@alexbloodfire

Replying to @DreyfusJames @DebbieHayton and @ALLIANCELGB

A massively brilliant conference from the pro LGB charity - LGB Alliance and I'm getting ready and prepared for LGB Alliance Conference 2022!!!

There was a good proper debate!

It was a pleasure to chat with you James!

8:19 PM · Oct 23, 2021 · Twitter Web App

Riot Grrl
@RiotGrrl19

Post the @ALLIANCELGB conference on Thursday it's reminded me how deeply important it is to NEVER backdown to bullies. Bullied all through my schooling life, those scars never leave. We know who the bullies are. 👊💥👊 Enough is enough! #IStandWithCeri 🔥🔥grahamlinehan.substack.com/p/ceri-black-t...



7:34 PM · Oct 23, 2021 · Twitter Web App



Tiberius Kirk 🇬🇧
@TibbyKirk

@ALLIANCELGB Conference has been a triumph. A joyful, welcoming celebration of sex and same-sex issues with open, free and incredibly intelligent discussion and debate. Outstanding speakers that lay to waste any hint of hate within this noble, new organisation.

10:30 AM · Oct 23, 2021 · Twitter Web App



Karldin
@karldinmanfor

Replying to @ALLIANCELGB

Glad to see so many of my twitter mutuals attend your conference. You guys are doing really good, important work. Keep leading the way; you're inspiring people from all over the world to speak out and draw the line.

5:16 PM · Oct 22, 2021 · Twitter for Android



🦙AliceB🦕🇺🇦🌻
@AYomTov

Sat on the train home after yesterday's brilliant @ALLIANCELGB conference, wearing my lovely new hoodie. No better testimony to the day than having a man go past and, seeing the logo, say "great day, wasn't it?" 😊 We are everywhere …

9:44 AM · Oct 22, 2021 · Twitter for iPhone

94 Retweets **4** Quote Tweets **1,368** Likes

Alexander Bramham 🇬🇧🦕
@BramhamAlex

Replying to @AYomTov and @ALLIANCELGB

I just popped into a cafe morning after and bumped into two familiar faces. Message of inclusion, community and respect is winning.



10:54 AM · Oct 22, 2021 · Twitter for iPhone

4 Retweets **127** Likes



Emma Harriet Nicholson @Baroness_Nichol · Oct 21, 2021

Today with Dr Az @ALLIANCELGB and @LesbianLabour and a huge crowd this morning at coffee break ☕☕☕☕☕



15 32 611



Iris_I Am Woman 🇪🇨 🇬🇧
@Ecuadorian_Mum

Replying to @Baroness_Nichol @ALLIANCELGB and @LesbianLabour

Such a happy picture. Hope you had a great time x

9:29 PM · Oct 21, 2021 · Twitter for iPad

9 Likes

Safe Schools Alliance
@SafeSchools_UK

We had a fantastic day yesterday at @ALLIANCELGB conference. We feel really privileged to have been invited to attend & our spokeswoman be given the opportunity to speak about child #safeguarding. There was a fantastic line up speakers #LGBAlliance2021 #LGBT #edutwitter #WomenEd



12:11 PM · Oct 22, 2021 · Twitter for iPhone

21 Retweets **169** Likes

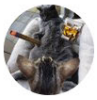


Helen Saxby
@helensaxby11

Congratulations on your successful conference LGB Alliance @ALLIANCELGB - from the pictures it looks like it was enthusiastic and joyful and all about the love 😘
#LGBAlliance2021

9:07 AM · Oct 22, 2021 · Twitter for Android

4 Retweets **39** Likes



FPL_Dave🟥
@Klopps_mug

Lovely pictures from the LGB Alliance conference yesterday, it's a long time since Section 28 was over turned, but 2003 doesn't seem that long ago when written down. Today, they have a new fight and I stand with them

7:45 AM · Oct 22, 2021 · Twitter for Android



Simone C. Bacchini.
@curzio70

I wish @ALLIANCELGB the best for their conference today. Sorry I can't be there. You are now the only organisation in the U.K. fighting for the rights of lesbians, gays, and bisexuals and affirming the reality of sex and same-sex attraction. Bon courage!

7:44 AM · Oct 22, 2021 · Twitter for iPhone

Truth and Beauty 🦕👩‍🎨🦙
@trashalou

I am delighted the @ALLIANCELGB has rec'd this letter of support from Downing St and the presence of so many MPs. I note it sits in contrast w the public support of politicians for the FILiA conference the previous week.

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> We appreciate the support of MPs and peers from all parties. Today, we are delighted and honoured to receive congratulations on our "incredible hard work" from the Prime Minister, @BorisJohnson as well as his best wishes for our conference. #LGBAlliance2021 👇



10 DOWNING STREET
LONDON SW1A 2AA
www.gov.uk/number10

Head of the Direct Communications Unit

20 October 2021

Gender Atheist 🥬🥛🍆
@gayfeministally

Thank you @ALLIANCELGB team for putting together a brilliant #LGBAlliance2021 conference. Exactly the positive, energetic, loving event that we all needed. The venue was an inspired choice. Those of us who want both LGB rights and women's rights are inspired and strengthened. x

11:37 PM · Oct 21, 2021 · Twitter for Android



John James
@JohnJamesTV

Congratulations on an historic conference @ALLIANCELGB!

The days of Stonewall speaking on behalf of lesbians, bisexuals and homosexuals are over.

LGB Alliance are here to stay x

#LGBAlliance2021 #LGBAlliance #LGBA

11:07 PM · Oct 21, 2021 · Twitter for iPhone

22 Retweets **4** Quote Tweets **184** Likes



Maureen O'Hara
@OHaraMaureen9

Great speech from @jo_bartosch at LGB Alliance conference today:



thecritic.co.uk
The way forward | Josephine Bartosch | The Critic Magazine
Below is an extract from Jo Bartosch's speech at the LGB Alliance Conference, 21 October 2021 I want to talk about pride and about shame. I have never been...

10:28 PM · Oct 21, 2021 · Twitter for Android



Dr Viv Pointon, angry woman 🇪🇺💜🤍💚🦕🐐
@VPointon

Absolutely amazing day at @ALLIANCELGB conference. Fabulous to talk to Rosie Duffield, Jo Cherry and James Dreyfus. And so many more familiar faces, friends old and new. The bonus was meeting Ann McManus, writer of Bad Girls.

9:57 PM · Oct 21, 2021 · Twitter for iPad

2 Retweets **153** Likes



Aphrodite Philomeddes
@philomeddes

Today's @ALLIANCELGB conference was fab. Tanya Carter for @SafeSchools_UK gave a brilliant speech. Neale Harvey asked in whose interest is it to erode child safeguarding?
@jo_bartosch got a standing ovation and was a straight taking and fabulous as ever.
Great day.

9:35 PM · Oct 21, 2021 · Twitter Web App

20 Retweets **1** Quote Tweet **143** Likes



Ian Acheson
@NotThatBigIan

Very interesting evening at the @ALLIANCELGB conference with @NoXYinXXprisons who is doing so much to protect women's rights in custody. Banging tunes too, as the youth might say.

9:22 PM · Oct 21, 2021 · Twitter for Android

1 Retweet **10** Likes



Baron Stuart Rutherford 🌻🇺🇦🦕💙🟩⬜🟪🦖🦋
@doodlewhale

Can we have an @ALLIANCELGB conference every day? I've cried tears, mostly of joy, reading the stories coming out of the event and seeing the huge support on and offline. I am awash with hope. 🌱

#LGBAlliance2021

8:57 PM · Oct 21, 2021 · Twitter for iPad

1 Retweet **9** Likes



deb 💜🤍💚🇺🇦
@nomadawn68

To all the amazing women and men at the fabulous @ALLIANCELGB conference, hope you are having an absolute ball this evening 🎪🥂🍾🍻🎉
P.S. please look after @DreyfusJames he's a wild one 🕺
#LGBAlliance2021

8:19 PM · Oct 21, 2021 · Twitter for Android

1 Retweet **24** Likes



Neale Hanvey MP ❤️🏴‍☠️✊ 

@JNHanvey

Delighted to finally catch up with the wonderful @DebbieHayton in person at @ALLIANCELGB conference today

#CourageCallsToCourageEverywhere



7:49 PM · Oct 21, 2021 · Twitter for iPhone

57 Retweets **6** Quote Tweets **771** Likes



Tony Guillan
@TonyGuillan

What an inspiring day listening to inspiring people @ALLIANCELGB conference. Passion, and compassion, grounded in the biological and social realities faced by us all, differently. I wanted to say to the protesters - come in, and listen. There is another way #LGBAlliance2021



7:32 PM · Oct 21, 2021 · Twitter for Android

11 Retweets **139** Likes



Charlotte Edwards 🦖🤍💜
@rafaellacj

So thrilled to meet @RosieDuffield1 at the @ALLIANCELGB conference!



7:16 PM · Oct 21, 2021 · Twitter for iPhone

7 Retweets **341** Likes



Samira #IndyWales #EndFGM
@abdisamira1

Congratulations to @ALLIANCELGB on their 1st conference. Hoping next year @LGBAllies_Cymru can hold one in Wales #LGBACymru2022 ✊🏾

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> Well this is a good result for a day's work. "Boris Johnson backs Kathleen Stock and LGB Alliance"
>
> thetimes.co.uk/article/bcd547...

6:57 PM · Oct 21, 2021 · Twitter for iPhone



Problem Being 🏴‍☠️🇭🇰🇮🇱🇬🇧🇨🇦✡️
@BeingProblem

Replying to @ALLIANCELGB and @BluskyeAllison

So pleased you managed to have such a successful conference. I so wish. I could have been there with you.

6:52 PM · Oct 21, 2021 · Twitter for iPad



LesbianStrength
@StrengthLesbian

Congratulations to LGB Alliance for their wonderful conference.

6:46 PM · Oct 21, 2021 · Twitter for Android

4 Likes

Here to read
@Soph33761225

@ALLIANCELGB amazing conference! What a line up! Such incredible speakers, so much positive energy and such a lot of hope for the future. Thanks for organising - here's to next year! #LGBAlliance2021

6:34 PM · Oct 21, 2021 · Twitter Web App

1 Like

Dr Sarah Rutherford
@sarahrutherfor2

I had the pleasure of listening to these three politicians speak this afternoon @ALLIANCELGB conference showing that female solidarity extends beyond party lines. Thank you @JackieDP @RosieDuffield1 and @joannaccherry

> **Nicky Edwards** @NickyEdwards · Oct 21, 2021
> I'm really grateful to my sisters here @JackieDP @RosieDuffield1 and @joannaccherry looking out for each other in Parliament and beyond @ALLIANCELGB



6:30 PM · Oct 21, 2021 · Twitter for iPhone

4 Likes

FiLiA
@FiLiA_charity

What a conference!

Thanks to @ALLIANCELGB for making it possible.

#NoDebate is extinct

#LGBAConference #LGBA2021



5:22 PM · Oct 21, 2021 · Twitter for Android

55 Retweets **221** Likes



Sean McGrath
@SeanMcG53

@ALLIANCELGB .. an excellent conference today at QE2 Westminster .. brilliant & inspiring speakers Joanna Cherry, Graham Linehan Maya Forstater..Sinead Watson..Allison Bailey ...thank you @BevjacksonAuth & Kate Harris... 👍👍👍🏳️‍🌈



5:08 PM · Oct 21, 2021 · Twitter for iPhone

2 Likes



slightlyatsea (Deb) 💙NHS
@slightlyatsea

Love and support to everyone at the LGB Alliance conference today. ❤️

> **Sam Morgan** @CrunchAlias · Oct 21, 2021
> Replying to @PpoliticsForAll
> The LGB Alliance have had to put up with a torrent of abuse for not caving in to the redefine of homosexuality to homogenderality. They deserve praise for being the only remaining charity in the UK which officially supports and campaigns for homosexuals.

4:12 PM · Oct 21, 2021 · Twitter Web App

1 Retweet **9** Likes



Anne Jenkin
@Baronessjenkin

Me too 👇 . @ALLIANCELGB conference great speakers and great atmosphere. Good to see half a dozen @Conservatives colleagues from @UKHouseofLords and @UKParliament there too.

> **Philip Hunt** @LordPhilofBrum · Oct 21, 2021
> Delighted to have joined this important conference twitter.com/LesbianLabour/...

4:12 PM · Oct 21, 2021 from London, England · Twitter for iPhone

7 Retweets **35** Likes

Genspect
@genspect

Congratulations @ALLIANCELGB and best wishes for a productive conference today !

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> We appreciate the support of MPs and peers from all parties. Today, we are delighted and honoured to receive congratulations on our “incredible hard work” from the Prime Minister, @BorisJohnson as well as his best wishes for our conference. #LGBAlliance2021 👇



10 DOWNING STREET
LONDON SW1A 2AA
www.gov.uk/number10

Head of the Direct Communications Unit

20 October 2021

Claire Fox
@Fox_Claire

This #CancelCulture panel debate at @ALLIANCELGB conference is humbling and inspiring in England measure. Free speech really does matter. It's a visceral feeling in the room.

> **Claire Fox** @Fox_Claire · Oct 21, 2021
> Brilliant, shocking, funny and self-effacing speech by @Pomegranate2021 on how #CancelCulture works, how it fuels cowardice and disloyalty. BUT in the end, it can also inspire bravery, create new networks of solidarity, even spawn new journalism. We shall overcome.

3:46 PM · Oct 21, 2021 from London, England · Twitter for Android

7 Retweets **46** Likes



Pink_CarbonUnit
@PCarbonunit

Listening to @Pomegranate2021 at the conference. I cannot believe the @THTorguk removed a VITAL HIV drive from @BoyzMagazine within moments of David's tweet neutrally welcoming @lgballiance!

It leaves an indelible mark on THT. As a HIV man of 21 years I will NEVER FORGIVE YOU.

3:34 PM · Oct 21, 2021 · Twitter for iPhone

24 Retweets **2** Quote Tweets **84** Likes



Angela Richardson MP
@AJRichardsonMP

I wish the LGB Alliance well as they hold their conference today.

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> We appreciate the support of MPs and peers from all parties. Today, we are delighted and honoured to receive congratulations on our "incredible hard work" from the Prime Minister, @BorisJohnson as well as his best wishes for our conference. #LGBAlliance2021 👇

10 DOWNING STREET
LONDON SW1A 2AA
www.gov.uk/number10

Head of the Direct Communications Unit

20 October 2021

Dear Ms Harris

Thank you to you and Ms Bev Jackson for your email of 15 October, kindly inviting the Prime Minister to attend the first LGB Alliance national conference on 21 October.

The Prime Minister is delighted to learn of this ground-breaking event and is aware of what a truly momentous occasion this will be. Unfortunately, as I hope you will understand, it will not be possible for the Prime Minister to attend, due to pressures on his diary. However, on his behalf, I would like to thank the LGB Alliance for their incredible hard work and send my best wishes for a successful conference.

Thank you, once again, for writing.

Yours sincerely

MANDY GODRIDGE

Ms Kate Harris and Ms Bev Jackson

37



Ruth Richards-Hill ♿♀🏳️‍🌈🐾🇺🇦
@Tantrumfly

@BluskyeAllison is making the most incredible keynote speech at the @ALLIANCELGB conference 2021. I hope we will be able to get a copy online for those that could not attend

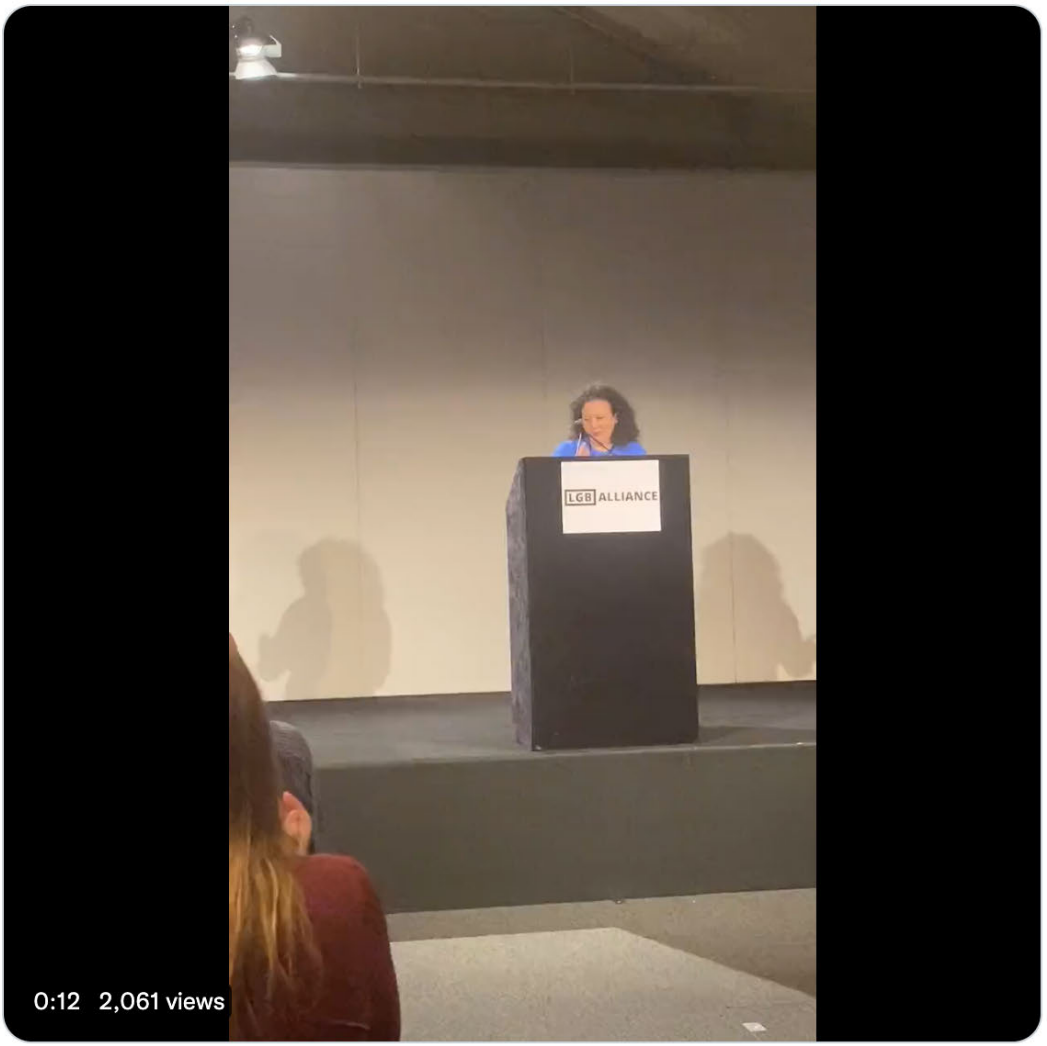
2:37 PM · Oct 21, 2021 · Twitter for iPhone

5 Retweets **26** Likes



Paola Diana
@paoladiana_

What a pleasure to see the force of nature of @MForstater at #LGBAlliance2021 and a room full of incredibly amazing people fighting for human rights and freedom. What a huge success! Well done to @ALLIANCELGB for organising this much needed conference #sexnotgender



2:16 PM · Oct 21, 2021 · Twitter for iPhone

14 Retweets **6** Quote Tweets **53** Likes

LGB Alliance Australia
@LGBAlliance_Aus

Sending all our support from the other side of the world, to the group who made our group possible. Best wishes @ALLIANCELGB for their inaugural conference today! Wish we could be there ourselves, but amazing to see such an incredible line-up of speakers and supporters.

2:14 PM · Oct 21, 2021 · Twitter Web App

3 Retweets **45** Likes

Hassan Mamdani
@HassanMamdani

@ALLIANCELGB have put on a fantastic conference... inspiring, knowledgable, insightful speakers and a wonderful chance to meet so many people I've only interacted with on Twitter. Amazing atmosphere! Thanks @BevJacksonAuth, Kate, @TwisterFilm and the team #LGBAlliance2021

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> We appreciate the support of MPs and peers from all parties. Today, we are delighted and honoured to receive congratulations on our "incredible hard work" from the Prime Minister, @BorisJohnson as well as his best wishes for our conference. #LGBAlliance2021 👇
>
> 10 DOWNING STREET
> LONDON SW1A 2AA



Liath Luachra
@liath_luachra

Replying to @ALLIANCELGB

Beautiful flag design. Congratulations on getting your conference off the ground and on countering the blatant lies and mistruths being promulgated about your organisation. I would love to be there.

1:39 PM · Oct 21, 2021 · Twitter Web App



Notorious VFT 🌻
@ChunLisa

Replying to @Bjerkeley @PrideInSurrey and @KirstySNP

They speak for the LGB people who are there and who support them. I support LGB Alliance because I believe same-sex attraction is being demonised. If you don't feel that way, that's good for you. But we disagree, as do the hundreds of people at the conference today.

1:03 PM · Oct 21, 2021 · Twitter for Android

14 Likes



Allenomura
@Allenomura

Truth about LGB Alliance: Who campaigns for what, then, and when. 👇

It's perfectly clear, demonstrable and uncomplicated, as truth often tends to be. Today is #LGBAlliance2021 Conference: the Alliance is here to stay! 👍 Well done to Bev & the team for stepping up so we can all 🗣️

> **LGB Alliance** @ALLIANCELGB · Oct 20, 2021
> 4./ Our critics then said we were hateful by breaking up a long-standing LGBT relationship. We didn't. Here's one of many Stonewall publications from before 2014. It's a Guide for Lesbians that gives information on How to Get Pregnant. 👇 stonewall.org.uk/resources/preg...
> Show this thread

12:53 PM · Oct 21, 2021 · Twitter Web App



Brenda Ellis
@sapphitweet

Replying to @joannaccherry @LesbianGayNews and @ALLIANCELGB

Sounds like you are all having a fantastic conference. Wish I could be there.

12:43 PM · Oct 21, 2021 · Twitter Web App

14 Likes



Joanna Cherry QC
@joannaccherry

At @ALLIANCELGB conference listening to a fantastic panel event. Lucy Masoud firefighter & barrister says the new attack on same sex attraction is homophobia dressed up as progressive & inclusive. She won't be bullied back into the closet. #LGBAlliance2021



12:31 PM · Oct 21, 2021 · Twitter for iPhone

234 Retweets **12** Quote Tweets **927** Likes



FirechildAmericano ☕
@CathycoffeeUS

Replying to @ALLIANCELGB and @SpeechUnion

Best wishes for a peaceful and productive conference. Finally lesbians may have half a chance to be recognized

12:25 PM · Oct 21, 2021 · Twitter for Android



Tiberius Kirk 🇬🇧
@TibbyKirk

Replying to @Blackbox666 @Jebadoo2 and @ALLIANCELGB

I hope the LGBA conference evolves to include a new gay and lesbian pride march.

12:14 PM · Oct 21, 2021 · Twitter for iPhone

4 Likes



You know it makes sense 💚🤍💜
@NeverTheSun23

Replying to @ALLIANCELGB

Hope you have a wonderful conference!

11:15 AM · Oct 21, 2021 · Twitter Web App



Yvonne M
@mcwhirr11

Replying to @ALLIANCELGB

Have a fantastic conference. Im looking forward to updates.

11:12 AM · Oct 21, 2021 · Twitter for Android



Susan B Mouse💚🤍💜
@SusanBMouse1

Replying to @ALLIANCELGB

Wishing you a wonderful and powerful conference, I hope to join you next time. X

11:04 AM · Oct 21, 2021 · Twitter for iPhone



SophieXY ♂KPSS
@SophieXY44

I have major FOMO over the @ALLIANCELGB conference. I hope there will be videos aplenty!

10:59 AM · Oct 21, 2021 · Twitter for iPhone

2 Retweets **93** Likes

BenC42 #KPSS #SWS #NPBFC
@BenC42

Solidarity to @LesbianLabour members attending the @ALLIANCELGB Conference in London. Definitely NOT a "hate group"!
Best regards - Ben
(@UKLabour member A618905)
Cc: @Keir_Starmer @AngelaRayner @AnnelieseDodds @lisanandy @DrRosena @jessphillips @Alison_McGovern @TaiwoOwatemi

> **LesbianLabour** @LesbianLabour · Oct 21, 2021
> Lesbian Labour here we go! #LGBAlliance conference



Carol Cunningham 🏴🏴🇮🇱✝️✡️🌻🌻🌻
@CarolM_CC

Replying to @ForwomenScot and @ALLIANCELGB

Have a great conference everyone 💜🤍💚

10:53 AM · Oct 21, 2021 · Twitter for iPhone



Fran StaniFan 🟥🐐💚🤍💜
@gladys3467

LGB Alliance making history with their first conference this weekend. Have a good one all of you, you've achieved so much in such a short time 💕💕

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> Oh look there's light in the sky and our flags are up.





Antonia Frances 💙🦕
@antoniafrances

Replying to @ALLIANCELGB

Have a good conference everyone. You have some great speakers.

10:32 AM · Oct 21, 2021 · Twitter for iPhone

1 Retweet **9** Likes



Resist
@L0V3Printworks

Replying to @LGBAlliance_USA @ALLIANCELGB and @BevJacksonAuth

#freetobelgb Love this! Wish I was there! Happy Conference kick-off @ALLIANCELGB

10:20 AM · Oct 21, 2021 · Twitter for Android

3 Likes



Emma Harriet Nicholson
@Baroness_Nichol

Undoubtedly we are already doing that and this magnificent @ALLIANCELGB conference will propel our determined campaign much further on

>  **seonaid dawn barber** @seonaidsnail · Oct 21, 2021
> Replying to @Baroness_Nichol and @ALLIANCELGB
> Hope u have fun n productive time -finding way forward to protect young people from maddening ideology

10:11 AM · Oct 21, 2021 · Twitter for iPhone

3 Retweets **32** Likes



Susan Dalgety
@DalgetySusan

Replying to @ForwomenScot and @ALLIANCELGB

Have a great conference!

10:03 AM · Oct 21, 2021 · Twitter for iPhone

7 Likes



Niko
@girltimeintl

Replying to @ALLIANCELGB

Love to see it 😍😍😍 Have a great conference!

9:59 AM · Oct 21, 2021 · Twitter Web App



Wendy Stephenson
@WendySteph

Replying to @ALLIANCELGB

Have a great conference. Solidarity!

9:46 AM · Oct 21, 2021 · Twitter for iPhone



🦕 Enhehuanna 🌸
@wrongthinkorg

Replying to @BramhamAlex and @ALLIANCELGB

Have a wonderful conference ❤️

9:44 AM · Oct 21, 2021 · Twitter for iPhone



🦕🍒 Sisters KPSS
@SistersOfAnne

@ALLIANCELGB Good luck with the conference today. Sorry we couldn't be there with you!

9:50 AM · Oct 21, 2021 · Twitter for iPhone



Lizzie Morris 🏳️‍🌈 🦕
@LizzieM70

Replying to @ALLIANCELGB

Have a fantastic conference. SO sorry I can't join you today.

9:44 AM · Oct 21, 2021 · Twitter Web App



Julian Vigo
@_JVigo

I am excited about today's @ALLIANCELGB conference. We've had many of the participants on the Savage Minds podcast and it warms my heart to see a truly grassroots movement come together in person. I wish I were there! @simonjedge @MForstater @HJoyceGender @ProfAliceS

9:40 AM · Oct 21, 2021 · Twitter Web App

4 Retweets **63** Likes

Sally Jackson
@Blackbox666

Proud to be supporting @ALLIANCELGB at their first conference!



9:39 AM · Oct 21, 2021 · Twitter for iPhone

73 Retweets **6** Quote Tweets **1,259** Likes



Samantha 🇺🇦💚🤍💜🦕🦕
@samanthasrants

Wish I was able to be at the @ALLIANCELGB conference to show my support in person but sadly all I can do is send my best wishes.

Have fun everyone ❤️

9:37 AM · Oct 21, 2021 · Twitter for Android



Rachel Terfasaurus 🦕🦕💚🤍💜🏝️
@raychilled

Have a wonderful day all attending @ALLIANCELGB conference #SexNotGender

> **Hybrid Transsexual Humanoid**🏳️‍🌈🏳️‍⚧️🌊 @JaeDQuinn · Oct 20, 2021
> I'm a transsexual and I support this. twitter.com/BuckAngel/stat...

9:29 AM · Oct 21, 2021 · Twitter Web App



shelley charlesworth
@charlesworth102

Fantastic to be here at this groundbreaking conference. #Free2Be#LGBAlliance 2021

9:15 AM · Oct 21, 2021 · Twitter for iPhone

3 Likes

LGB Alliance Deutschland
@LGBAlliance_DE

The first LGB Alliance Conference in London has started. We wish all participants a successful and informative conference. Best regards from Germany!

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> Oh look there's light in the sky and our flags are up.



Martin in Yorkshire 🇺🇦
@martinradio

Wishing everyone attending the @ALLIANCELGB conference a happy and productive day.

8:58 AM · Oct 21, 2021 · Twitter for Android

Rick Westhorpe
@YnYCae

Its the LGB Alliance Conference today. Really sad I can't be there, but sending love and gratitude for the brilliant work you do. xx

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> Please feel free to RT, spread the Truth and ...encourage people to follow us. Can we get to 46K by the end of our conference today? 👀🤞
> twitter.com/ALLIANCELGB/st...

8:47 AM · Oct 21, 2021 · Twitter Web App



Lachlan Stuart 🌹🗽🇺🇦
@Lachlan_Edi

Solidarity to all those organising and attending the @ALLIANCELGB conference in London today.

When they call us hateful bigots, remember, it's them sterilising gay youth, not us. Who would have thought we're back to asserting the normality of same sex love?



8:29 AM · Oct 21, 2021 · Twitter Web App

68 Retweets **2** Quote Tweets **386** Likes



Littlest HOMOsexual
@HomoLittlest

Have a great @ALLIANCELGB conference. 👍❤️
Unable to attend because of work so I donated a ticket and will be there in spirit.
Remember truth is not hateful.
Thank you wonderful people for standing up for our hard won rights based on sex and same-sex attraction.

7:02 AM · Oct 21, 2021 · Twitter for Android

8 Retweets **160** Likes



LabourWomen'sDeclaration 🐐 🐐
@LabWomenDec

Congrats to @ALLIANCELGB on their conference. Lots of us will be there & the rest cheering from afar. You'll find LWD leaflets & new banner at stall of our sister org @LesbianLabour. All supporters attending Plse say hi. Special cheers for any @UKLabour politicians speaking up!

> **LGB Alliance** @ALLIANCELGB · Oct 20, 2021
> 1./ What's the TRUTH about LGB Alliance? Our critics like to claim we're funded by extremists and, despite the fact we've many trans supporters, that we don't support trans rights, even although we do. So WHY do so many people believe the myths? 👇 pinknews.co.uk/2021/10/19/lgb...
> Show this thread

6:32 AM · Oct 21, 2021 · Twitter for iPhone

44 Retweets **2** Quote Tweets **246** Likes



Eve 🦖🐈‍⬛🌱🐹🦋
@eve_eveander

Shout out to my lovely lesbian and gorgeous gay friends heading off to @ALLIANCELGB conference 😘😘😘

6:24 AM · Oct 21, 2021 · Twitter for iPhone

2 Retweets **13** Likes



Louisa Jones
@FilmLecturer

Replying to @ALLIANCELGB and @Matt_Zeleo

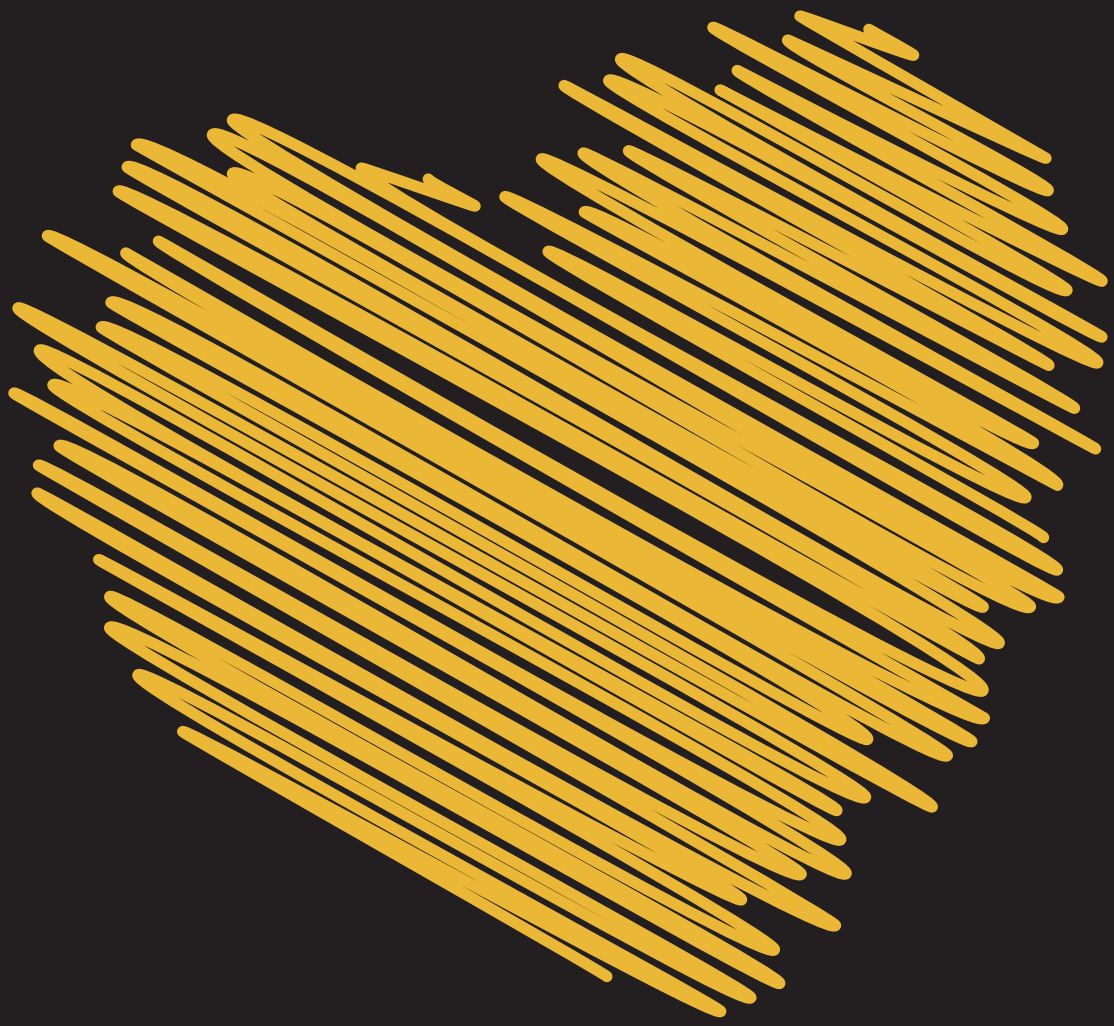
Wishing you all a great conference! X



8:10 PM · Oct 20, 2021 · Twitter for iPhone

8 Likes

Friends of LGB ALLIANCE



FUN draising pack

Host a virtual coffee morning, organise a regular fun run, book out your local pub for a gay karaoke night, cycle in fancy dress, arrange a life drawing class and offer to be the first model...

The Friends of LGB Alliance is an initiative designed to give you the excuse you need to get together with friends, and make new ones, as you celebrate everything that's creative, joyous and fun about our community.

It doesn't matter whether you collect £25 or £25,000 because the point is to build the friendships and support network we all need to make life that much better.

However you decide to raise money for the LGB Alliance, and however much you raise, you can be certain that your efforts will help us make a huge difference for lesbian, gay and bisexual people.

Take a look at guidance about making your event a success on the following pages. And remember to let us know about your plans in advance and we'll be happy to promote your event on all of our social media



Thanks so much for being a supporter. It means the world to us.

Essentials

For the best outcome whilst fundraising, you should observe some basics:

- **Keep to LGB Alliance Values**
  We engage with others respectfully. We discuss, propose and oppose ideas; we do not attack individuals. Disagreement does not equal hate. We do not condone, endorse or encourage any abusive or discriminatory behaviour towards any group or individual. Take a look at our Code of Conduct at the end of this pack.
- **Write a statement of purpose**
  Write a short statement describing what you're hoping to achieve, how you're going about it, including who's in charge of decision making. See our template on page 7.
- **Assess the risks**
  Protect yourself by assessing the risk to organisers, volunteers and participants. If your event is very large, you may need to consider having an insurance policy in place.
- **Secure the money**
  You must write down how you'll keep track of the money you raise (cash and online) so that there's no room for accusations later. It's best to do your calculations with pen and paper for ease of signing and dating. Scan or photograph the document at the end for saving and for future reference.

Organise a fun fundraiser in six questions

Consider six questions with the other organisers and write down what you agree:

1. What do you want to achieve?
2. Why are you doing this event?
3. When will the event take place?
4. Where will the event take place?
5. How will you advertise the event?
6. Who will do what to make it happen?

If you have ambitious plans, get in touch and we may be able to support you to make them happen.

Organise social outings: coffee morning, treasure hunt, pub quiz

Social events are the foundation of civil society. This is where the relationships are made that sustain the organisation. You can do this by general publicity, which, of course, might bring security issues, or by invitation, which is a good way to start a friendly local group. And it's a great way to raise a little money by asking for a small donation from each participant. It's also an opportunity for a raffle and a sales table. And, to minimise complaints, it's a good move to get a couple of people to count the money and announce at the end how much is going to the LGB Alliance and how much will be retained locally to facilitate your next gathering.

Auction goods or promises

Actioning goods or promises can be an entertaining focus for a social gathering. It can be the main event or a side show in a bigger gathering. You'll need to find someone who is good at taking the stage and plugging your sales. With promises, you need to be clear what's on offer. It's best to get it in writing.

Organise a raffle

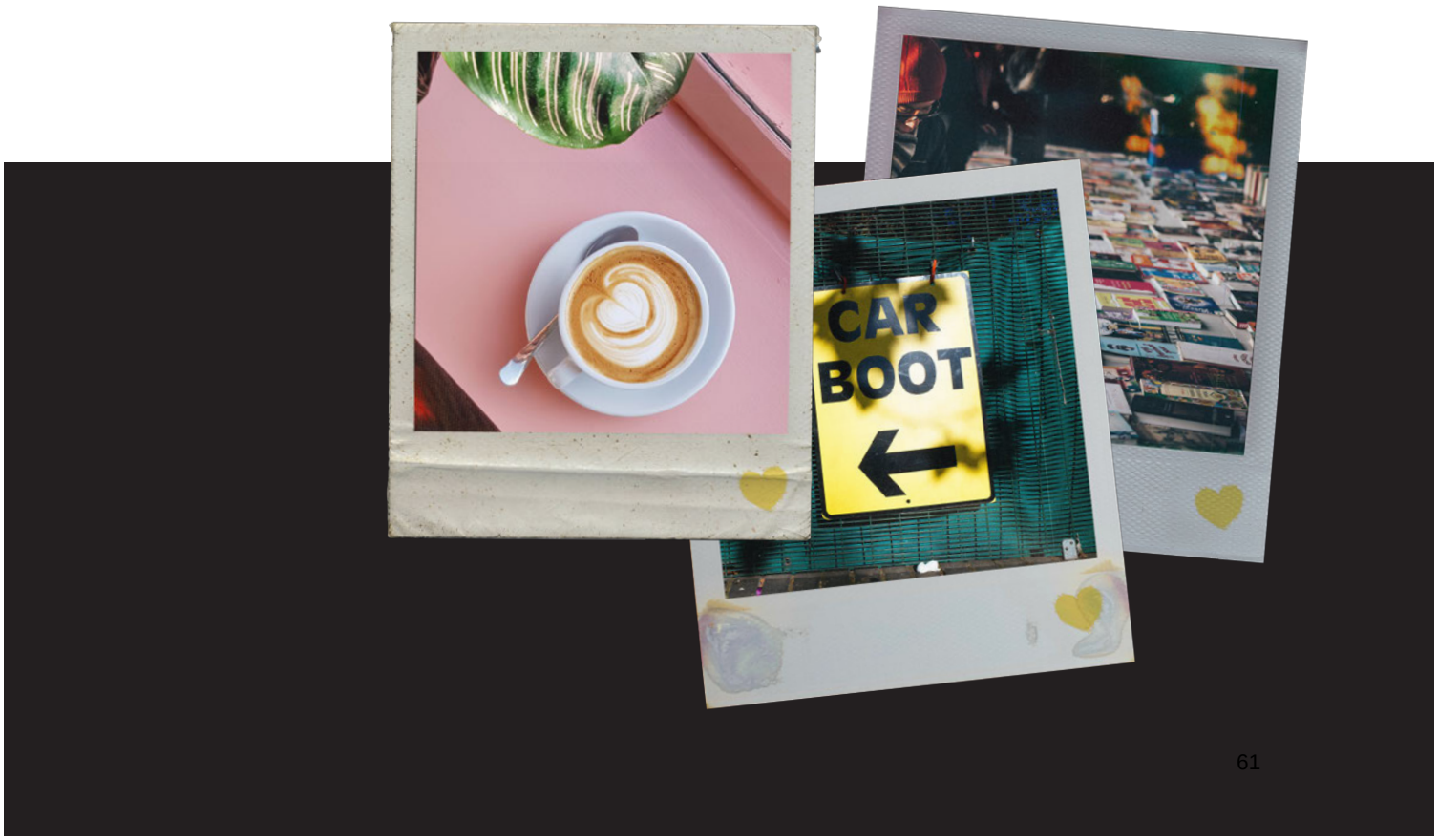
Add a simple raffle to any social, such as picnic or coffee morning, or as a build up to a bigger, formal gathering. You just need to find suitable prizes, including the option of cash from your takings, buy some cloakroom tickets, get an extrovert to officiate and a VIP to draw the tickets. It can be a great focus for a small gathering and a light-hearted side show to a big event.

Run a sales stall, sale of work, car boot

This is an opportunity for some discrete fund raising that's easy to organise. Ask for donation of sale goods from supporters and set up your stall at a local event.

Promote regular donations

Regular donation is the best way to provide the LGB Alliance with a steady income to support its work. Your challenge is to publicise the opportunity to supporters and to encourage people to sign up. Perhaps have someone with a phone or tablet that people can use to sign up on the spot. As the donor will have a direct relationship with the HQ donor team you won't have to do any auditing, although you may want to keep track of donor activity to measure your success.



Set up challenge-event sponsorship

A small, local challenge can be as much fun in the organising as in the doing. It works well with a small group of people seeking sponsorship from friends and family. You can simplify the money handling by registering with a sponsorship website such as JustGiving or GoFundMe. You could organise your own challenge event or participate in one organised locally or nationally.

Organise crowd funding for a named LGB Alliance service

Crowd funding through an established internet site is easy to arrange. Your challenge is to publicise it with the good arguments needed to generate support. It's also a secure method to transfer the money you raise to the LGB Alliance bank account, via the donate button on the website, with auditing done by the crowd funder site.

Organise ticketed celebrations

A ticketed celebration event can be a great occasion to raise money and socialise. But you need to start your advertising in good time to sell tickets in advance, unless you're going for the high-risk convenience of sales at the door.

Organise ticketed dance, drama or musical entertainment

Any ticketed event is a good focus for a social gathering, but it requires longer term planning and good advertising. You'll need to find performers as volunteers or at a good price for your audience. And you'll need to give some thought to security on the day.

Organise a ticketed talk, lecture, debate

This can be an effective way to highlight an issue you feel may have an impact on LGB people But, a ticketed event needs long term planning and good advertising if you are to get the desired effect. You'll need to choose your venue, speaker or panel carefully.



Arts & Crafts Sale
Auction of Promises
Alcohol Free Month
Abseil

Barbecue
Barn Dance
Bingo Night
Book Sale/Group
Bake Sale
Bike Ride
Boardgame Night

Cookery Competition
Come Dine With Me
Coffee Morning
Car Boot Sale

Disco
Danceathon
Dance Competition
Dinner party
Dog Walk

Ebay Sale
Eurovision Party
Easter Egg Hunt
Eighties Night

Fete
Fancy Dress
Fashion Show
Five-a-side Tournament
Film Night
Fun Run

Gig for local bands
Go Karting
Guess the Name
Garden Party
Garage Sale

Half Marathon
Halloween Party
Hill Climb

Indoor Games Night
International Food Evening
Ironman Triathlon

Jazz Night
Jumble sale
Jigsaw Contest
Jewellery Sale
Joke-athon
Jogging

Karaoke
Knitathon
Kite Flying

Lunch Event
Long Distance Walk
Live Music Night

Magic Show
Mountain Bike Race
Murder Mystery Evening
Midsummer Ball
Marathon

New Year's Eve Party
Netball Tournament
Nature Trail

Overseas Trek
Obstacle Course
Odd Socks Day

Picnic
Parachute Jump
Ping Pong Competition
Pub Quiz

Quiz Night
Quit Something

Rock and Roll Night
Rowing
Raffle

Summer/Solstice Fair
Sponsored Silence
Sixties / Seventies Night
Salsa Evening
Sweepstake

Talent Show
Treasure Hunt
Tea Party

University Challenge

Valentines Ball
Volleyball Competition
Vegetarian/Vegan Evening
Variety Show
Video Game Tournament

Wine Tasting
Walking Event

Xmas Fair
Xmas Party

Yoga Event

Zorbing
Zip Lining

A - Z of fundraising Ideas

Name of the fund-raising event you're planning:

Event date, time and venue:

Your name:

Your contact details:

Names of other organisers:

Name of the person controlling the money:

What are you hoping to achieve?

FUN FUNDRAISING EVENT

Statement of Purpose

Step 1.	Step 2.	Step 3.
What's the activity you're assessing? Conduct a risk assessment for activities of setting up, running and breaking down the event. Eg. Arranging furniture; separating participants and vehicles.	**What hazards are present or may be generated?** Look for hazards that could be reasonable expected to result in significant harm under the conditions at your event. Eg. Slips, trips, weather, moving machinery, power failure.	**Who may be harmed by the hazards?** List the groups of people affected: contractors, participants, performers, volunteers etc.
Step 4.	**Step 5.**	**Notes.**
What precautions are already in place? For the hazards listed, ensure precautions already taken represent good practice and reduce risk as far as reasonably practicable.	**What additional precautions are required to eliminate or reduce risk?** Where the risk is inadequately controlled under Step 4, indicate what more you need to do in this section (an 'action' list) Eg. Use suitable barriers; make hazards clearly visible; use of safety equipment, if appropriate; ensure stewards are clearly identifiable.	Consider public liability insurance in consultation with your venue. If purchased, attach a copy of the PLI certificate to the risk assessment.

EVENT RISK ASSESSMENT - GUIDANCE NOTES

Friends of LGB ALLIANCE

SPONSORSHIP FORM

Please sponsor me (name) _____

To (event) _____

In aid of LGB Alliance

I have ticked the box headed Gift Aid. I confirm that I am a UK Income or Capital Gains taxpayer. I have read this statement and want LGB Alliance to reclaim tax on the donation detailed below, given on the date shown. I understand that I must pay an amount of Income Tax and/or Capital Gains Tax in the tax year at least equal to the amount of tax that all the charities and CASCs I donate to, will reclaim on my gifts for that tax year. I understand that other taxes such as VAT and Council Tax do not qualify.
I understand the charity will reclaim 25p of tax on every £1 I have given.

Full Name (First name and surname)	**Home Address** (Only needed if you are Gift Aiding your donation. Please don't put your work address here.)	**Post Code**	**Amount**	**Date Paid**	**Gift Aid**

Total donations received	
Total Gift Aid donations received	
Date donations given to Resources for LGB Alliance	

Please note: For Resources for LGB Alliance to claim the extra 25% donation via Gift Aid this form must be returned with the money donated.

Small-scale informal fundraising is vulnerable to accusations of theft. You must follow a sound audit procedure to counter that.

Cash-income audit

Ticket sales

- Reconcile the cash taken with the ticket sales
- Get a trusted and independent person to verify your calculations
- Deposit the cash in your bank account
- Transfer the money to the LGB Alliance account using the 'Donate' form online. You'll see that there's a box to tick to show it's a Friends donation
- Take screen shots of your bank transactions
- Redact screen shots where necessary
- Attach redacted screenshots to the cash audit

[Event] held xx/xx/xx
Tickets sold: xx @ xx
Cash income = xx
Organiser:
Verifier:
Banked on xx/xx/xx by:

Collection

- Get two people to count the cash
- Do the counting in public view
- Get a trusted and independent person to verify your calculations
- Deposit the cash in your bank account
- Transfer the money to the LGB Alliance account using the 'Donate' form online. You'll see that there's a box to tick to show it's a Friends donation
- Take screen shots of your bank transactions
- Redact screen shots where necessary
- Attach screenshots to the cash audit

[Event] held xx/xx/xx
Cash collected = xx
Organiser:
Verifier:
Banked on xx/xx/xx by:

Finally, you can transfer the money you raise by using the 'Donate' button on our website. We couldn't be more grateful for your support.

Please take a few moments to read our code of conduct. As you are organising an event to support us, we would ask that you only proceed if you are able to meet the standards we impose upon ourselves as an organisation.

Principles

All adults working at or for LGB Alliance – whether as a member of staff or a volunteer – have a responsibility to ensure that everyone attending or otherwise engaged in LGB Alliance's activities, particularly children, young people and adults at risk, are protected from harm. It is the responsibility of each adult working in LGB Alliance to ensure that:

- ✓ their behaviour is appropriate at all times;
- ✓ they observe the rules established for the safety and security of children, young people and adults at risk;
- ✓ they follow the procedures following suspicion, disclosure or allegation of child abuse;
- ✓ they recognise the position of trust in which they have been placed; and
- ✓ in every respect, the relationships they form with children, young people and adults at risk are appropriate

All persons who wish to work in or for LGB Alliance, must accept and understand this policy. They must also agree to put LGB Alliance's policies on safeguarding children and young people and adults at risk into practice.

Meeting your responsibilities

To give positive guidance, the Code of Conduct (below) provides a list of 'do's and don'ts' to help you ensure that:

- ✓ the welfare of the children and/or young people and/or adults at risk for whom you have a duty of care is safeguarded;
- ✓ you avoid compromising situations or opportunities for misunderstandings or allegations.



Code of Conduct

Code of behaviour

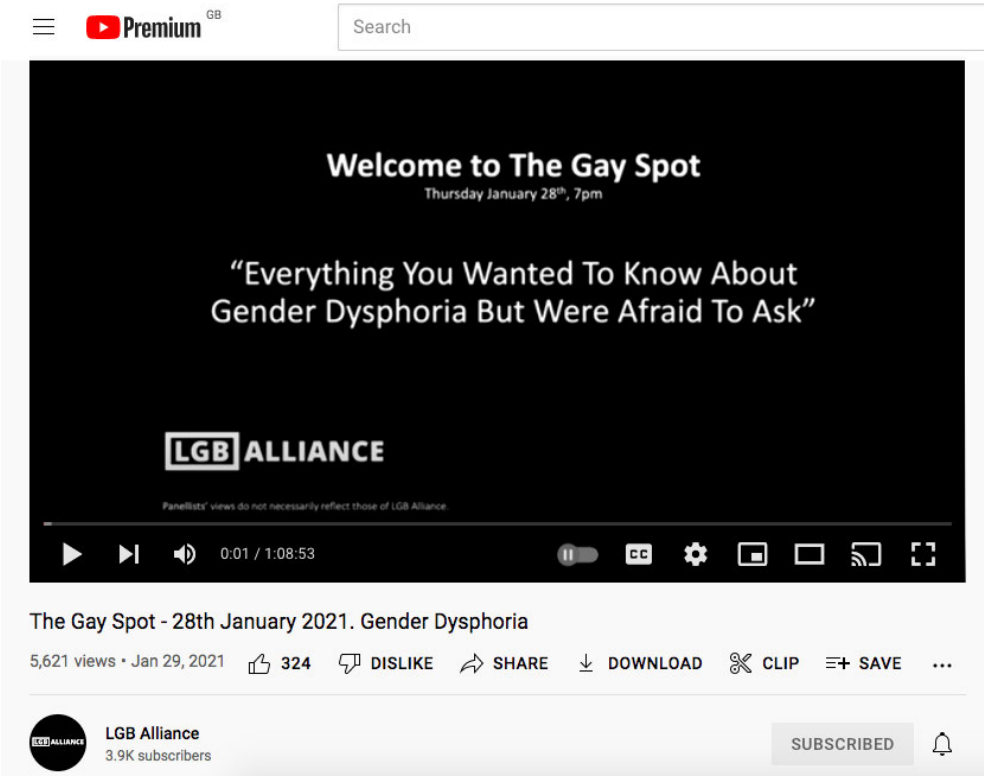
a) **DO** put this code into practice at all times;
b) **DO** treat everyone with dignity and respect;
c) **DO** set an example you would wish others to follow;
d) **DO** treat all young people equally – show no favouritism;
e) **DO** plan activities that involve more than one other person being present, or at least are within sight and hearing of others and particularly those from the host organisation or authority e.g., a school at all times
f) **DO** follow recommended adult/young people ratios for meetings and activities;
g) **DO** respect the right to privacy of a child, young person or adult at risk, except where they disclose any plan or activity by themselves or others that will put them at serious risk of harm
h) **DO** allow children, young people and adults at risk to talk about any concerns they may have;
i) **DO** encourage others to challenge any attitudes or behaviours they do not like;
j) **DO** avoid being drawn into inappropriate attention seeking behaviour, eg: tantrums and crushes;
k) **DO** follow LGB Alliance's 'no alcohol' guidance;
l) **DO** make everyone aware of LGB Alliance's procedures for safeguarding children, young people and adults at risk;
m) **DO** remember this code even at sensitive moments, e.g. when responding to bullying, bereavement or abuse;
n) **DO** keep other members of staff/volunteers informed of where you are and what you are doing;
o) **DO** remember someone else might misinterpret your actions, no matter how well-intentioned;
p) **DO take any allegations or concerns of abuse seriously and refer immediately.**

I. **DO NOT** trivialise abuse;
II. **DO NOT under any circumstances** form a relationship with a child, young person or adult at risk that is an abuse of trust;
III. **DO NOT** engage in inappropriate behaviour or contact – physical, verbal, sexual;
IV. **DO NOT** play physical contact games with children, young people or adults at risk;
V. **DO NOT** make suggestive remarks or threats to a young person, even in fun;
VI. **DO NOT** use inappropriate language – writing, phoning, email or internet;
VII. **DO NOT** let allegations, suspicions, or concerns about abuse go unreported;
VIII. **DO NOT just rely on your good name to protect you.**

Code of Conduct

LGB Alliance Webinars

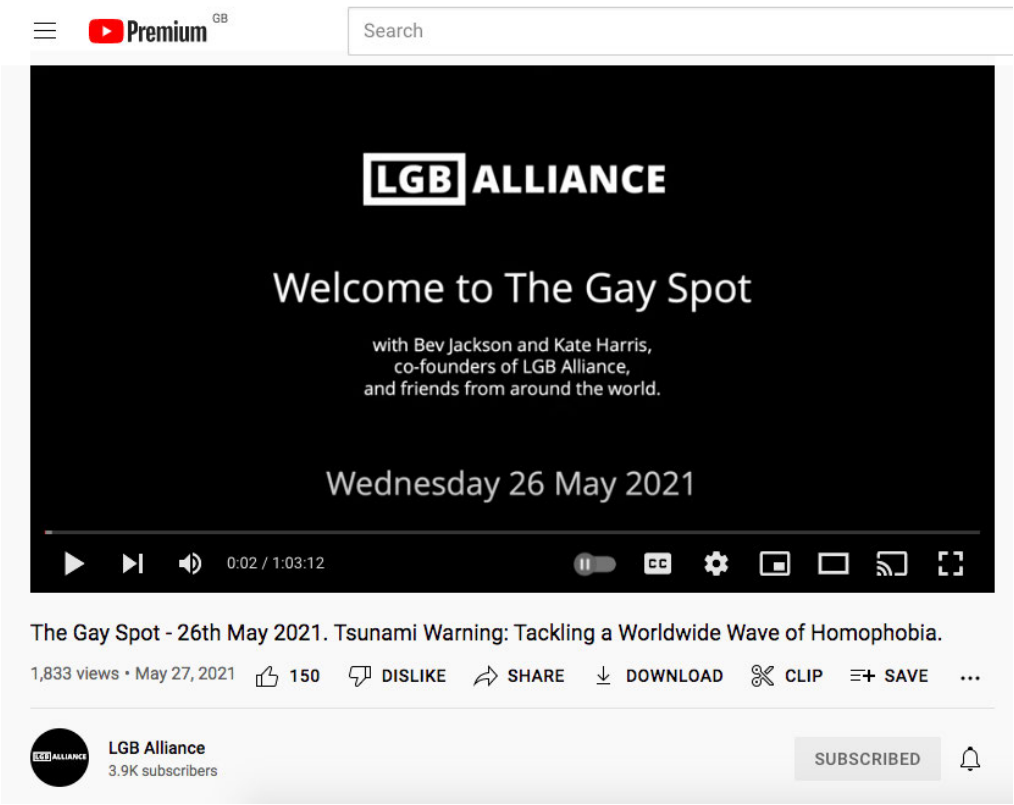
https://www.youtube.com/watch?v=XpqOkqNm6EQ



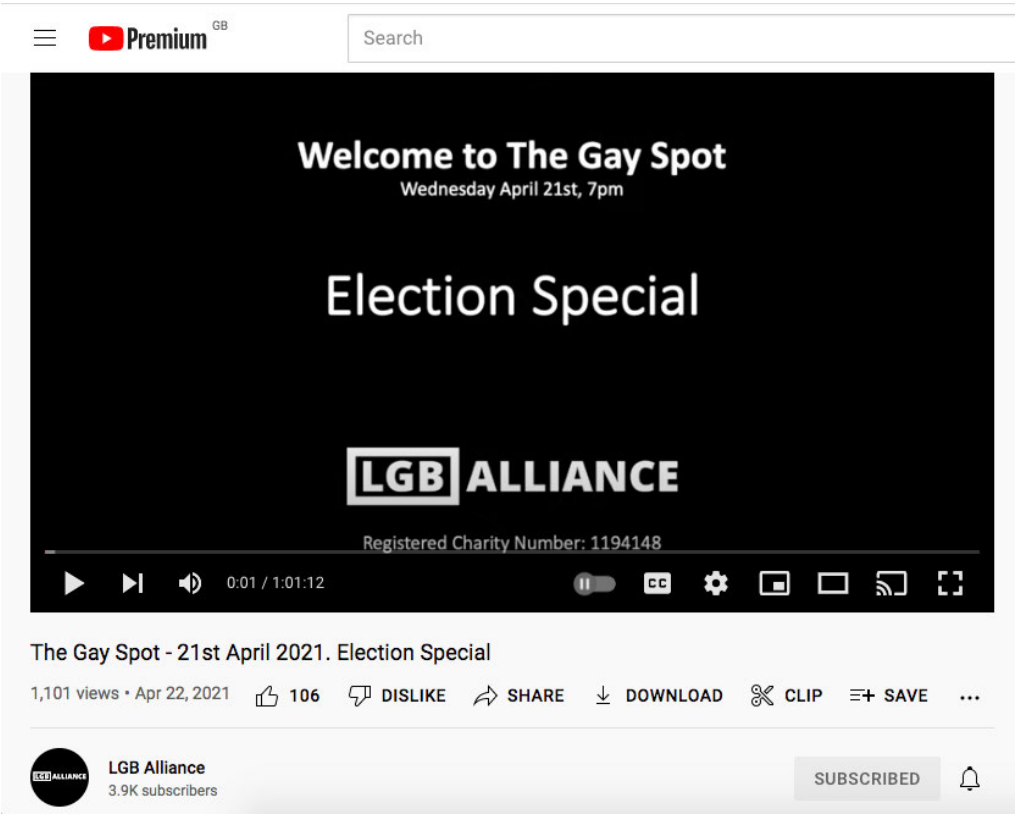
https://www.youtube.com/watch?v=WVtGbS1MNeg&t=375s



https://www.youtube.com/watch?v=qAwJkgK_4M8&t=1s



https://www.youtube.com/watch?v=2L_T15G8h4w







The Gay Spot - 25th February 2021. LGB History Pub Quiz
https://www.youtube.com/watch?v=WVtGbS1MNeg&t=2s

View this email in your browser

LGB ALLIANCE

August Issue

Welcome!

Introduction

Non-stop, moving forward



Welcome to the LGB Alliance Supporter list. This is a copy of the August newsletter, which went out just before you subscribed.

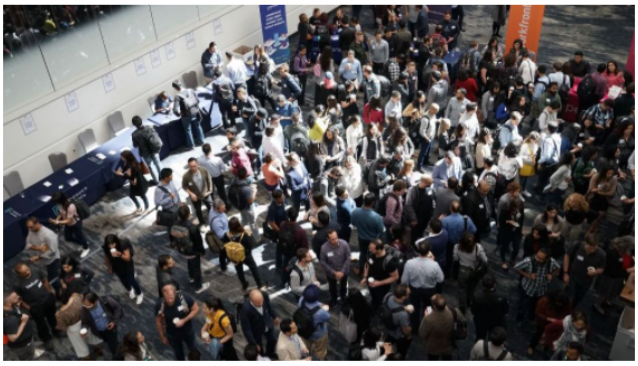
It's been a strange summer, for many reasons, not least the ever-changing Covid restrictions and extreme weather. As we head towards the autumn, and our second anniversary, we're making great progress as a registered charity. Our Trustee Board and Management Team had an in-person strategy and communication planning day last month. This has refined our mission aims and messaging and will form part of our five-year strategy, to be launched formally at our conference in October.

Our first-year financial accounts are about to be submitted to Companies House and will also be available on our website. We will always be transparent about where our funding comes from and where it is being spent. We are extremely grateful to all our supporters who make individual donations, regularly or one-offs, that collectively add up and keep us going. Our longer-term fundraising strategy is in development, and we'll be stepping things up in the coming months. If fundraising is your area of expertise and you'd like to get involved, sign up as a volunteer via the button below and join the fundraising team.

Finally, we've been welcoming on board many new volunteers joining our various working groups. It's only with the dedication and expertise of a long list of people that we've been able to get so far so fast. It's down to these same people that we will continue to grow and achieve great things in the future. If you have the skills and time to help us as a volunteer, take a look at the volunteer form and get involved.

Sign up to become a volunteer

Latest Hear2Stay conference news



Planning for our first annual conference on October 21st is progressing well. We'll share the full programme with you, before anyone else, in our September newsletter, as well as

announce the central London venue (sorry to keep you in suspense about where we'll be but, trust us, it's going to be amazing!)

In the meantime, below are some highlights of the kind of speakers and sessions you can expect:

- Helen Joyce talking about key themes in her new book
- Julie Bindel in conversation
- Alice Sullivan speaking on the impact of Queer Theory on data collection
- Kate Grimes chairing a panel on LGB health issues
- Eileen Gallagher, Graham Linehan and others discussing representation of LGB people on TV
- Jo Bartosch on discrimination and erasure of bisexuals in the world of gender wars
- A panel of MPs discussing how LGB people engage in politics
- An exploration of corporate rainbow-washing during Pride and year-round
- Rachel Ara and Jonny Best talking about being LGB in a woke Arts sector
- Professional panel exploring approaches to gender dysphoria and gender non-conforming children (and why this is an LGB issue)
- Plus, some firsts and some surprise guests

As subscribers to our Supporter mailing list, the £49 ticket price is still available to you via the ticket link button below.

Buy your discounted tickets now

As well as the great speakers and content, one of the main recurring reasons people are telling us they're coming to the event is to meet up and talk to lots of new people who share similar views and concerns. If you're thinking about buying a ticket and worried that you'll not know anyone else there, fear not. We'll be actively encouraging you to speak to strangers, and will have a range of fun, informal ways to help you break the ice and provide conversation starters on topics related to our work. You will be among friends.

There will be a vibrant exhibition area where you can meet and find out more about other organisations including:

- Lesbian and Gay News
- Sex Matters
- Keep Prisons Single Sex
- FiLiA
- Women's Human Rights Campaign (WHRC)
- Lesbian Labour
- Transgender Trend
- Bayswater Support Group

If you are part of an organisation that would like to exhibit, or to be a sponsor, please fill out the form via the button below.

Exhibitor and sponsorship enquiry form

We'll have a stall with the latest LGB Alliance merch, t-shirts, caps, mugs, and a range of other brand-new goodies we'll be launching at the event. Alongside this, there will be a bookshop stocking the latest titles from any of our speakers with books out, and a range of other titles covering issues for LGB people and related topics.

Remember, if you're not able to make it to the conference but would like to support the event, and be part of history, the ticket page has options to make a donation that gets your name and comment included in the official printed programme.

Click here to register your place or make a donation

Welsh consultation on a fundamentally flawed plan



The Welsh Government has announced a consultation on its long-awaited LGBTQ+ Action Plan and we encourage all of you to respond to the recommendations laid out in this regressive and homophobic document. Read more about our thoughts on the action plan on our blog, and how you can give your views. Responses to the consultation need to be submitted by 22nd October 2021.

Read our thoughts on the Action Plan

Bullied out of a career



James Esses was expelled from his Master's in Psychotherapy without warning after expressing his views on improving safeguarding, therapy, and counselling for vulnerable children with gender dysphoria. He has launched a crowdfunder to raise money for legal action against the institute that expelled him, which has so far raised more than £50,000 in less than a week. We think this reflects the public's concern and awareness on this issue.

Like LGB Alliance, James is simply calling for a broad and rational discussion of the approach to gender dysphoria in minors. This is a core issue for LGB Alliance, as we are concerned that gender non-conforming children, many of whom are likely to grow up to be lesbian, gay or bisexual, are receiving inappropriate and harmful treatment.

Please support this important case if you are able to donate.

Donate to CrowdJustice fundraiser

Party conference season



We'll be exhibiting at this year's Conservative Party conference in Manchester. This will be a chance to meet and engage with MPs, local councillors, party activists and others to speak about the rights of lesbians, gay men and bisexuals based on our biological sex, and issues that affect us. If you're going to the event, then come and find us to say hello. We have also applied to exhibit at the conferences of the Labour Party and the SNP but nothing has been confirmed yet.

Engaging with policy makers, and standing up for the rights of lesbians, gay men, and bisexuals is a key part of why we exist. We would appreciate any donations from supporters to help cover the cost of this activity.

Donations page

Call to action **Call to action**

Forward this to a friend



Are you enjoying our newsletters? Do you know other people who you think might enjoy reading them too? Hit the button below to forward this email to a friend. You can also let them know how to sign up to receive newsletters, and other updates and email content of their choice, via the subscribe link on our website.

Forward to a friend

Do we have your details right?



Some of you will have joined the Supporter mailing list before we updated the data fields. We've also had to consolidate details that were in a couple of different places. It would be really helpful for us to tailor content, and also get a better understanding of our supporters, if you could check and update your details.

Update your details

Tweet Share Forward

LGB Alliance is a charity registered with the Charity Commission for England and Wales (no. 1194148)

Want to change how you receive these emails?
You can update your preferences or unsubscribe from this list.

View this email in your browser

LGB ALLIANCE

Conference 2021

Exciting Venue News

We are beyond thrilled to be able to tell you that our venue for Conference 2021 on Thursday 21 October is…drumroll…
...the prestigious and extremely smart **Queen Elizabeth II Conference Centre** in Westminster.



Located just a few steps from Parliament, this superb space will provide the perfect backdrop to what's set to be an action-packed day.

World-class facilities include an impressive auditorium to showcase our fantastic speakers, panels and films.

In addition, a huge social space, with views across Parliament Square will be filled with exhibitors, stalls, our LGB bookshop, an authors' area so that you can get this year's most important books signed, and Conversation Stations where you can meet up with people to discuss the issues that matter most to you.

It's where we'll be providing lunch (fancy sandwiches, home-baked tart, fresh salad and your choice of dessert seeing as you asked) and as much tea and coffee as you can handle.

In the evening the bars will open and that space will be transformed into our very gay indeed disco.

Many people have told us they're planning to come alone. If that's you, be assured that we've created lots of opportunities specifically designed for making introductions. You'll leave on a high, having made new friends for life.

This is our first National Conference and it will be a milestone for LGB people at a crucial point in our history. Book your ticket today to make sure you're a part of it.

Allison Bailey launched LGB Alliance with a single Tweet.



Two years on, she's back to deliver the keynote speech at our conference.

The redoubtable, irrepressible and entirely unstoppable Allison Bailey has played a crucial part in our history. You will not want to miss her speech!

Allison will be flanked by a range of expert voices, newsworthy commentators, thought leaders and high profile supporters from the world of the media, law, healthcare, education and politics throughout the day.

Watch this space for our announcement of the complete line-up in the coming weeks.

Don't miss out. Click here to book now.

Merch Alert!



It wouldn't be a Conference without merch.

So on 21 October you'll be able to choose from our range of our classic black and white branded merchandise. You'll find T-shirts, hoodies, caps, mugs, tote bags and even something which has become something of a cult object of late – the infamous beanie.

In addition, especially to celebrate this landmark event, we'll be launching our collectible funky slogan Ts.

Numbers are limited so if one of these takes your fancy, remember to make a beeline to our merchandise stall as soon as you arrive. When they're gone they're gone.

Don't miss out. Click here to book now.

What a Belter

We're looking for a professional singer to record our Conference song. We're hoping you'll be more Carnegie Hall than Karaoke. It would be wonderful to hear whether anyone out there is keen to help. We can certainly cover costs and add a modest fee. Please email contact@lgballiance.org.uk with 'singer' as your subject if that sounds like you.

Card Payments

Please note that we are only able to accept payment by card at Conference. If you would like to buy merchandise or purchase drinks at the evening event, you must use a credit or debit card.

Don't miss out. Click here to book now.

Tweet Share Forward

LGB Alliance is a charity registered with the Charity Commission for England and Wales (no. 1194148)

Want to change how you receive these emails?

You can update your preferences or unsubscribe from this list.

View this email in your browser

LGB ALLIANCE

January Issue

Happy New Year!

Hello everyone! As this is our first newsletter of 2022, we are pleased to be able to tell you that we're feeling energised about the many challenges ahead and positive about their outcomes. You need to know that it would be completely IMPOSSIBLE to do it without your support. That's why we wanted to start with a heartfelt thank you – from us all.

New Campaign Hits The Road

We're committed to asking difficult questions on your behalf and the question as to why the majority of young people referred to gender identity services are same-sex attracted (gay or bi) is an important one.

We launched our high-profile campaign – Gay Teens Aren't Sick – with a digital ad van in central London over a two day period. In the meantime we contacted MPs and ministers to highlight our concerns.

It's clear that these efforts to gain a 'seat at the table' are working. We are increasingly consulted on relevant policy issues and met with Equalities Minister Mike Freer MP at the Government Equalities Office in mid January to discuss the proposed Conversion Therapy Bill.

The next stage of this campaign will involve turning our focus to the pharmaceutical companies. We'll be asking how much the gender industry is worth and trying to find out what the drug companies are doing to understand why gay teens are increasingly becoming customers of this worrying trade.



Our Parliamentary supporters include Mark Jenkinson MP who we nabbed for a photo.
Pic Eleanor Bentall.

How do we look?

OK, we admit it; our website is not a thing of beauty.

In our defence, we've grown so quickly and been so busy there always seems something more pressing to do. However, we do want to make it simpler to navigate, easier to update, more content rich – as well as looking a bit fancier.

It's clear that it's a really important shop window for our work.

Our site was visited 21,000 times during our conference alone and we can see that our message is spreading. 70% of our visits are from the UK, 11% from the US, 2.2% from Canada and the rest from Germany, France, Ireland, Spain and the Netherlands.

So here's a sneak peek at our new design. We can reveal it will include some stunning images from the talented photographer Eleanor Bentall. The new site will be launched at the end of February.



The Write Stuff

Our co-founder and all round big brain Bev Jackson is now a regular columnist on LGN. She'll be covering a range of topics with her usual incisive and illuminating analysis of the issues that matter to LGB people. Remember to check it out.



Defending Workplace Rights

Management Team member Kate Grimes is a retired NHS CEO . (You'll remember her powerful speech at Conference.) Her insights into the employment practices of Europe's largest employer are extensive. She is developing an important report, based on data and a series of interviews with current staff, about the experience of being LGB within the NHS. It will be published in early spring with a list of our recommendations for change.

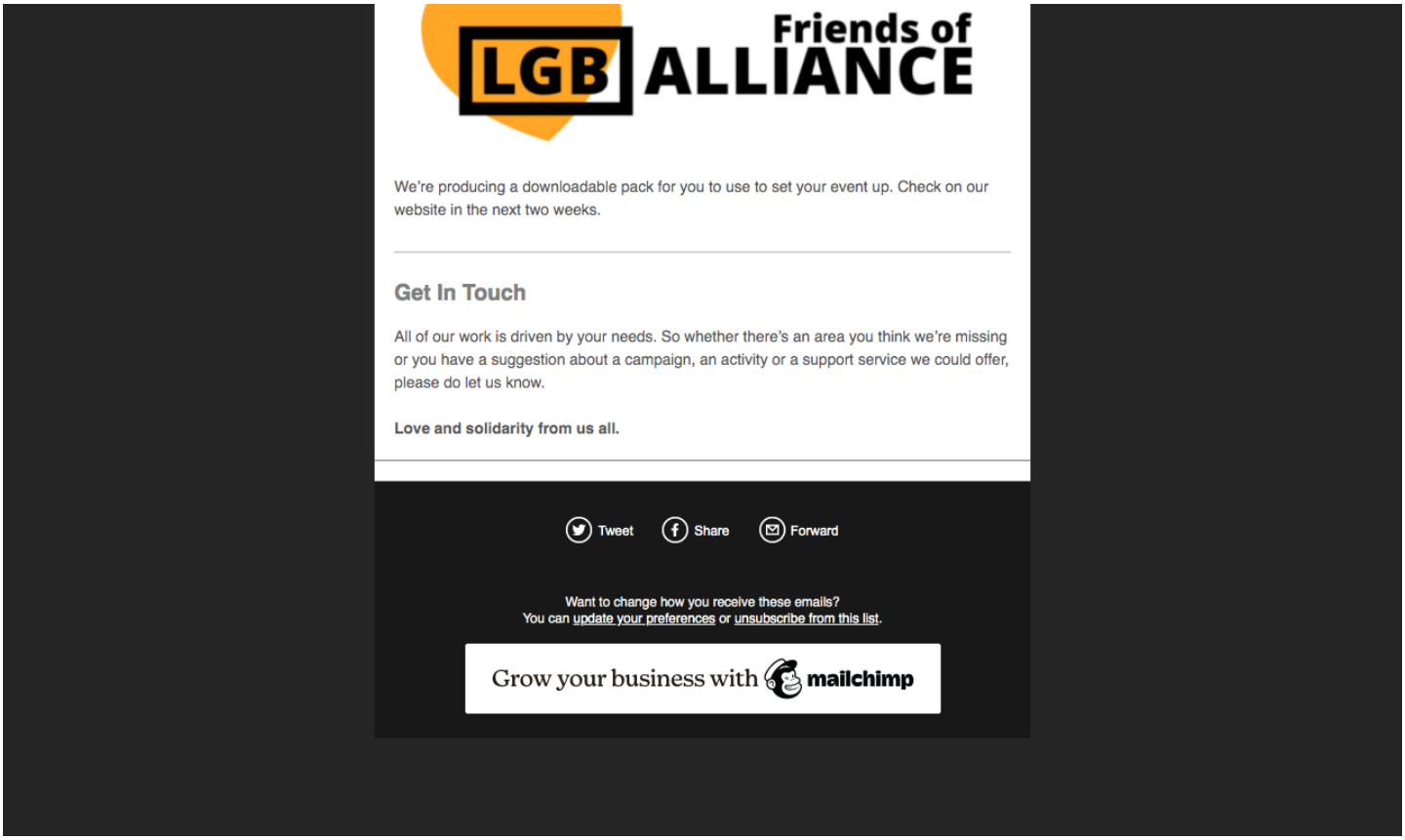
It will be available to view on our website and is the first in series of in-depth reports, on a wide range of subjects, that will help us to shape the government policies and initiatives that impact all of our lives.

Time For A Hug

Covid-19, the growth of online working as well as the decline of physical LGB spaces has left many of us feeling isolated.

Our supporters often tell us that they miss having the opportunity to get together in LGB spaces and celebrate everything that's wonderful, joyous and inspiring about our community. And we agree.

That's why we're launching Friends of LGB Alliance. It's the perfect excuse to get together with friends, and make new ones, by organising a cocktail evening, dawn swim, regular book club, camping expedition or anything that inspires you and fundraise for your favourite charity (that's us!) at the same time.


Friends of
LGB ALLIANCE
We're producing a downloadable pack for you to use to set your event up. Check on our website in the next two weeks.
Get In Touch
All of our work is driven by your needs. So whether there's an area you think we're missing or you have a suggestion about a campaign, an activity or a support service we could offer, please do let us know.
Love and solidarity from us all.
Tweet
Share
Forward
Want to change how you receive these emails?
You can update your preferences or unsubscribe from this list.
Grow your business with mailchimp

LGB Alliance @ALLIANCELGB · Oct 5, 2021

We love formidable and opinionated women ….especially those who stand up for free speech and other women's rights. That's why we're so delighted @_Lisa_Townsend is speaking at our conference. LGB rights must complement and uphold women's hard won rights. 👇

> **David Bridle** @Pomegranate2021 · Oct 4, 2021
>
> @_Lisa_Townsend, Police and Crime Commissioner for Surrey, signs her "I stand with @ALLIANCELGB sticker" on the charity's stand @Conservatives conference this morning #CPC21



9 27 208

LGB Alliance @ALLIANCELGB · Oct 5, 2021

At #CPC21 our goal was merely to start a discussion with a few delegates about the confusion between 'gender' and 'sex'. And why it matters. We did so much more than that. Did we convince @JustineGreening? Maybe not yet. But the debate has started. "No Debate" is over. 😏



LGB Alliance @ALLIANCELGB · Oct 5, 2021

"Definite highlight" is a pretty good review. 😉

> **Claire Fox** @Fox_Claire · Oct 5, 2021
>
> Definite highlight of my visit to #ConservativePartyConference (speaking at fringe mtgs). Humbled by hard work of @ALLIANCELGB; great to meet crew. Don't worry, they don't agree with me on lots of issues (some trying to do guilt by association) but I agree with their work totally twitter.com/Pomegranate202...

4 84

LGB Alliance @ALLIANCELGB · Oct 5, 2021

We're delighted so many MPs have come to our stand to express support for free speech and for debate around 'gender' issues. As @ScottBentonMP points out "57% of British people in a recent poll felt political correctness is undermining their free speech". We share his concern.



LGB Alliance @ALLIANCELGB · Oct 5, 2021

Love is a wonderful thing. Thank you to @Baronessjenkin and her husband @bernardjenkin for passing by to offer support. Apparently, it was 37 years to the day when they first met at a Conservative Conference. Happy Anniversary from @ALLIANCELGB 😘🥰



3 26 240

LGB Alliance @ALLIANCELGB · Oct 5, 2021

Great to chat with Flick Drummond MP. She welcomed our determination that the rights of lesbians, gay men and bisexuals must complement women's hard won rights and not undermine them. Protecting young troubled children is a shared concern.



LGB Alliance @ALLIANCELGB · Oct 5, 2021

Thanks to @ArchRose90 for popping by our stand. He's one of the funniest guys on Twitter poking fun at woke pomposity. @BevJacksonAuth may have disagreed with Chris on loads but when he started on free speech and cancel culture they soon became besties. 😏



LGB Alliance @ALLIANCELGB · Oct 5, 2021

Uh uh trouble has arrived! Great fun to welcome one of Britain's most passionate campaigners for free speech @Fox_Claire She says she's determined to stop the advance of unscientific notions into our institutions and laws. We wish her well. #CPC21



6 28 224

LGB Alliance @ALLIANCELGB · Oct 5, 2021

Today, at #CPC21 Paul Barnes, Campaign Director of Conservatives Abroad told us he has serious concerns about attempts to replace the words 'same sex' with 'same gender'. He worries LGB people could be erased in law. We agree.



12 67 421

LGB Alliance @ALLIANCELGB · Oct 5, 2021

It was fantastic to welcome @Bren4Bassetlaw to our stand at #CPC21 "When politicians start denying basic biological facts and science we're all in trouble," he said. We really couldn't agree more. 👇



LGB Alliance
@ALLIANCELGB

We appreciated today's discussions between us and individual members of @LGBTCons. We don't have to agree to respect each other's strongly held convictions. We don't have all the answers, but challenging each other respectfully benefits both 'sides' in these important debates.

> **David Bridle** @Pomegranate2021 · Oct 4, 2021
> I was there, and without wishing to break confidences, today I saw a wide range of @Conservatives members engaging with the @ALLIANCELGB including a large number of MPs and peers. Many supported the group, some didn't but there was genuine debate. I'm sad that one recently...
> Show this thread



10:40 PM · Oct 4, 2021 · Twitter for iPhone

LGB Alliance
@ALLIANCELGB

The point of being at #CFC21 is to raise concerns. Today, we discussed the proposed "conversion therapy bill" with @RobBAylesbury. Of course we're against gay conversion but how do you protect kids if you INSIST on gender identity affirmation? Kids have a right to puberty.



LGB Alliance @ALLIANCELGB · Oct 4, 2021

Great to get such solidarity from Paula Wren at #CPC21. As Paula said, "As a transwoman I totally support your right to be here and it's really not in the interests of trans people to bully ordinary people, telling them what to say or think." Bravo Paula! 👏👏👏😍



LGB Alliance @ALLIANCELGB · Oct 4, 2021

During #CPC21 we've been overwhelmed by the support of delegates who've come to our stand to wish us luck. As @DamianGreen told us this morning ...a plurality of views is the wellspring of democracy. 'No Debate' is unsustainable. 👇



16 68 553

LGB Alliance
@ALLIANCELGB

Delighted to chat to @markjenkinsonmp at #CPC21 about the importance of recognising biological sex in our laws. From health to the justice system recording sex properly is essential. ‘Gender’ is a vague and fluid social construction. Sex is immutable and it matters.



12:13 PM · Oct 4, 2021 · Twitter for iPhone

Jackie Doyle-Price
@JackieDP

Nice to catch up with the lovely people at @ALLIANCELGB. If you are at #cpc21 why not go and say hello



2:44 PM · Oct 3, 2021 · Twitter for iPhone

LGB Alliance @ALLIANCELGB · Oct 3, 2021

What a delight to meet two of our favourite supporters at #CPC21 @Baroness_Nichol and @HJoyceGender. It was freedom of expression that allowed LGB to gain our legal rights. It's freedom of expression that will help us defend them. Free speech matters. 👇




THE LGB FILM FUND
FILM
MAKERS
If you are a lesbian, gay or bisexual film maker and need funding to bring your project to life, apply for a £10,000 grant for your drama or documentary. Your film should have LGB themes or characters and, once completed, will be celebrated and showcased at a high profile screening. It's your chance to get your work in front of industry luminaries and the wider public. Visit URL to download the application.
IT'S YOUR TIME TO TELL STORY
LGB ALLIANCE
www.lgballiance.org.uk/filmfund
THE LGB FILM FUND
THE LGB FILM FUND
LGB ALLIANCE

LGBA Alliance – Queens – 70 Years of LGB History

Executive Summary/Project Description

'Queens - 70 Years of LGB History' is a two-part project comprising 'Queens' a short film and an LGB online memory bank/archive, to be called 'No Erasure'.

‘Queens’ will be a short (20 minute) film that celebrates the astonishing turnaround in rights for gay men, lesbians and bisexual people in the UK since the accession of HM Queen Elizabeth II in 1952 through to her diamond Jubilee in 2022.

Out of the film 'Queens' will come the LGB Online Memory Bank, to be entitled 'No Erasure'. This will be a wider project whereby many more LGB people will be invited to record their own 2-minute memories that will illuminate their lives, struggles, loves and lived experience of being gay and bisexual during the reign of Queen Elizabeth II. These short clips will then be edited and curated as an online publicly accessible living museum/archive that will memorialise the breadth of experience of LGB people in a critical period of LGB history in the UK.

Organisation Background

LGB alliance aims to advance the interests of lesbians, gay men and bisexuals, and stand up for our right to live as same-sex attracted people without discrimination or disadvantage. We will ensure that the voices of lesbians, gay men and bisexuals are heard in all public and political discussions affecting our lives.

LGB Alliance engages with others respectfully. We discuss, propose, and oppose ideas; we do not attack individuals. Disagreement does not equal hate. We do not condone, endorse, or encourage any abusive or discriminatory behaviour towards any group or individual.

LGB Alliance amplifies the voices of lesbians and highlight the dual discrimination experienced by lesbians as women who are same-sex attracted in a male-dominated society. We work to protect children from harmful, unscientific ideologies that may lead them to believe either their personality or their body is in need of changing. Any child growing up to be lesbian, gay or bisexual has the right to be happy and confident about their sexuality and who they are.

LGB Alliance promotes freedom of speech and informed dialogue on issues concerning the rights of lesbians, gay men and bisexuals. We assert that different opinions, even those we may disagree with, should be heard as part of the public debate. We work collaboratively, standing together, sharing information, and building connections with like-minded groups and individuals, curating community and resilience, to achieve positive outcomes.

Current Programmes Activities and Accomplishments

LGB Alliance currently have the following active projects:

- A website offering news and support to the LGB Alliance
- A scoping exercise to establish feasibility and parameters for an LGB Helpline

- A Friends of LGB Alliance group undertaking fundraising activities
- A project for an online educational resource

Evidence of Need and Impact of the Project

There is no equivalent LGB social history project to that being developed as the 'No Erasure' online memory-bank at this time.

The film 'Queens' is being proposed as one of 70 projects that are being funded to make the Platinum Jubilee of Queen Elizabeth II. It is essential that these projects include a history of LGB people during Her Majesty's reign to ensure that the full diversity of the UK population is represented.

Success Criteria and Measurable Outputs and Outcomes of the Project

Success will be determined by the following measurable outputs:

- A 20-minute film entitled 'Queens' to be premiered both at a venue and online
- An online memory-bank of LGB recorded interviews that is accessible to all and which will continue to be developed over time

Goals and Objectives

'Queens - 70 Years of LGB History' is a two-part project comprising 'Queens' a short film and an LGB online memory bank/archive, to be called 'No Erasure'.

'Queens' will be a short (20 minute) film that celebrates the astonishing turnaround in rights for gay men, lesbians and bisexual people in the UK since the accession of HM Queen Elizabeth II in 1952 through to her diamond Jubilee in 2022.

In interviews with 6 LGB people of many different backgrounds and ages we will discover the highs and lows of life for gay men and lesbians in the last 70 years and remind ourselves how bigotry, discrimination and criminalisation were overturned both by noisy activism, quiet determination and determined resistance.

Punctuated with revealing personal and often wickedly funny anecdotes 'Queens' reveals just how much Britain has changed for the better in the past 70 years.

The interviews will be interspersed with informative and revealing montages of key moments in the history of LGB rights from 1952 to 2022. For example: the legalisation of homosexual acts in the 1967 sexual offences Act, the repeal of Section 28, the first Pride March and the legalisation of equal marriage.

The film will be premiered at a small cinema venue in London with an audience of approximately 300 people. It will then have an online premier that is expected to reach many more people from all ages and backgrounds. The film will be promoted via the LGB Alliance web-site and social media, primarily. A press-release will be sent to all major news/media outlets.

Out of the film 'Queens' will come the LGB Online Memory Bank, to be entitled 'No Erasure'. This will be a wider project whereby many more LGB people will be invited to record their own 2-minute memories that will illuminate their lives, struggles, loves and lived experience of being gay and bi-sexual during the reign of Queen Elizabeth II. These short clips will then be edited and curated as an online publicly accessible living museum/archive that will memorialise the breadth of experience of LGB people in a critical period of LGB history in the UK.

A selected number of participants will be contacted to provide longer filmed segments. These will also be uploaded to the 'No Erasure' archive and will provide more in-depth stories for people to access and engage with.

Timeline

Funding bid submitted to LCF/ACE Diamond Jubilee 18/02/2022
Funding decision: 01/04/2022 through an LCF/ACE Diamond Jubilee bid
Selecting interviewees – 02/04/2022 – 03/04/2022
Filming interviews and background footage – 04/04/2022 – 09/04/2022
Selecting archive material – 10/04/2022
Editing to a rough cut – 11/04/2022 – 14/04/2022
Editing to picture lock and final production – 15/04/2022 – 16/04/2022
Premiere – Venue – 01/06/2022
Premier – Online – 02/06/2022
Creation of 'No Erasure' online memory-bank – 03/06/2022 – 08/06/2022

Budget/Staffing

Artistic Director

2 days to design/oversee project

Director/Filmer

2 days selecting interviewees
4 days filming contributors
2 days filming LGB culture scenes, etc.
1 day: select/finalise archive shots.
4 days editing to a rough-cut
2 days editing rough cut to Picture Lock
Total: 17 days @ £250 a day = £4250

Producer

3 days Executive Production @ £300 a day = £900

Musician

3 tracks = £450

Recording = £300

Web-designer

2 days to design/set up archive web-site
2 days to select/edit submitted clips
2 days uploading/indexing clips on ‘No Erasure’ website
6 days @ £250 per day = £1500

Venue hire for premiere

Cinema and refreshments = £1000

Total: £9400

Long-term Funding Strategy

LGB Alliance will undertake further fundraising activities to ensure that the ‘No Erasure’ project can be further developed and added to over time. Strategies for this will include some or all of the following:

- Subscription by organisations to the archive
- Bids to Trusts & Funds for additional funding
- Crowd-funding initiatives

Forward from the chair

Introduction from KG

Findings

1. LGB staff suffer more violence and discrimination from patients than their heterosexual colleagues
2. LGB staff suffer more harassment and discrimination from their colleagues than heterosexual staff
3. LGB staff relationship with their managers is worse than heterosexual colleagues and deteriorating
4. LGB staff are more stressed than their heterosexual colleagues
5. LGB staff are less satisfied at work and feel less able to deliver the care they want to than their heterosexual colleagues
6. Despite lots of initiatives, this has not changed over time and in some cases is getting worse

Discussion

Recommendations

Appendices

- Methodology
- data
- Semi structured interview questions
- references

DRAFT

Forward

LGB Alliance mission is to advance lesbian, gay and bisexual rights

We have chosen to focus on the NHS as it is one of the largest employers of LGB people in Europe, and a lot of NHS staff have approached us since our inception expressing concerns about what it is like to work in the NHS at the moment.

We used the NHS annual staff survey which had a response rate of around 50%. In 2020, nearly 600,000 responded with well over 20,000 stating that they were LGB. An extremely robust data source.

These results should act as a wake-up call to the NHS and its constituent parts.

NHS employers need to look at LGB staff separately from other groups. They need to take responsibility for the working life experiences of these staff, speak and work with them directly. LGB staff are keen to work with their employers, but many do not feel able to at present or if they do they feel their voices are not heard.

If this is the experience for the NHS workforce, the caring profession who should be leading the way, it makes us worry about what working life must be like for other workers elsewhere

We look forward to working with government, the NHS and LGB staff to drive improvements. And as patients, we need to see improvements because research shows that if staff are happy at work, their patients' clinical outcomes and experience is significantly improved (Michael West & Jeremy Dawson, 2011).

DRAFT

Introduction/Summary

In preparation for a speech I was giving in October 2021, I spoke to a number of LGB staff about their experience working in the NHS. What I heard from them horrified me – they spoke of changing their hair style and the way they dress to try to hide their sexual orientation, of their fear of speaking up or being found out and of the way the prevailing narrative in the NHS made them feel deeply oppressed. So, with a colleague who is an academic and a Director in the NHS, I began to explore the data more formally. This colleague does not feel safe enough, as a gay man working in the NHS, to put his name to this report, despite the weeks of evening and weekends he has devoted to it. We looked at the results of the last five years of staff surveys in the NHS. Over 20,000 LGB staff complete this survey in 2020, meaning this is probably the biggest consecutive survey of LGB staff in Europe. We found that on all 10 themes of the survey, LGB staff experience was worse than heterosexuals.

The figures are shocking. In the last year of the survey 55% of LGB staff had felt unwell are a result of work-related stress and 22% had experienced violence from a patient. Worse, in many areas the gap between LGB staff and their heterosexual colleagues experience is widening. For example, only four years ago LGB and heterosexual staff had very similar views on the effectiveness of communication with senior management, but over the last three years a gap has opened up that has increased by over 200%. To try to get a feel for the reasons behind the poor working life experience of LGB staff we undertook some semi structured interviews. Whilst the findings from the interviews are not generalisable, they can begin to shed some light on what is going on.

LGB staff have told us that their experience in the NHS is getting worse rather than better. They tell us that the merging of sexual orientation and gender identity as a single issue, rather than two separate groups who both need action to improve their working life experience, has led to a lack of focus on LGB staff experience and difficulties in particular when the needs of these two different groups come into conflict. The silencing of debate in this area has meant that LGB staff told us they no longer speak up, some have taken to hiding their sexuality at work and those that do speak up feel distressed, fearful and exposed.

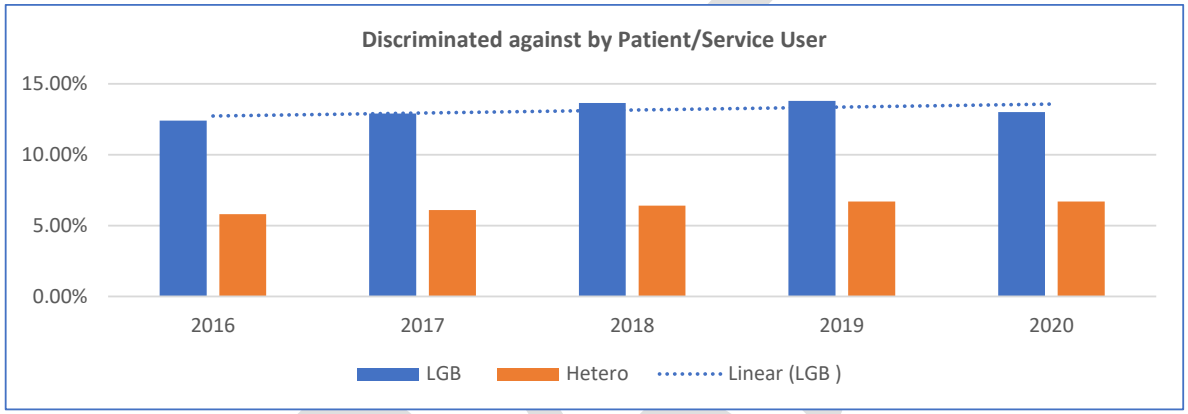
We know that this is not good for patients. There is a direct link between clinical outcomes, including mortality rates, with staff engagement (Michael West & Jeremy Dawson, 2011). Staff who are fearful, experiencing high levels of harassment, bullying and even violence at work and who do not feel safe to be themselves, cannot give their best to patients. So there is not only a moral duty, but also a patient safety duty, to act.

We make four recommendations in this report. We urge the NHS to take ownership of the experience of their LGB staff, to undertake further research to understand what is going on for its LGB staff and then to act. To do this, it will need to separate sexual orientation from gender identity as staff are telling us that the issues and solutions are very different and at times can come into conflict. The NHS needs engaged, happy, confident staff who feel safe at work. Change is needed to improve the working lives of LGB staff and the outcomes of the patients they care for.

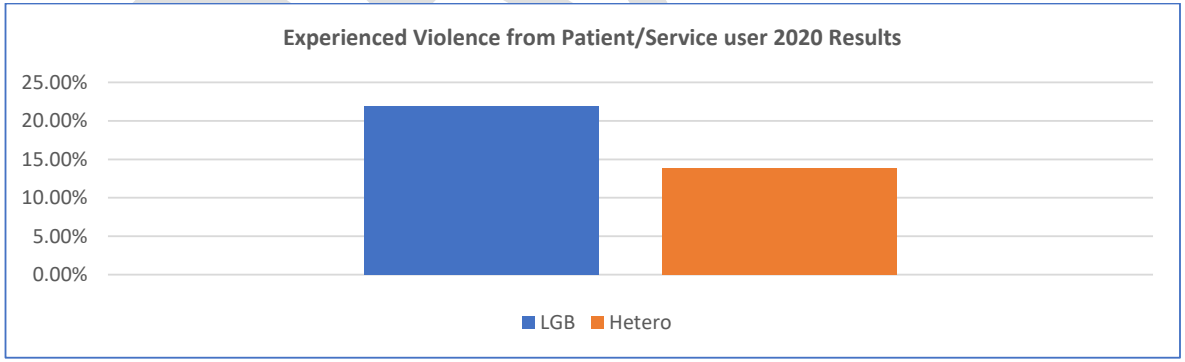
Kate Grimes

Finding 1. – LGB staff experience significantly more violence, harassment and discrimination from patients than heterosexual staff

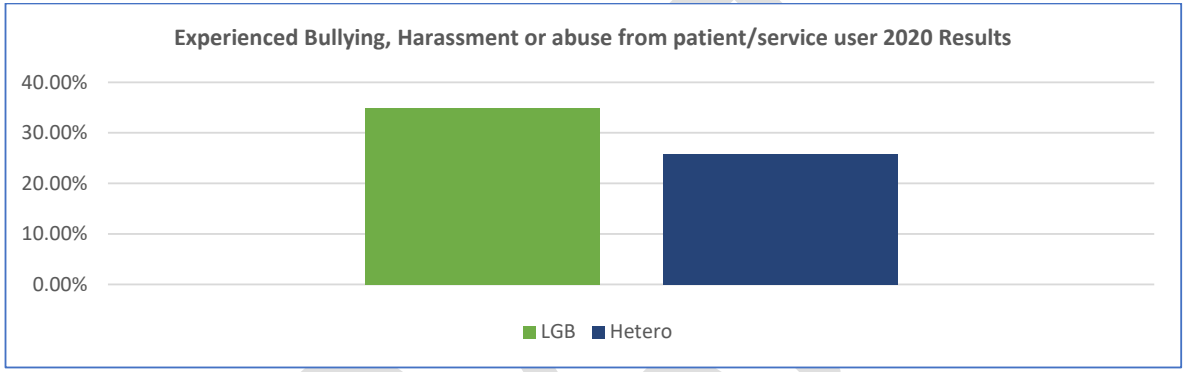
LGB staff experienced almost double the levels of discrimination at work from patients than their heterosexual colleagues in 2020 – 13.0% vs 6.7%. Over the last five years the levels have increased slightly for both groups, but the gap between them has remained the same.



In 2020 LGB staff experienced nearly 60% more violence from a patient than their heterosexual colleagues 21.8% vs 13.9%. The gap between LGB and heterosexual staff is getting worse.



In 2020, 35% of LGB staff have experienced harassment, abuse or bullying from patients in the past 12 months compared with 26% of their heterosexual colleagues. Whilst there have been improvements for heterosexual staff, levels of harassment, bulling and abuse from patients have remained high for LGB staff leading to the gap between LGB and heterosexual staff increasing to over 9%



Selected Quotes:

"I suddenly feel not as confident – I could get a hostile reaction"

"The gay male nurses are often called terrible names"

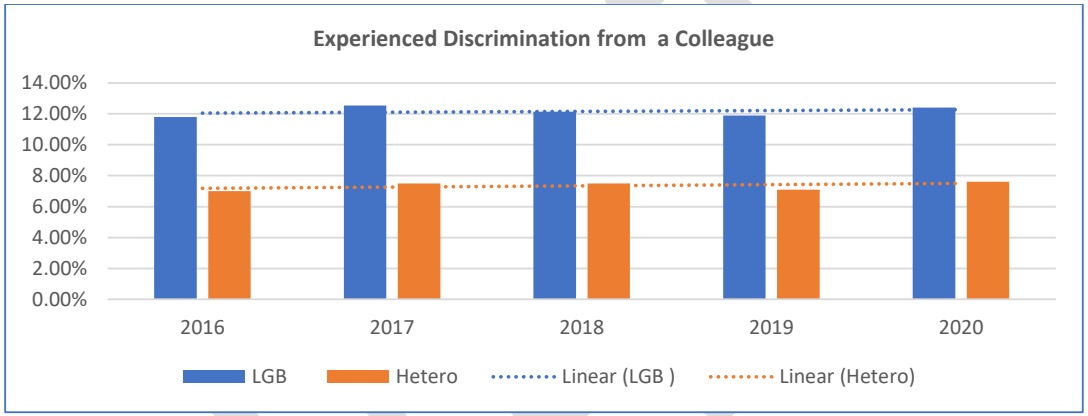
"It discomforting to realise that homophobia is just under the surface and comes out in intense situations in Hospital"

"People make fun of my more effeminate mannerisms, sometimes to my face"

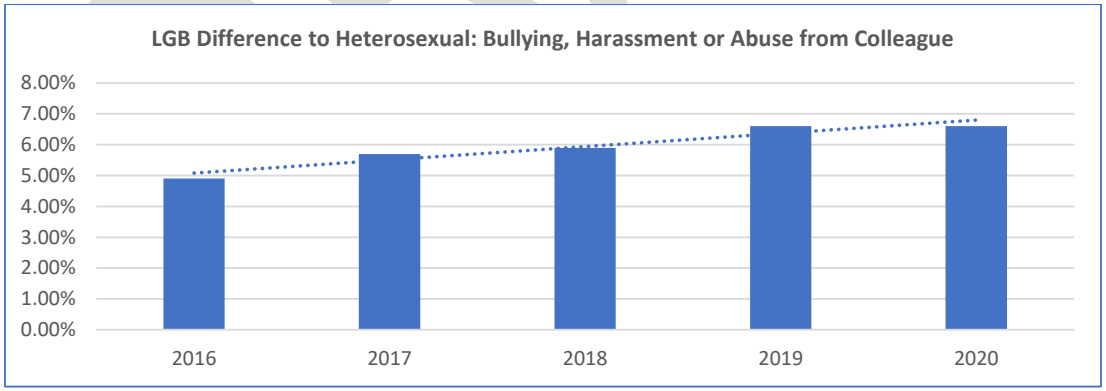
DRAFT

Finding 2 – LGB staff experience more discrimination and harassment from their colleagues than heterosexual staff

In 2020, LGB staff reported almost 63% higher levels of discrimination from a manager, team leader or other colleagues than their heterosexual counterparts. Both groups have seen a very slight rise over the last five years with the gap between the two remaining static since 2016.



In 2020, 24.4% of LGB staff experienced harassment, abuse or bullying from colleagues compared with 17.8% of heterosexual staff. Over the last five years, the levels have remained relatively static for heterosexual staff, but worsened for LGB staff meaning the gap has increased by about 35% from 2016.



3% more Heterosexual staff agreed or strongly agreed that they receive the respect they deserve from colleagues compared with LGB staff: 69.8% vs 72.8%

Selected Quotes:

"A lot goes on behind my back"

"She used the limp wrist action to describe me"

"I have never experienced hatred like this in my life before as a lesbian".

"Lots of asides that are supposed to be banter"

"They said " you just haven't met the right man yet"

"The feeling of anticipating being attacked is a new one for me"

"It is no longer a safe environment"

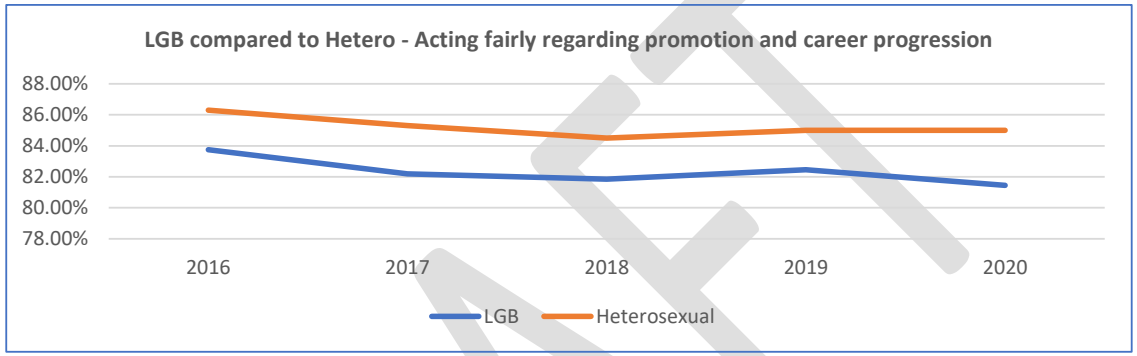
"It's bizarrely common for my colleagues to want to see me in a dress. They seem to have a fascination about whether I could meet their expectations of what a woman looks like"

"I feel safe in my office with the people I know, but am more cautious when I am elsewhere in the Hospital"

DRAFT

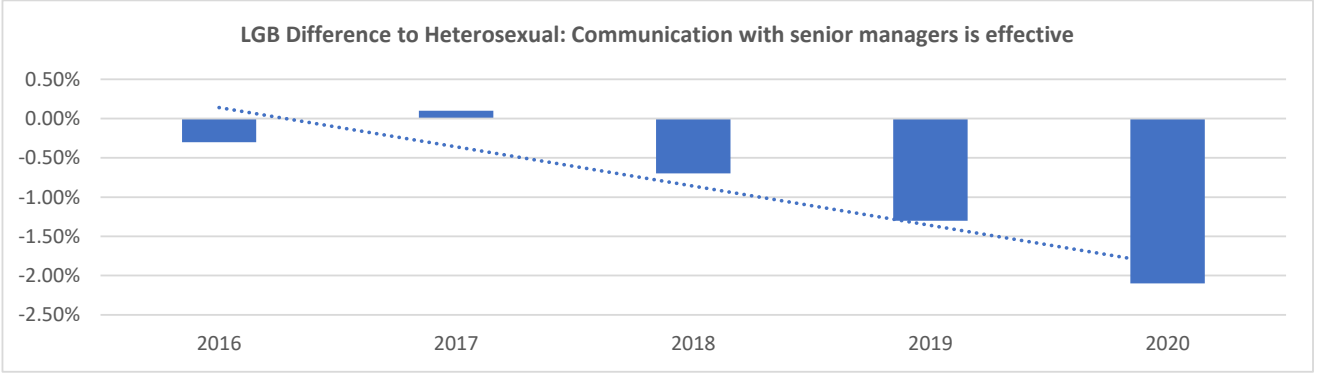
Finding 3 – LGB staff relationship with management is worse than heterosexual colleagues and is deteriorating

Less LGB staff agree or strongly agree with the statement *'my organisation acts fairly with regards to progression and promotion regardless of protected characteristic'*. In addition, the gap between LGB staff and their heterosexual colleagues is widening



Over 30% more LGB staff have experienced harassment, abuse or bullying from a manager in the last 12 months compared to their heterosexual colleagues. 15.3% vs 11.5%. The gap has remained the same for the last four years.

Whilst overall, more staff agree that communication with senior management is effective, there has been a significant shift in the difference between LGB and heterosexual staff agreeing or strongly agreeing that communication with senior managers is effective. Five years ago, LGB staff had a very similar perspective to their heterosexual colleagues. From almost the same four years ago, this gap has increased by over 200% in the last three years.



Selected Quotes:

"My chief nurse told me If I wanted to go further, I needed to act less gay"

"My CEO was noticeably uncomfortable around me"

"I was told I needed to dress differently if I wanted to be more appealing to everyone"

"There is a lack of understanding of those of us who are gay"

"My CEO said: "we don't want to be like them down the road (meaning a very gay friendly town)"

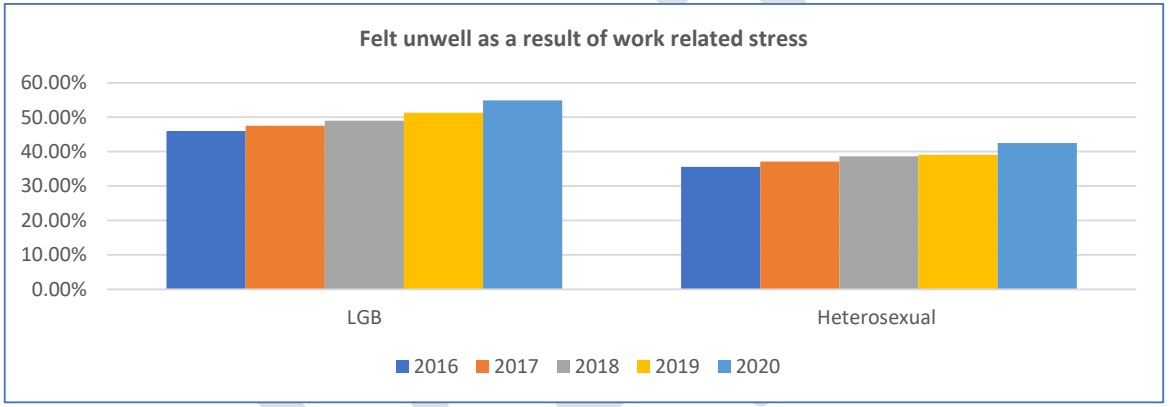
"My boss used to mimic another colleague who was gay"

"They just slap a rainbow on it and say they are doing something for the LGB when they are not"

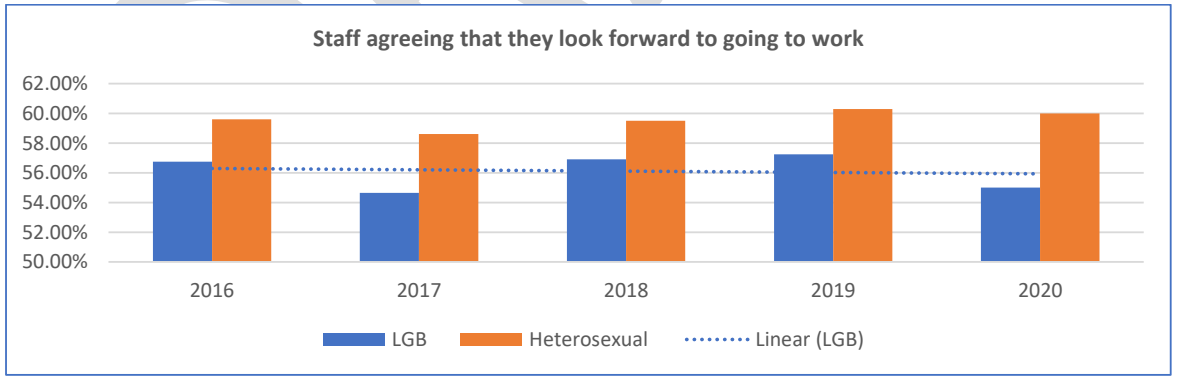
DRAFT

Finding 4. This means that LGB staff suffer more work-related health issues and are more likely to be dissatisfied at work

In 2020, 55% of LGB staff said that in the last twelve months they had felt unwell due to work related stress. This is over 13% more than heterosexual staff at 42%. Over the last five years there has been a significant deterioration for both groups and the gap between LGB and heterosexual staff has got wider. Whilst Covid may explain some of the overall deterioration, there is a clear upward trajectory for both groups and **C**ovid would not explain why the gap is widening between LGB and Heterosexual staff.



In 2020, 5% less LGB staff said that they look forward to going to work compared with their heterosexual colleagues. The gap between LGB and Heterosexual staff has increased from 2.9% to 5% over the last five years.



LGB staff report experiencing more pressure from a manager to come to work. The levels and gap have remained about the same for the last five years gap 5.8%

Selected Quotes

"It's exhausting and unsustainable trying to monitor myself"

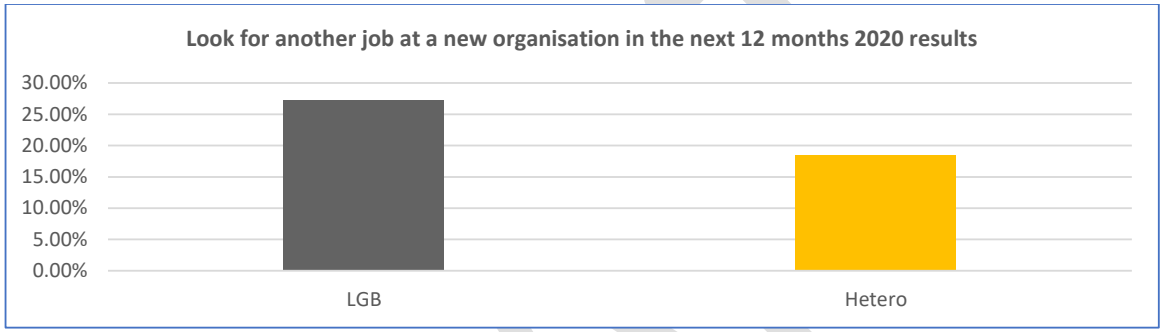
"I feel uncomfortable"

"I don't feel safe at work anymore – I used to, but that has changed in the last few years".

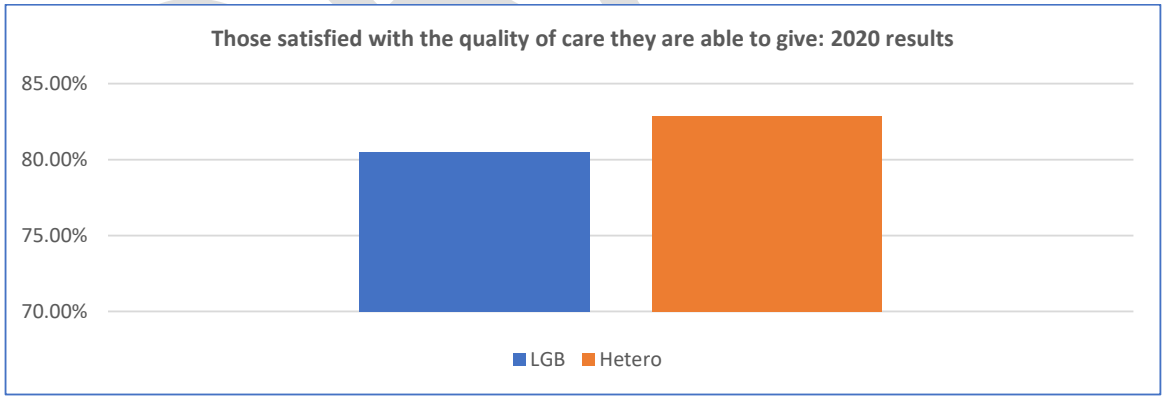
DRAFT

Finding 5 – LGB staff are more dissatisfied with the care they are able to provide and more report searching for another job

In 2020, almost 50% more LGB staff agreed that they would probably look for new job in next 12 months compared with their heterosexual colleagues– 27.3% vs 18.5% – gap 8.8%

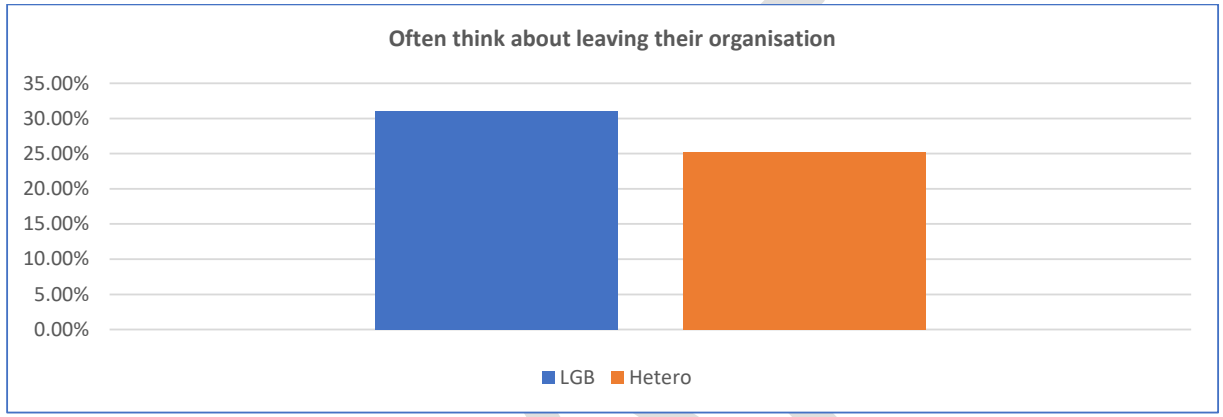


In 2020 there was a 3.6% gap between LGB staff saying that they felt able to deliver the care the aspire to, when compared with their heterosexual colleagues – 67% vs 70.6% – gap 3.6%



Almost 25% more LGB staff said they often think about leaving their organisation than their heterosexual colleagues 31.1% vs 25.2% a gap of 5.9%

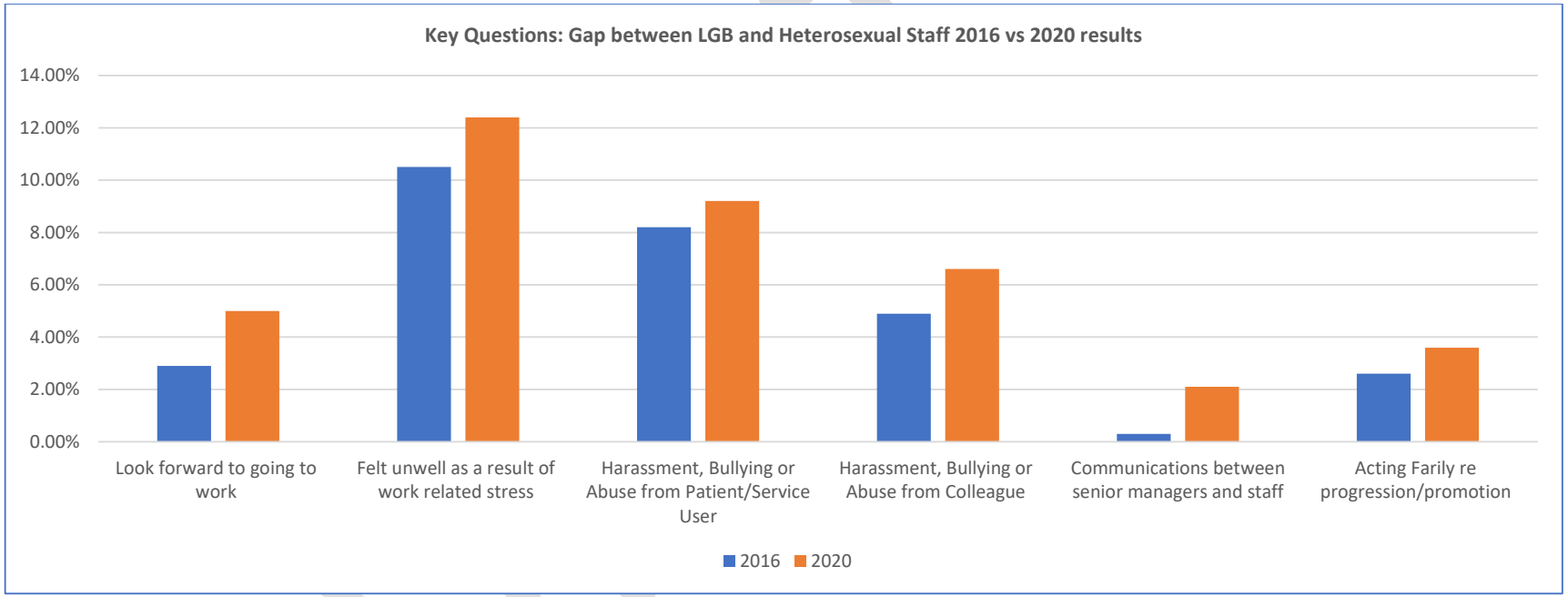
The levels have remained about the same over the last five years with only a small widening of the gap between LGB and heterosexuals



DRAFT

Finding 6 – Despite the initiatives the 'gap' is widening

Despite a variety of initiatives which have taken place in the NHS, the experience of LGB staff in the NHS is consistently worse than their heterosexual colleagues and in many areas the gap has worsened over the last five years.



Discussion – What can we learn from our interviews?

LGB staff suffer more violence, harassment and discrimination from patients and their colleagues than heterosexual staff, and their relationship with managers is worse than heterosexual colleagues and deteriorating. They are more stressed than their heterosexual colleagues, less satisfied at work, feel less able to deliver the care they want to and more of them think of leaving. Despite (or perhaps because of) the initiatives that have taken place in the NHS, the experience of LGB staff in the NHS is consistently worse than their heterosexual colleagues and in many areas the gap is worsening.

We undertook a thematic analysis of our interviews to identify issues that might help answer the questions thrown up by this data, focusing only on experiences from the last five years to match the data set. Findings include:

1. Even though LGB and Heterosexual staff say that they would report issues in similar levels, none of our interviewees had formally reported any issues they had experienced because of being LGB at work. We asked them why.

   "I have not reported because its subtle and often not direct"

   "I preferred to deal with it myself"

   "People don't report it because they think nothing will be done"

   "I have never known reporting to happen"

   "No one reports homophobia – it's unacceptable to be racist but not so with homophobia "

   I think inherent shame prevents reporting – I think "of course you are abusing me, why wouldn't you?"

   "Others do not report it on our behalf like we all do for racism"

   This suggests that employers cannot rely upon the current reporting systems to help them identify and take action on negative experiences their LGB staff encounter at work. Employers may not be aware of the levels of discrimination, harassment, abuse and bullying their LGB staff are experiencing unless they interrogate the NHS staff survey data for their organisation by sexuality or use another mechanism to investigate.

DRAFT

2. LGB leaders at all levels feel less able to speak up than they used to. The leaders within our group of interviewees tended to have been out as LGB at work for some time. Some had previously been very visible in leading on LGB issues in the past. They told us that as LGB rights activity had been extended to include gender identity they had been increasingly ostracised and on longer felt able to lead on LGB issues at all.

   "I am concerned about what I should and shouldn't say"

   "There is no safe space to have a clear conversation about the needs to LGB staff and patients"

   "I was told it would look bad if the Stonewall badge came off "

   "I cannot be part of the LGBTQIA+ network as I would not be welcome"

   "I got more confident as I became more senior – but I'm not confident now"

   "I have never experienced abuse like this in my life for being a lesbian. Its horrific"

   "I used to speak up, but things have moved so quickly"

   "Adding the trans has had a chilling effect"

   "I don't think there is space to only focus on the LGB"

   "Those of us who ought to be leading those conversations feel it's an unsafe place to do so"

   "I may well have a very short career "

Historically, only some LGB staff felt confident and strong enough to speak out and help work to improve the visibility and experience of LGB staff in the NHS. It is concerning, therefore, that even those staff who were prepared to take the risk and speak out previously, no longer feel confident enough to speak out now. The loss of LGB visibility in senior conversations and decision making, and the oppressive atmosphere described by our interviewees may be contributing to the poor and worsening data highlighted in this report.

3. NHS employers do not seem to be aware of the data on the experience of the LGB workforce and it does not seem to be used to make improvements.

   "We need to have discussion based on data, not ideology or opinion"

DRAFT

"The NHS has abdicated responsibility for the welfare of its LGB staff to Stonewall"

"An organisational change was going to disproportionally impacted gay men – as leader of our LGBT+ network I raised this issue, but I was overlooked, told the numbers were too small even though the percentage was big. It reduced our organisations out LGB staff by one third"

"There should be a drive to collect and use data"

"We should focus on the evidence (about LGB staff experience) again"

"I feel responsible there – why were we not looking at the data and shouting about it"

"I don't think the NHS is doing anything – the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) are nationally mandated, where is the same for LGB staff?"

There are, rightly, national requirements to gather data on the experience of ethnic minority and disabled employees and to develop action plans. There is no such mandated requirement for LGB staff, despite the data suggesting that LGB staff experience is worse than other minority groups. For example, LGB staff experience is worse than heterosexual staff on all ten of the staff survey theme areas, whereas ethnic minority staff experience is worse than white staff on only four of the ten theme areas. The experience of ethnic minority staff has worsened in two theme area over the last five years, whereas the experience of LGB staff has worsened in four theme area. This suggest that the requirement for employers to gather data and analyse the experience of their ethnic minority staff and develop an action plan under the WRES may be making a difference.

4. All the LGB staff we interviewed told of how current initiatives aimed at improving the experience of LGB staff make no impact and that some of the initiatives, particularly badges and flags, alienate them.

"I've recently removed my rainbow badge from my lanyard because it doesn't mean anything – it doesn't require the organisation to do anything"

"I don't feel proud to wear the rainbow badge anymore - I don't agree with the ideology it promotes"

"I feel annoyed and angry (at the initiatives) as they are just performative – I know that problems have not been solved"

"I thought Stonewall were useless, they never contributed at all, never helped when we asked, they just took stuff we had done, and I had the impression they sold it on to others"

"The workforce equality index was a senseless tick box exercise"

"Even refusing to wear the rainbow badge could put you in a very difficult position now"

DRAFT

"I won't wear the (rainbow) *badge. If I were a patient and a staff member had the badge on, I would feel uncomfortable – I could be putting myself in a difficult situation because I am a lesbian"*

"It feels like we are going against the equalities act by not protecting women, or religious minorities or LGB people"

"They are keeping a note of who is not wearing them (the badge)"

"There was a time when seeing the badge would have been a comfort to me as a patient – but now it's the opposite because I think it demonstrates support for a homophobic and misogynistic ideology."

"I've taken my pledge down from my wall because I am embarrassed and ashamed as a gay person to be associated with gender ideology"

In an attempt to be inclusive, the NHS may well be alienating the very people it is trying to support. Many of these initiatives are led from the very top of the NHS, by leaders who may not have heard or understood the perspectives of a broader group of LGB staff. In driving these initiatives, the NHS is seen by some to be supporting one side of what the EHRC recently acknowledged is a *"polarised debate causing much harm and distress to people on all sides" (EHRC, 2022)* and breaching its' public sector equality duty to balance the needs of all protected groups. The NHS should consider producing guidance on the flying of any flags, badges or other symbols seen to support a belief/ideology or in support one protected group over another. One option would be to only fly the NHS flag, so that all staff feel included as members of the NHS family.

5. Many of our interviewees felt that the merging of sexual orientation with gender identity created significant problems and led to a loss of focus on and invisibility of LGB issues. The issues for these groups are often different and sometimes conflicting. Solutions will therefore be different too. Interviewees felt that any conflicts were ignored, and one groups needs overridden rather than worked through to resolution.

"The conversation is all about the gender identity, if you say the issues are different you are assumed to be transphobic"

"The community does not reflect me and my friends anymore, because they are all straight"

"I'm told to accept my privilege as a white cis gay male"

"They (my local LGBT+ network) say "You all need to be quiet now" (because you are cis)"

"We don't get the discussions we need any more"

DRAFT

"Trans has become the dominant narrative"

"We have to separate out sexual orientation work – be clear about the difference between gender identity and LGB"

"There has been a distinct change over the last three to four years. All of a sudden, I felt I needed to justify myself all over again"

"People are too scared to say anything"

"There is a whole new lack of safety about being LGB"

"There is virtually no discussion of LGB issues now"

"It's suddenly become a really frightening place to have these conversations because of the addition of the 'T'"

The needs of LGB staff and the needs of staff whose feel their gender identity is different from their biological sex both need to be progressed. These groups have differing needs and the solutions to those needs will often be different. The current focus on the needs of staff who feel their gender identity is different from their biological sex means that the needs of LGB staff are not being advanced. Until the two are separated the poor and worsening experience of LGB staff will continue.

DRAFT

Recommendations

1. The NHS should undertake further work to understand what lies beneath these statistics

The data included in this report is produced by the NHS and is robust and reliable. The same questions have been asked of all NHS staff each year for five years. In 2020 over half a million staff completed the survey and over 20,000 of them declared themselves to be either lesbian, gay or bisexual. However, more work needs to be undertaken to understand what lies beneath these data. In undertaking this research, the NHS will need to ensure

   a. that they only ask people who are same sex attracted for their views, to get a clear view of those who are LGB
   b. that LGB staff feel safe enough to give their views – most LGB staff are frightened to go against the prevailing narrative around gender identity
   c. that the research is undertaken independent of the influence of LGBT+ lobby groups and individuals

2. The NHS should separate LGB issues from those of gender identity. This means having separate structures for LGB and gender identity at all levels of the NHS from the most senior roles such as the current national LGBT+ health advisor to having separate LGB and Gender Identity networks at organisation level. This will enable the NHS to focus on issues affecting LGB staff without getting distracted by gender identity and create a feeling of safety for LGB staff to begin to get involved and bring LGB leadership to this area again.

3. The NHS should mandate the systematic collection of staff experience data against sexual orientation and ensure actions plans are in place to resolve issues identified by that data collection. Systems could be put in place similar to those of the WRES. The NHS needs to take ownership of and lead this area itself, rather than engaging external highly partisan groups and should engage local LGB staff in the improvement effort

4. The NHS should immediately stop “performative” national initiatives such as flags, badges etc that are perceived to privilege one group over others, including all of the other protected characteristic groups as well as LGB people. There is a polarised national debate that the NHS should not be seen to be taking sides in. The NHS should urgently consider developing national guidance on this issue to ensure that it and its constituent employers are complying with their public sector equality duty and that they do not inadvertently make some of their LGB staff (and other protected groups) feel unsafe.

DRAFT

DRAFT

Appendices

1. Methodology

The data utilised for this review is taken from the annual national staff survey and includes data from 2016 to 2020 inclusive. The NHS staff survey includes data from England and Wales and is one of the largest staff surveys in the world. In 2020 it had a response rate of almost 50% and was competed by nearly 600,000 employees.

The national staff survey asks participants their sexuality. In 2020 nearly 4% of those who responded to the survey declared their sexuality to be lesbian, gay or bisexual. A further 8% stated other or prefer not to say and we have excluded these from our data set. We have compared the data between those who stated they were heterosexual or straight against the average reported response from those who said they were Lesbian or Gay and those who declared they were Bisexual. In 2020 the average number of LGB respondents to the staff survey questions utilised for this review was around 21,500 which is an increase from the 10,500 respondents in 2016. No matter the year, this represents a high number of responses and therefore this data is based on a relatively large sample of people.

In every one of the ten themes of the survey, the results for LGB staff were worse than for heterosexual staff. We drilled down into the key questions under the most relevant themes – the questions that the NHS staff survey uses to calculate the theme scores in the relevant themes. In total 18 questions reflecting a range of staff experiences were identified for review, aligned to the National People Plan and People Promise. The detailed results are shown in appendix 3

In addition to the data from the national staff survey eight semi structured interviews were conducted (see appendix 2). Interviewees were identified using convenience sampling (using staff networks, word of mouth and an open call for input at our conference) and ranged from band 3 to Board level and included clinical and non-clinical staff in hospitals and non-patient facing NHS organisations and included both men and women. The aim was to identify interviewees' experiences and knowledge of areas identified by the staff survey data and their thoughts and experiences of what this data was saying. Whilst some of these staff had worked in the NHS for some time, we have only used information or quotes from their experiences over the years covered by the staff survey data i.e. 2016 to 2020 in this report. We specifically excluded any experiences they described that happened before 2016 in order to retain the focus of this report on the last five years. Whilst the information from the interviews is not generalisable, it does begin to throw some light on the issues and identify some areas for further investigation and action.

DRAFT

DRAFT

Appendix 2. – Questions for Semi-structured Interviews (these questions were used to structure the interview around the data with follow up questions asked in response to the information given by the interviewee)

About you:

General Role in the NHS

Length of service:

Sexual Orientation:

Sex:

Age:

About your organisation

Q. Does the organisation you work in have any formal programme relating to LGB staff? e.g Stonewall Diversity Champion. Rainbow Badges. LGB Staff network, ETC

Q. Does your organisation 'celebrate' any specific LGB events – e.g Pride? LGB(T) History month?

Q. What difference has this made?

Q. Have you ever experienced any of the following:

- Discrimination
- Harassment
- Violence

If yes to any, can you tell us when this occurred and describe them.

If yes – did you report it? What was your experience of that process?

DRAFT

Q. Are you or have you been ‘out’ at work?

Follow Up Questions – Out to everyone?

If no, why?

Q. Do you ever ‘cover’ yourself to downplay your sexual orientation?

If yes, how does this make you feel?

Q. Do you feel the NHS is doing enough to support LGB staff?

What more could be done?

Q. Do you speak up about issues relating to LGB staff or patients?

Q. Is there enough discussion on LGB (only) issues?

Q. What more could be done to improve working life for LGB staff in the NHS?

DRAFT

Appendix 3

Theme	Q	Year		N LGB	LGB	Hetero	LGB Difference to Heterosexual
Health and wellbeing	q11c	2020	Percentage answer yes to the question 'during the last 12 months have you felt unwell as a result of work-related stress'	21437	54.90%	42.50%	12.4%
		2019		19460	51.35%	39.10%	12.3%
		2018		15309	49.05%	38.70%	10.4%
		2017		13832	47.60%	37.10%	10.5%
		2016		11166	46.05%	35.60%	10.5%
	q11e	2020	Percentage answering yes to 'have you felt pressure from your manager to come to work'	11341	30.10%	24.30%	5.8%
		2019		12070	27.90%	22.70%	5.2%
		2018		9455	30.25%	24.10%	6.2%
		2017		8559	30.45%	24.60%	5.9%
		2016		6741	31.70%	25.20%	6.5%
Morale/Staff Engagement	q4j	2020	I receive the respect I deserve from my colleagues at work	21433	69.80%	72.80%	-3.0%
		2019		19459	70.90%	73.40%	-2.5%
		2018		15339	70.70%	73.20%	-2.50%
	q2a	2020	Percentage of staff saying they often or always 'look forward to going to work'	21425	55.00%	60.00%	-5.0%
		2019		19464	57.25%	60.30%	-3.1%
		2018		15322	56.90%	59.50%	-2.6%
		2017		13842	54.65%	58.60%	-4.0%
		2016		11183	56.75%	59.60%	-2.9%
	q19a	2020	Percentage of staff agreeing or strongly agreeing that 'I often think about leaving my organisation'	21469	31.10%	25.20%	5.9%
		2019		19492	32.45%	27.40%	5.1%
		2018		15371	33.80%	28.90%	4.9%
	q19b	2020	Percentage of staff agreeing or strongly agreeing 'I will probably look for a job at a new organisation in the next 12 months'	21440	27.30%	18.50%	8.8%
		2019		19462	28.55%	20.10%	8.5%

DRAFT

		2018		15355	29.40%	20.70%	8.7%
Equality, diversity and inclusion	**q14**	2020	Percentage answering yes to 'does your organisation act fairly with regards progressions and promotion regardless of … (protected characteristic)	15229	81.45%	85.00%	-3.6%
		2019		14081	82.45%	85.00%	-2.6%
		2018		11069	81.85%	84.50%	-2.7%
		2017		10252	82.20%	85.30%	-3.1%
		2016		8243	83.75%	86.30%	-2.6%
	q15b	2020	Percentage answering yes to 'in the last 12 months have you personally experienced discrimination at work from your manager, team leader or other colleague	21350	12.40%	7.60%	4.8%
		2019		19311	11.90%	7.10%	4.8%
		2018		15196	12.15%	7.50%	4.7%
		2017		13798	12.55%	7.50%	5.1%
		2016		11113	11.80%	7.00%	4.8%
	q15a	2020	Percentage answering yes to 'in the last 12 months have you personally experienced discrimination from a patient/service user, their relative or other member of the public'	21406	13.00%	6.70%	6.3%
		2019		19380	13.80%	6.70%	7.1%
		2018		15255	13.65%	6.40%	7.3%
		2017		13799	12.90%	6.10%	6.8%
		2016		11143	12.40%	5.80%	6.6%
Safe Environment - Violence, Bullying & Harrassment	**q12a**	2020	Percentage saying that in the last 12 months they have personally experienced at least one incident of violence at work from a patient/service user, their relative or other member of the public	21437	21.85%	13.90%	8.0%
		2019		19463	22.45%	14.40%	8.1%
		2018		15332	21.75%	14.00%	7.8%
		2017		13842	22.35%	14.80%	7.6%
		2016		11163	22.40%	14.60%	7.8%
	q13a	2020	Percentage saying that in the last 12 months they have personally experienced at least one incident of harassment, bullying or abuse at work from a patient/service user, their relative or other member of the public	21252	35.00%	25.80%	9.2%
		2019		19437	36.90%	27.80%	9.1%
		2018		15342	36.20%	27.60%	8.6%
		2017		13816	35.35%	27.30%	8.1%
		2016		11145	35.40%	27.20%	8.2%
	q13b	2020	Percentage saying that in the last 12 months they have personally experienced at least one incident of harassment, bullying or abuse at work from managers	21194	15.30%	11.50%	3.8%
		2019		19340	15.25%	11.50%	3.8%
		2018		15191	16.20%	12.40%	3.8%

DRAFT

		2017		13693	15.95%	12.10%	3.9%
		2016		11054	16.80%	12.10%	4.7%
	q13c	2020	Percentage saying that in the last 12 months they have personally experienced at least one incident of harassment, bullying or abuse at work from other colleagues	21143	24.40%	17.80%	6.6%
		2019		19272	24.75%	18.20%	6.6%
		2018		15172	24.30%	18.40%	5.9%
		2017		13681	23.00%	17.30%	5.7%
		2016		11036	22.05%	17.20%	4.9%
Quality of Care	q7a	2020	Percentage selecting often or always to the question 'I am satisfied with the quality of care I give to patients/ service users'	18769	80.50%	82.90%	-2.4%
		2019		17102	79.25%	81.80%	-2.6%
		2018		13416	78.95%	81.30%	-2.3%
		2017		12048	79.25%	81.90%	-2.7%
		2016		9710	81.90%	83.20%	-1.3%
	q7c	2020	Percentage agreeing or strongly agreeing to the statement 'I am able to deliver the care I aspire to'	18716	67.00%	70.60%	-3.6%
		2019		17076	66.25%	69.20%	-2.9%
		2018		13418	65.15%	68.00%	-2.9%
		2017		12046	64.55%	67.60%	-3.1%
		2016		9720	66.00%	68.90%	-2.9%
Reporting & Safety Culture	a12d	2020	Percentage answering yes to 'The last time you experienced violence at work did you or a colleague report it'	4278	72.10%	72.60%	-0.5%
		2019		3952	71.90%	72.50%	-0.6%
		2018		2926	70.30%	71.10%	-0.8%
		2017		2676	70.55%	72.60%	-2.1%
		2016		2289	71.05%	72.30%	-1.3%
	q13d	2020	Percentage answering yes to 'The last time you experienced harassment or bullying or abuse at work did you or a colleague report it'	9441	48.50%	48.90%	-0.4%
		2019		8874	49.35%	49.00%	0.4%
		2018		6685	46.60%	47.60%	-1.0%
		2017		6078	47.20%	48.40%	-1.2%
		2016		4950	46.75%	48.00%	-1.3%
Other	q9b	2020	Communication between senior management and staff is effective	21479	42.40%	44.50%	-2.1%
		2019		19502	41.50%	42.80%	-1.3%
		2018		15350	40.75%	41.40%	-0.7%

DRAFT

2017		13784	41.20%	41.10%	0.1%
2016		11161	40.35%	40.60%	-0.3%

DRAFT

References

EHRC. (2022, January 26). letter to Shona Robison, Cabinet Secretary for Social Justice, Scottish Government. Retrieved from https://www.equalityhumanrights.com/en/our-work/news

Michael West & Jeremy Dawson. (2011). *Empoyee engagment and NHS performance.*

DRAFT

LAW COMMISSION CONSULTATION ONLINE COMMUNICATION
Closing date 18 December 2020

QUESTIONS

Consultation Question 1.
7.1 We provisionally propose that section 127(1) of the Communications Act 2003 and section 1 of the Malicious Communications Act 1988 should be repealed and replaced with a new communications offence according to the model that we propose below. Do consultees agree?
7.2 By way of summary (though we make separate proposals in respect of each of these below), the elements of the provisionally proposed offence are as follows:
(1) The defendant sent or posted a communication that was likely to cause harm to a likely audience;
(2) in sending or posting the communication, the defendant intended to harm, or was aware of a risk of harming, a likely audience; and
(3) the defendant sent or posted the communication without reasonable excuse.
(4) For the purposes of this offence, definitions are as follows:
(a) a communication is a letter, article, or electronic communication;
(b) a likely audience is someone who, at the point at which the communication was sent or posted by the defendant, was likely to see, hear, or otherwise encounter it; and
(c) harm is emotional or psychological harm, amounting to at least serious emotional distress.
(5) When deciding whether the communication was likely to cause harm to a likely audience, the court must have regard to the context in which the communication was sent or posted, including the characteristics of a likely audience.
(6) When deciding whether the defendant had a reasonable excuse for sending or posting the communication, the court must have regard to whether the communication was, or was meant as, a contribution to a matter of public interest.

No. As argued below, the proposed model does not adequately address the issues it sets out to resolve and creates a fresh set of problems that are in some ways more serious. The proposed model provides no legal certainty. Only the court can make the final determination as to the emotional or psychological distress caused by a communication. It is unreasonable to expect everyone expressing views on social media to imagine how these views may affect the most over-sensitive person in the likely audience.

Our organisation is accused of causing such distress on a daily basis, for instance by asserting the dictionary definition of "woman" as "adult human female" and by asserting that lesbians do not have penises. Maya Forstater was dismissed from her job for challenging the view that a person can change sex. We are therefore "aware" of the risk that some will find such assertions emotionally or psychologically distressing. We nonetheless assert our right to make these statements because they are true.

The Cass Review

Independent review of gender identity services for children and young people: Interim report

February 2022



Independent review of gender identity services for children and young people: Interim report

February 2022

The copyright holder has consented to third parties republishing the material contained in this report. Where any material, or the copyright in such material, is identified as being owned by a third party you will need to obtain permission from that third party before republishing such material.

Contents

About this report 7

A letter to children and young people 9

Introduction from the Chair 11

1. Summary and interim advice 14

Summary 15
- Conceptual understanding and consensus about the meaning of gender dysphoria 16
- Service capacity and delivery 16
- Service standards 17
- International comparisons 18
- Existing evidence base 18
- The mismatch between service user expectations and clinical standards 19

Interim advice 20
- Service model 20
- Clinical approach 22

2. Context 25

Transgender, non-binary and gender fluid adults 26
Terminology and diagnostic frameworks 26
Conceptual understanding of gender incongruence in children and young people 27

3. Current services 29

Current service model for gender-questioning children and young people 30
Changing epidemiology 32
Challenges to the service model and clinical approach 34
NHS England Policy Working Group 35
- Feminising/masculinising hormones 36
- Puberty blockers 37

Initiation of Cass Review 39
CQC inspection 39
Legal background 40
The Multi-Professional Review Group 43

4. What the review has heard so far 44

Listening sessions 45
- What we have heard from service users, their families and support and advocacy groups 45
- What we have heard from healthcare professionals 47

Structured engagement with primary, secondary and specialist clinicians 49
- Professional panel – primary and secondary care 49
- Gender specialist questionnaire 50
- Findings 50

5. Principles of evidence based service development 53

Evidence based service development 54
Key stages of service development 55
- New condition observed 55
- Aetiology 55
- Natural history and prognosis 55
- Epidemiology 57
- Assessment and diagnosis 59
- Developing and implementing new treatments 61
- Service development and service improvement 65

6. Interim advice, research programme and next steps 67

Dealing with uncertainty 68
Interim advice 69
- Service model 69
- Clinical approach 71

Research programme 73
- Literature review 73
- Quantitative research 74
- Qualitative research 74
- Progress 75

Ongoing engagement 76

Glossary 77

Appendix 1: Terms of reference 86

Appendix 2: Letter to NHS England 89

Appendix 3: Diagnostic criteria for gender dysphoria 94

Appendix 4: Clinical service development 98

References 107

About this report

This interim report represents the work of the independent review of gender identity services for children and young people to date. It reflects a point in time. It does not set out final recommendations; these will be developed over the coming months, informed by our formal research programme.

This Review is forward looking. Its role is to consider how to improve and develop the future clinical approach and service model. However, in order to do this, it is first necessary to understand the current landscape and the reasons why change is needed, so that any future model addresses existing challenges, whilst retaining those features that service users and the professionals supporting them most value.

This report is primarily for the commissioners and providers of services for children and young people needing support around their gender. However, because of the wide interest in this topic, we have included some explanations about how clinical service development routinely takes place in the NHS, which sets the context for some of our interim advice.

The care of this group of children and young people is everyone's business. We therefore encourage the wider clinical community to take note of our work and consider their own roles in providing the best holistic support to this population.

Since the Review began, it has focused on hearing a wide range of perspectives to better understand the challenges within the current system and aspirations for how these could be addressed. This report does not contain all that we have heard during our listening sessions but summarises consistent themes. These conversations will continue throughout the course of the Review and there will be further opportunities for stakeholders to engage and contribute.

It is important to note that the references cited in this report do not constitute a comprehensive literature review and are included only to clarify why specific lines of enquiry are being pursued, and where there are unanswered questions that will be addressed more fully during the life of the Review. A formal literature review is one strand of the Review's commissioned work, and this will be reported in full when complete.

A note about language

There is sometimes no consensus on the best language to use relating to this subject. The language surrounding this area has also changed rapidly and young people have developed varied ways of describing their experiences using different terms and constructs that are relevant to them.

The Review tries as far as possible to use language and terms that are respectful and acknowledge diversity, but that also accurately illustrate the complexity of what we are trying to describe and articulate.

The terms we have used may not always feel right to some; nevertheless, it is important to emphasise that the language used is not an indication of a position being taken by the Review. A glossary of terms is included.

The Review is cognisant of the broader cultural and societal debates relating to the rights of transgender adults. It is not the role of the Review to take any position on the beliefs that underpin these debates. Rather, this Review is strictly focused on the clinical services provided to children and young people who seek help from the NHS to resolve their gender-related distress.

A letter to children and young people

Children and young people accessing the NHS deserve safe, timely and supportive services, and clinical staff with the training and expertise to meet their healthcare needs.



Dr Hilary Cass

I understand that as you read this letter some of you may be anxious because you are waiting to access support from the NHS around your gender identity. Maybe you have tried to get help from your local services, or from the Gender Identity Development Service (GIDS), and because of the long waiting lists they have not yet been able to see you. I hope that some of you have had help – maybe from a supportive GP, a local Child and Adolescent Mental Health Service (CAMHS), or from GIDS.

I have heard that young service users are particularly worried that I will suggest that services should be reduced or stopped. I want to assure you that this is absolutely not the case – the reverse is true. I think that more services are needed for you, closer to where you live. The GIDS staff are working incredibly hard and doing their very best to see you as quickly as possible but providing supportive care is not something that can be rushed – each young person needs enough time and space for their personal needs to be met. So, with the best will in the world, one service is not going to be able to respond to the growing demand in a timely way.

I am advising that more services are made available to support you. But I must be honest; this is not something that can happen overnight, and I can't come up with a solution that will fix the problems immediately. However, we do need to start now.

The other topic that I know is worrying some of you is whether I will suggest that hormone treatments should be stopped. On this issue, I have to share my thoughts as a doctor. We know quite a bit about hormone treatments, but there is still a lot we don't know about the long-term effects.

Whenever doctors prescribe a treatment, they want to be as certain as possible that the benefits will outweigh any adverse effects so that when you are older you don't end up saying 'Why did no-one tell me that that might happen?' This includes understanding both the risks and benefits of having treatment and not having treatment.

Therefore, what we will be doing over the next few months is trying to make sense of all the information that is available, as well as seeing if we can plug any of the gaps in the research. I am currently emphasising the importance of making decisions about prescribing as safe as possible. This means making sure you have all the information you need – about what we do know and what we don't know.

Finally, some of you may want the chance to talk to me and share your thoughts about how services should look in the future. Over the coming months we will need your help and there will be opportunities to get involved with the Review, so please keep an eye on our website (www.cass.independent-review.uk), where we will provide updates on our work.



Dr Hilary Cass, OBE

Introduction from the Chair

Anyone with an interest in the care of gender-questioning children and young people, as well as those with lived experience, may have wondered what qualifies me to take on this Review, and whether I have a pre-existing position on this subject.

I am a paediatrician who was in clinical practice until 2018, my area of specialism being children and young people with disability. I have also held many management and policy roles throughout my career, most notably as President of the Royal College of Paediatrics and Child Health (RCPCH) from 2012-15.

Children's services are often at a disadvantage in healthcare because health services are usually designed around the needs of adults. As President of RCPCH, a key part of my role was to advocate for services to be planned with children and families at their heart.

I have not worked in gender services during my career, but my strong focus on hearing the voice of service users, supporting vulnerable young people, equity of access, and strong clinical standards applies in this area as much as in my other work.

With this in mind, the aim of the Review is to ensure that children and young people who are experiencing gender incongruence or gender-related distress receive a high standard of NHS care that meets their needs and is safe, holistic and effective.

I have previously set out the principles governing this Review process, namely that:

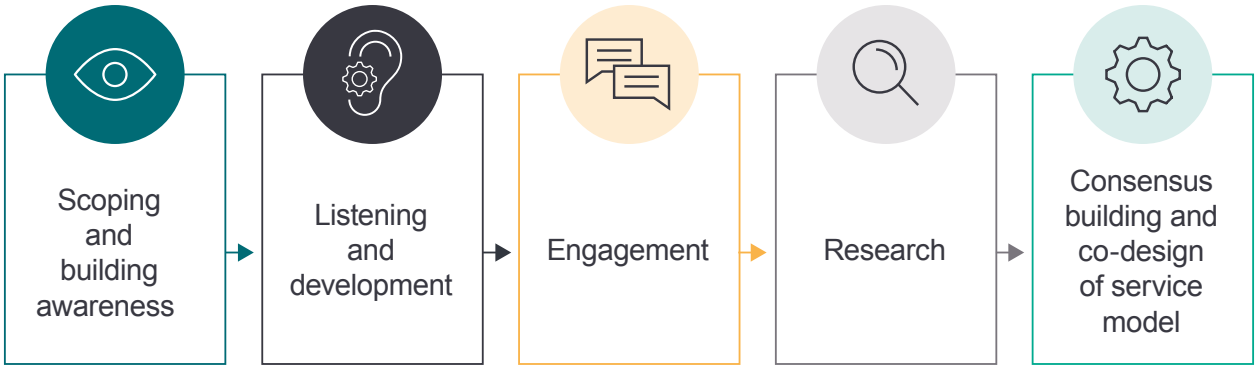
- The welfare of the child and young person will be paramount in all considerations.
- Children and young people must receive a high standard of care that meets their needs.
- There will be extensive and purposeful stakeholder engagement, including ensuring that children and young people can express their own views through a supportive process.
- The Review will be underpinned by research and evidence, including international models of good practice where available.
- There will be transparency in how the Review is conducted and how recommendations are made.
- There are no pre-determined outcomes with regards to the recommendations the Review will make.

The Review's terms of reference (**Appendix 1**) are wide ranging in scope, looking at different aspects of gender identity services across the whole pathway through primary, secondary and specialist services, up to the point of transition to adult services. This includes consideration of referral pathways, assessment, appropriate clinical management and workforce recommendations.

I have also been asked to explore the reasons for the considerable increase in the number of referrals, which have had a significant impact on waiting times, as well as the changing case-mix of gender-questioning children and young people presenting to clinical services.

The Review is taking an investigative approach to understanding what the future service model should look like for children and young people. This means that its outcomes are not being developed in isolation or by committee but rather through an ongoing dialogue aimed at building a shared understanding of the current situation and how it can and should be improved.

The key aspects of the approach to the Review are:



My starting point has been to hear from a variety of experts with relevant expertise and those with lived experience to understand as many perspectives as possible. To date, this has included hearing directly from those with lived experience, from professionals and support and advocacy groups. This listening process will continue.

We have been very fortunate in the generosity of all those who have been prepared to talk to the Review and share their experiences. In addition to some divergent opinions, there are also some themes and views which seem to be widely shared. The commitment of professionals at all levels is striking and I genuinely believe that with collective effort we can improve services for the children and young people who are at the heart of this Review.

These discussions have been valuable to get an in-depth sense of the current situation and different viewpoints on how it may be improved. However, it is essential that this initial understanding is underpinned by more detailed data and an enhanced evidence base, which is being delivered through the Review's academic research programme.

Providing this evidence base for the Review is going to take some time. I recognise there is a pressing need to enhance the services currently available for children, young people, their

parents and carers, some of whom are experiencing considerable distress. Clinicians providing their treatment and care are also under pressure and cannot sustain the current workload. As such, I know the time I am taking to complete this Review and make recommendations will be difficult for some, but it is necessary.

I wrote to NHS England in May 2021 (**Appendix 2**) setting out some more immediate considerations whilst awaiting my full recommendations. This report builds on that letter and looks to provide some further interim advice.

Through our research programme, the Review team will continue to examine the literature and, where possible, will fill gaps in the existing evidence base. However, there will be persisting evidence gaps and areas of uncertainty. We need the engagement of service users, support and advocacy groups, and professionals across the wider workforce to work with us in the coming months in a collaborative and open-minded manner in order to reach a shared understanding of the problems and an agreed way forward that is in the best interests of children and young people.

My measure of success for this Review will be that this group of children and young people receive timely, appropriate and excellent care, not just from specialists but from every healthcare professional they encounter as they take the difficult journey from childhood to adulthood.

1. Summary and interim advice



Summary

1.1. In recent years, there has been a significant increase in the number of referrals to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust. This has contributed to long waiting lists and growing concern about how the NHS should most appropriately assess, diagnose and care for this population of children and young people.

1.2. Within the UK, the single specialist service has developed organically, and the clinical approach has not been subjected to some of the usual control measures that are typically applied when new or innovative treatments are introduced. Many of the challenges and knowledge gaps that we face in the UK are echoed internationally,[1] and there are significant gaps in the research and evidence base.

1.3. This Review was commissioned by NHS England to make recommendations on how to improve services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence and ensure that the best model for safe and effective services is commissioned (**Appendix 1**).

1.4. This interim report represents the Review's work to date. It sets out what we have heard so far and the approach we are taking moving forward. There is still much evidence to be gathered, questions to be answered, and voices to be heard, and our perspective will evolve as more evidence comes to light. However, there is sufficient clarity on several areas for the Review to be able to offer advice at this stage so that action can be taken more quickly.

1.5. The Review is not able to provide definitive advice on the use of puberty blockers and feminising/masculinising hormones at this stage, due to gaps in the evidence base; however, recommendations will be developed as our research programme progresses.

Every gender-questioning child or young person who seeks help from the NHS must receive the support they need to get on the appropriate pathway for them as an individual.

Children and young people with gender incongruence or dysphoria must receive the same standards of clinical care, assessment and treatment as every other child or young person accessing health services.

[1] Vrouenraets LJ, Fredriks AM, Hannema SE, Cohen-Kettenis PT, de Vries MC (2015). Early medical treatment of children and adolescents with gender dysphoria: an empirical ethical study. J Adolesc Health 57(4): 367-73. DOI: 10.1016/.2015.04.004.

Conceptual understanding and consensus about the meaning of gender dysphoria

1.6. In clinical practice, a diagnosis of gender dysphoria is currently based on an operational definition, using the criteria set out in DSM-5 (**Appendix 3**). Some of these criteria are seen by some as outdated in the context of current understanding about the flexibility of gender expression.

1.7. At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual. Professionals' experience and position on this spectrum may determine their clinical approach.

1.8. Children and young people can experience this as a 'clinician lottery', and failure to have an open discussion about this issue is impeding the development of clear guidelines about their care.

Service capacity and delivery

1.9. A rapid change in epidemiology and an increase in referrals means that the number of children seeking help from the NHS is now outstripping the capacity of the single national specialist service, the Gender Identity Development Service (GIDS) at The Tavistock and Portman NHS Foundation Trust.

1.10. The mix of young people presenting to the service is more complex than seen previously, with many being neurodiverse and/or having a wide range of psychosocial and mental health needs. The largest group currently comprises birth-registered females first presenting in adolescence with gender-related distress.

1.11. Until very recently, any local professional, including non-health professionals, could refer to GIDS, which has meant that the quality and appropriateness of referrals lacks consistency, and local service provision has remained patchy and scarce.

1.12. The staff working within the specialist service demonstrate a high level of commitment to the population they serve. However, the waiting list pressure and lack of consensus development on the clinical approach, combined with criticism of the service, have all resulted in rapid turnover of staff and inadequate capacity to deal with the increasing workload. Capacity constraints cannot be addressed through financial investment alone; there are some complex workforce (recruitment; retention; and training) and cultural issues to address.

1.13. Our initial work has indicated that many professionals working at primary and secondary level feel that they have the transferable skills and the commitment to offer more robust support to this group of children and young people, but are nervous about doing so, partly because of the lack of formal clinical guidance, and partly due to the broader societal context.

1.14. Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters.

1.15. Children and young people are waiting lengthy periods to access GIDS, during which time some may be at considerable risk. By the time they are seen, their distress may have worsened, and their mental health may have deteriorated.

1.16. Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be overlooked.

1.17. The current move to adult services at age 17-18 may fall at a critical time in the young person's gender management. In contrast, young people with neurodiversity often remain under children's services until age 19 and some other clinical services continue to mid-20s. Further consideration will be needed regarding the age of transfer to adult services.

Service standards

1.18. The Multi-Professional Review Group (MPRG), set up by NHS England to ensure that procedures for assessment and for informed consent have been properly followed, has stated that the following areas require consideration:

- From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision.
- From documentation provided to the MPRG, there does not appear to be a standardised approach to assessment or progression through the process, which leads to potential gaps in necessary evidence and a lack of clarity.
- There is limited evidence of mental health or neurodevelopmental assessments being routinely documented, or of a discipline of formal diagnostic or psychological formulation.
- Of 44 submissions received by the MPRG, 31% were not initially assured due to lack of safeguarding information. And in a number of cases there were specific safeguarding concerns. There do not appear to be consistent processes in place to work with other agencies to identify children and young people and families who may be vulnerable, at risk and require safeguarding.

- Appropriate clinical experts need to be involved in informing decision making.

1.19. Many of these issues were also highlighted by the Care Quality Commission (CQC) in 2020.[2]

International comparisons

1.20. The Netherlands was the first country to provide early endocrine interventions (now known internationally as the Dutch Approach). Although GIDS initially reported its approach to early endocrine intervention as being based on the Dutch Approach,[3] there are significant differences in the NHS approach. Within the Dutch Approach, children and young people with neurodiversity and/or complex mental health problems are routinely given therapeutic support in advance of, or when considered appropriate, instead of early hormone intervention. Whereas criteria to have accessed therapeutic support prior to starting hormone blocking treatment do not appear to be integral to the current NHS process.

1.21. NHS endocrinologists do not systematically attend the multi-disciplinary meetings where the complex cases that may be referred to them are discussed, and until very recently did not routinely have direct contact with the clinical staff member who had assessed the child or young person. This is not consistent with some international approaches for this group of children and young people, or in other multi-disciplinary models of care across paediatrics and adult medicine where challenging decisions about life-changing interventions are made.[4,5]

1.22. In the NHS, once young people are started on hormone treatment, the frequency of appointments drops off rather than intensifies, and review usually takes place quarterly. Again, this is different to the Dutch Approach.[6] GIDS staff would recommend more frequent contact during this period, but the fall-off in appointments reflects a lack of service capacity, with the aspiration being for more staff time to remedy this situation.

Existing evidence base

1.23. Evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally.

---

[2] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.
[3] de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.
[4] Ibid.
[5] Kyriakou A, Nicolaides NC, Skordis N (2020). Current approach to the clinical care of adolescents with gender dysphoria. Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.
[6] de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.

1.24. A lack of a conceptual agreement about the meaning of gender dysphoria hampers research, as well as NHS clinical service provision.

1.25. There has not been routine and consistent data collection within GIDS, which means it is not possible to accurately track the outcomes and pathways that children and young people take through the service.

1.26. Internationally as well as nationally, longer-term follow-up data on children and young people who have been seen by gender identity services is limited, including for those who have received physical interventions; who were transferred to adult services and/or accessed private services; or who desisted, experienced regret or detransitioned.

1.27. There has been research on the short-term mental health outcomes and physical side effects of puberty blockers for this cohort, but very limited research on the sexual, cognitive or broader developmental outcomes.[7]

1.28. Much of the existing literature about natural history and treatment outcomes for gender dysphoria in childhood is based on a case-mix of predominantly birth-registered males presenting in early childhood. There is much less data on the more recent case-mix of predominantly birth-registered females presenting in early teens, particularly in relation to treatment and outcomes.

1.29. Aspects of the literature are open to interpretation in multiple ways, and there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint.

The mismatch between service user expectations and clinical standards

1.30. By the time children and young people reach GIDS, they have usually had to experience increasingly long, challenging waits to be seen.[8] Consequently, some feel they want rapid access to physical interventions and find having a detailed assessment distressing.

1.31. Clinical staff are governed by professional, legal and ethical guidance which demands that certain standards are met before a treatment can be provided. Clinicians carry responsibility for their assessment and recommendations, and any harm that might be caused to a patient under their care. This can create a tension between the aspirations of the young person and the responsibilities of the clinician.

[7] National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria.
[8] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

Interim advice

1.32. The Review considers that there are some areas where there is sufficient clarity about the way forward and we are therefore offering some specific observations and interim advice. The Review will work with NHS England, providers and the broader stakeholder community to progress action in these areas.

Service model

1.33. It has become increasingly clear that a single specialist provider model is not a safe or viable long-term option in view of concerns about lack of peer review and the ability to respond to the increasing demand.

1.34. Additionally, children and young people with gender-related distress have been inadvertently disadvantaged because local services have not felt adequately equipped to see them. It is essential that they can access the same level of psychological and social support as any other child or young person in distress, from their first encounter with the NHS and at every level within the service.

1.35. A fundamentally different service model is needed which is more in line with other paediatric provision, to provide timely and appropriate care for children and young people needing support around their gender identity. This must include support for any other clinical presentations that they may have.

1.36. The Review supports NHS England's plan to establish regional services, and welcomes the move from a single highly specialist service to regional hubs.

1.37. Expanding the number of providers will have the advantages of:

- creating networks within each area to improve early access and support;
- reducing waiting times for specialist care;
- building capacity and training opportunities within the workforce;
- developing a specialist network to ensure peer review and shared standards of care; and
- providing opportunities to establish a more formalised service improvement strategy.

Service provision

1.38. The primary remit of NHS England's proposed model is for the regional hubs to provide support and advice to referrers and professionals. However, it includes limited provision for direct contact with children and young people and their families.

1: The Review advises that the regional centres should be developed, as soon as feasibly possible, to become direct service providers, assessing and treating children and young people who may need specialist care, as part of a wider pathway. The Review team will work with NHS England and stakeholders to further define the proposed model and workforce implications.

2: Each regional centre will need to develop links and work collaboratively with a range of local services within their geography to ensure that appropriate clinical, psychological and social support is made available to children and young people who are in early stages of experiencing gender distress.

3: Clear criteria will be needed for referral to services along the pathway from primary to tertiary care so that gender-questioning children and young people who seek help from the NHS have equitable access to services.

4: Regional training programmes should be run for clinical practitioners at all levels, alongside the online training modules developed by Health Education England (HEE). In the longer-term, clearer mapping of the required workforce, and a series of competency frameworks will need to be developed in collaboration with relevant professional organisations.

Data, audit and research

1.39. A lack of routine and consistent data collection means that it is not possible to accurately track the outcomes and pathways children and young people take through the service. Standardised data collection is required in order to audit service standards and inform understanding of the epidemiology, assessment and treatment of this group. This, alongside a national network which brings providers together, will help build knowledge and improve outcomes through shared clinical standards and systematic data collection. In the longer-term, formalisation of such a network into a learning health system[9] with an academic host would mean that there was systematised use of data to produce a continuing research programme with rapid translation into clinical practice and a focus on training.

[9] Scobie S, Castle-Clarke S (2019). Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics. Learning Health Systems 4(1): e10209. DOI:10.1002/lrh2.10209.

5: The regional services should have regular co-ordinated national provider meetings and operate to shared standards and operating procedures with a view to establishing a formal learning health system.

6: Existing and future services should have standardised data collection in order to audit standards and inform understanding of the epidemiology, assessment and treatment of this group of children and young people.

7: Prospective consent of children and young people should be sought for their data to be used for continuous service development, to track outcomes, and for research purposes. Within this model, children and young people put on hormone treatment should be formally followed up into adult services, ideally as part of an agreed research protocol, to improve outcome data.

Clinical approach

Assessment processes

1.40. We have heard that there are inconsistencies and gaps in the assessment process. Our work to date has also demonstrated that clinical staff have different views about the purpose of assessment and where responsibility lies for different components of the process within the pathway of care. The Review team has commenced discussions with clinical staff across primary, secondary and tertiary care to develop a framework for these processes.

8: There needs to be agreement and guidance about the appropriate clinical assessment processes that should take place at primary, secondary and tertiary level.

9: Assessments should be respectful of the experience of the child or young person and be developmentally informed. Clinicians should remain open and explore the patient's experience and the range of support and treatment options that may best address their needs, including any specific needs of neurodiverse children and young people.

Hormone treatment

1.41. The issues raised by the Multi-Professional Review Group echo several of the problems highlighted by the CQC. It is essential that principles of the General Medical Council's Good Practice in Prescribing and Managing Medicine's and Devices[10] are closely followed, particularly given the gaps in the evidence base regarding hormone treatment. Standards for decision making regarding endocrine treatment should also be consistent with international best practice.[11,12,13]

10: Any child or young person being considered for hormone treatment should have a formal diagnosis and formulation, which addresses the full range of factors affecting their physical, mental, developmental and psychosocial wellbeing. This formulation should then inform what options for support and intervention might be helpful for that child or young person.

11: Currently paediatric endocrinologists have sole responsibility for treatment, but where a life-changing intervention is given there should also be additional medical responsibility for the differential diagnosis leading up to the treatment decision.

1.42. Paediatric endocrinologists develop a wide range of knowledge within their paediatric training, including safeguarding, child mental health, and adolescent development. Being party to the discussions and deliberations that have led up to the decision for medical intervention supports them in carrying out their legal responsibility for consent to treatment and the prescription of hormones.

12: 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.

---

[10] General Medical Council (2021). Good practice in prescribing and managing medicines and devices (76-78).
[11] Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, et al (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab 102(11): 3869–903. DOI: 10.1210/jc.2017-01658.
[12] Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). Treatment of adolescents with gender dysphoria in the Netherlands. Child Adolesc Psychiatr Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.
[13] Kyriakou A, Nicolaides NC, Skordis N (2020). Current approach to the clinical care of adolescents with gender dysphoria. Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.

1.43. Given the uncertainties regarding puberty blockers, it is particularly important to demonstrate that consent under this circumstance has been fully informed and to follow GMC guidance[14] by keeping an accurate record of the exchange of information leading to a decision in order to inform their future care and to help explain and justify the clinician's decisions and actions.

13: Within clinical notes, the stated purpose of puberty blockers as explained to the child or young person and parent should be made clear. There should be clear documentation of what information has been provided to each child or young person on likely outcomes and side effects of all hormone treatment, as well as uncertainties about longer-term outcomes.

14: In the immediate term the Multi-Professional Review Group (MPRG) established by NHS England should continue to review cases being referred by GIDS to endocrine services.

[14] General Medical Council (2020). Decision making and consent.

2. Context



Transgender, non-binary and gender fluid adults

2.1. NHS clinical services to support transgender adults with hormone treatment and subsequent surgery began in 1966.

2.2. Services were initially established within a mental health model, in conjunction with endocrinology and surgical services.

2.3. Currently, NHS services for transgender adults do not have adequate capacity to cope with demand.[15] In addition, the broader healthcare needs of this group are not well met. This is important in the context of the current generation of gender-questioning children and young people in that there are now two inflows into adult services – individuals transitioning in adulthood, and those moving through from children's services.

2.4. Legal rights and protections for transgender people lagged behind the provision of medical services, with the Gender Recognition Act 2004 coming into force in April 2005. Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial. This polarisation is such that it undermines safe debate and creates difficulties in building consensus.

2.5. It is not the role of this Review to take any position on the cultural and societal debates relating to transgender adults. However, in achieving its objectives there is a need to consider the information and support that children and young people access from whatever source, as well as any pressures that they are subject to, before they access clinical services.

Terminology and diagnostic frameworks

2.6. The Office for National Statistics defines sex as "referring to the biological aspects of an individual as determined by their anatomy, which is produced by their chromosomes, hormones and their interactions; generally male or female; something that is assigned at birth".[16]

2.7. The Office for National Statistics defines gender as "a social construction relating to behaviours and attributes based on labels of masculinity and femininity; gender identity is a personal, internal perception of oneself and so the gender category someone identifies with may not match the sex they were assigned at birth".[17]

2.8. Societal attitudes towards gender roles and gender expression are changing. Children, teenagers and younger adults may more commonly see gender as a fluid, multi-faceted phenomenon which

[15] Gender Identity Clinic, The Tavistock and Portman NHS Foundation Trust. Waiting times.
[16] Office for National Statistics (2019). What is the difference between sex and gender?
[17] Ibid.

does not have to be binary, whereas older generations have tended to see gender as binary and fixed. It is not unusual for young people to explore both their sexuality and gender as they go through adolescence and early adulthood before developing a more settled identity. Many achieve this without experiencing significant distress or requiring support from the NHS, but this is not the case for all.

2.9. For those who require support from the NHS, there are two widely used frameworks which provide diagnostic criteria. The International Classification of Diseases (ICD), which is the World Health Organization (WHO) mandated health data standard, and the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is the classification system for mental health disorders produced by the American Psychiatric Association. The current editions of these manuals – ICD-11 and DSM-5 – came into effect in January 2022 and 2013 respectively.

2.10. ICD-11[18] has attempted to depathologise gender diversity, removing the term 'gender identity disorders' from its mental health section and creating a new section for gender incongruence and transgender identities in a chapter on sexual health. These changes are part of a much broader societal drive to remove the stigma previously associated with transgender healthcare. ICD-11 defines gender incongruence as being "characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex." Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis. The full criteria for gender incongruence of childhood and gender incongruence of adolescence or adulthood are listed in **Appendix 3**.

2.11. DSM-5[19] is currently the framework used to diagnose gender dysphoria. This diagnostic category describes gender dysphoria as "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender". A diagnosis of gender dysphoria is usually deemed necessary before a young person can access hormone treatment, and criteria are listed in **Appendix 3**.

Conceptual understanding of gender incongruence in children and young people

2.12. Children and young people presenting to gender identity services are not a homogeneous group. They vary in their age at presentation, their cultural background, whether they identify as binary, non-binary, or gender fluid, whether they are neurodiverse and in a host of other ways.

[18] World Health Organization (2022). International Classification of Diseases Eleventh Revision.
[19] American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Health Disorders: DSM-5™, 5th ed.

2.13. Some children and young people may thrive during a period of gender-questioning whilst for others it can be accompanied with a level of distress that can have a significant impact on their functioning and development.

2.14. Alongside these very varied presentations, it is highly unlikely that a single cause for gender incongruence will be found. Many authors view gender expression as a result of a complex interaction between biological, cultural, social and psychological factors.

2.15. Despite a high level of agreement about these points, there are widely divergent and, in some instances, quite polarised views among service users, parents, clinical staff and the wider public about how gender incongruence and gender-related distress in children and young people should be interpreted, and this has a bearing on expectations about clinical management.

2.16. These views will be influenced by how each individual weighs the balance of factors that may lead to gender incongruence, and the distress that may accompany it. Beliefs about whether it might be inherent and/or immutable, whether it might be a transient response to adverse experiences, whether it might be highly fluid and/or likely to change in later adolescence/early adulthood, etc will have a profound influence on expectations about treatment options.[20]

2.17. All of these views may be overlaid with strongly held concerns about children's and young people's rights, autonomy, and/or protection.

2.18. The disagreement and polarisation is heightened when potentially irreversible treatments are given to children and young people, when the evidence base underlying the treatments is inconclusive, and when there is uncertainty about whether, for any particular child or young person, medical intervention is the best way of resolving gender-related distress.

2.19. As with many other contemporary polarised disagreements, the situation is exacerbated when there is no space to have open, non-judgemental discussions about these differing perspectives. A key aim of this review process will be to encourage such discussions in a safe and respectful manner so that progress can be made in finding solutions.

[20] Wren B (2019). Notes on a crisis of meaning in the care of gender-diverse children. In: Hertzmann L, Newbigin J (eds) Sexuality and Gender Now: Moving Beyond Heteronormativity. Routledge.

3. Current services



Current service model for gender-questioning children and young people

3.1. Currently there are no locally or regionally commissioned services for children and young people who seek help from the NHS in managing their gender-related distress. Within primary and secondary care, some clinical staff have more interest and expertise in initial management of this group of young people, but such individuals are few and far between.

3.2. The pathway for NHS support around gender identity for children and young people is designated as a highly specialised service.[21] The Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust is commissioned by NHS England to provide specialist assessment, support and, where appropriate, hormone intervention for children and young people with gender dysphoria. It is the only NHS provider of specialist gender services for children and young people in England. The Trust runs satellite bases in Leeds and Bristol. Until recently GIDS accepted referrals from multiple sources, for example, GPs, secondary care, social care, schools, and support and advocacy groups, which is unusual for a specialist service.

3.3. Children and young people are assessed by two members of the GIDS team who may be any combination of psychologists, psychotherapists, family therapists, or social workers. If there is uncertainty about the right approach, individual cases may be discussed in a complex case meeting. Those deemed appropriate for physical interventions are referred on to the endocrine team; under the current Standard Operating Procedure (SOP), this decision requires a multi-disciplinary team (MDT) discussion within GIDS. A member of the GIDS team attends new appointments in the endocrine clinic, but they will not routinely be the member of staff who saw the young person for assessment. However, very recently a triage meeting has been piloted to enable endocrinologists to discuss upcoming appointments with the clinician who saw the young person for assessment. The young person then attends an education session prior to their endocrine appointment. The endocrinologist will assess any medical contraindications prior to seeking consent from the patient for any hormone treatments.

3.4. For many years, the GIDS approach was to offer assessment and support, and to only start puberty blockers when children reached sexual maturity at about age 15 (Tanner Stage 5) as the first step in the treatment process to feminise or masculinise the young person, with

[21] National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

oestrogen or testosterone given from age 16. Feminising/masculinising hormones are not given at an earlier stage because of the irreversibility of some of their actions in developing secondary sex characteristics of the acquired gender.[22,23]

3.5. In 1998, a new protocol was published by the Amsterdam gender identity clinic.[24] It was subsequently named the Dutch Approach.[25] This involved giving puberty blockers much earlier, from the time that children showed the early signs of puberty (Tanner Stage 2), to pause further pubertal changes of the sex at birth. This stage of pubertal development was chosen because it was felt that although many younger children experienced gender incongruence as a transient developmental phenomenon, those who expressed early gender incongruence which continued into puberty were unlikely to desist at that stage.

3.6. It was felt that blocking puberty would buy time for children and young people to fully explore their gender identity and help with the distress caused by the development of their secondary sexual characteristics. The Dutch criteria for treating children with early puberty blockers were: (i) a presence of gender dysphoria from early childhood; (ii) an increase of the gender dysphoria after the first pubertal changes; (iii) an absence of psychiatric comorbidity that interferes with the diagnostic work-up or treatment; (iv) adequate psychological and social support during treatment; and (v) a demonstration of knowledge and understanding of the effects of gonadotropin-releasing hormones (puberty blockers), feminising/masculinising hormones, surgery, and the social consequences of sex reassignment.[26]

3.7. Under the Dutch Approach, feminising/masculinising hormones were started at age 16 and surgery was permitted to be undertaken from age 18, as in England.

3.8. From 2011, early administration of puberty blockers was started in England under a research protocol, which partially paralleled the Dutch Approach (the Early Intervention Study). From 2014, this protocol was adopted by GIDS as routine clinical practice. Results of the Early Intervention Study were published in December 2021.[27]

---

[22] Delemarre-van de Wall HA, Cohen-Kettinis PT (2006). Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. Eur J Endocrinol 155 (Suppl 1): S131–7. DOI: 10.1530/eje.1.02231.
[23] de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.
[24] Cohen-Kettenis PT, Van Goozen S (1998). Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. Eur Child Adolesc Psychiatry 7: 246–8. DOI: 10.1007/s007870050073.
[25] de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.
[26] Ibid.
[27] Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLoS One. 16(2):e0243894. DOI:10.1371/journal.pone.0243894.

3.9. However, the Dutch Approach differs from the GIDS approach in having stricter requirements about provision of psychological interventions. For example, under the Dutch Approach, if young people have gender confusion, aversion towards their sexed body parts, psychiatric comorbidities or Autism Spectrum Disorder (ASD) related diagnostic difficulties, they may receive psychological interventions only, or before, or in combination with medical intervention. Of note, in 2011, the Amsterdam team were reporting that up to 10% of their referral base were young people with ASD.[28]

Changing epidemiology

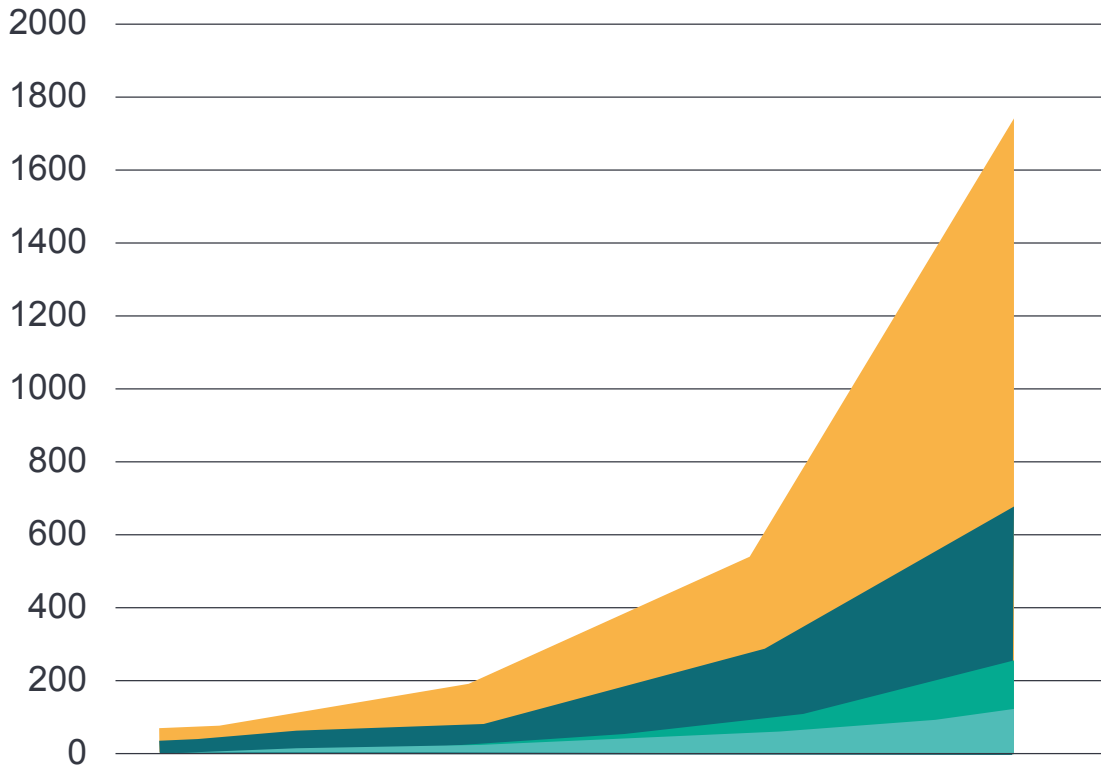
3.10. In the last few years, there has been a significant change in the numbers and case-mix of children and young people being referred to GIDS.[29] From a baseline of approximately 50 referrals per annum in 2009, there was a steep increase from 2014-15, and at the time of the CQC inspection of the Tavistock and Portman NHS Foundation Trust in October 2020 there were 2,500 children and young people being referred per annum, 4,600 children and young people on the waiting list, and a waiting time of over two years to first appointment.[30] This has severely impacted on the capacity of the existing service to manage referrals in the safe and responsive way that they aspire to and has led to considerable distress for those on the waiting list.

3.11. This increase in referrals has been accompanied by a change in the case-mix from predominantly birth-registered males presenting with gender incongruence from an early age, to predominantly birth-registered females presenting with later onset of reported gender incongruence in early teen years. In addition, approximately one third of children and young people referred to GIDS have autism or other types of neurodiversity. There is also an over-representation percentage wise (compared to the national percentage) of looked after children.[31]

---

[28] Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). Treatment of adolescents with gender dysphoria in the Netherlands. Child Adolesc Psychiatr Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.
[29] de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009-2016). Arch Sex Behav 47(5): 1301–4.
[30] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.
[31] Matthews T, Holt V, Sahin S, Taylor A, Griksaitis (2019). Gender Dysphoria in looked-after and adopted young people in a gender identity development service. Clinical Child Psychol Psychiatry 24: 112-128. DOI: 10.1177/1359104518791657.

Figure 1: Sex ratio in children and adolescents referred to GIDS in the UK (2009-16)



	2009	2010	2011	2012	2013	2014	2015	2016
Adolescents F	15	48*	78*	141*	221*	314*	689*	1071*
Adolescents M	24	44*	41	77*	120*	185*	293*	426*
Children F	2	7	12	17	22	36	77*	138*
Children M	10	19	29	30	31	55*	103*	131

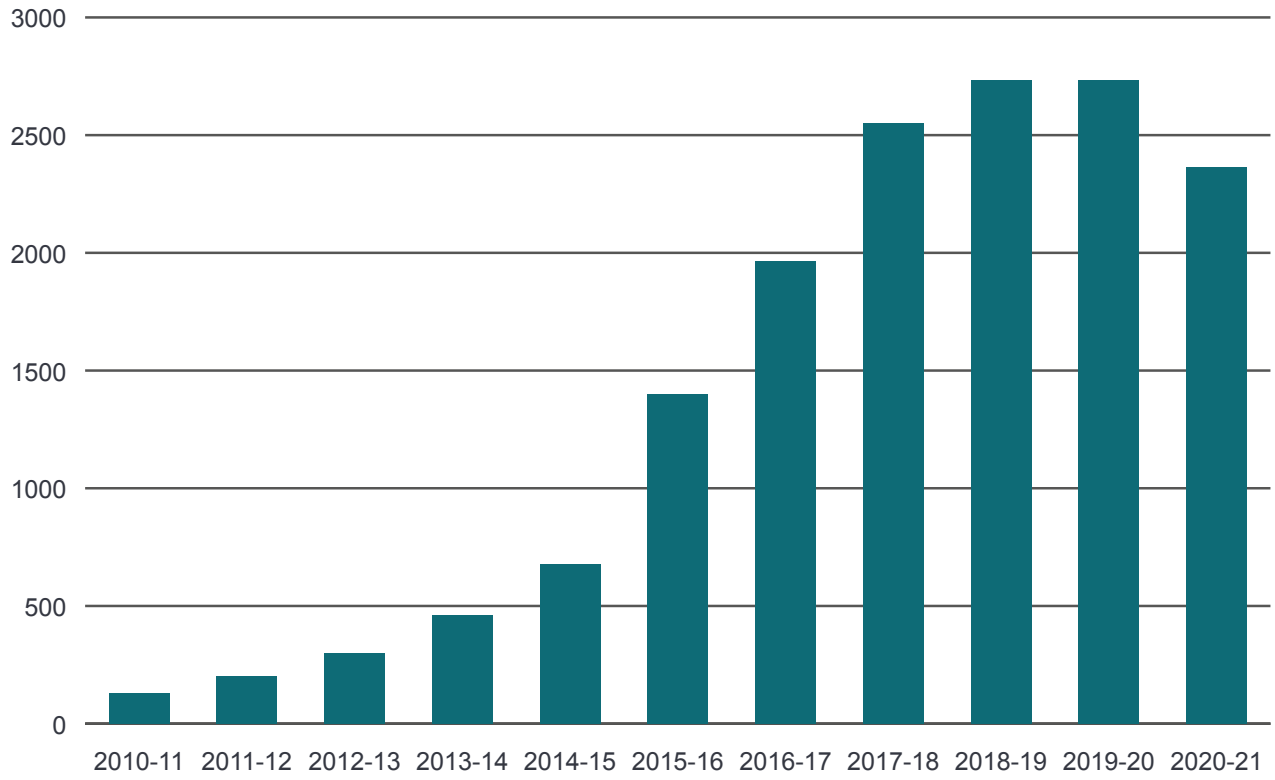
AFAB = assigned female at birth; AMAB = assigned male at birth

***Indicates** p<.05 which shows a significant increase of referrals compared to the previous year

Source: de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018).[32]

[32] de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009-2016). Arch Sex Behav 47(5): 1301–4.

Figure 2: Referrals to GIDS, 2010-11 to 2020-21



Source: Gender Identity Development Service.[33]

3.12. In 2019, GIDS reported that about 200 children and young people from a referral base of 2,500 were referred on to the endocrine pathway. There is no published data on how the other children and young people from this referral baseline were managed, for example if: their gender dysphoria was resolved; they were still being assessed or receiving ongoing psychological support and input; they were not eligible for puberty blockers due to age; they were referred to endocrine services at a later stage; they were transferred to adult services; or they accessed private services.

Challenges to the service model and clinical approach

3.13. Over a number of years, in parallel with the increasing numbers of referrals, GIDS faced increasing challenges, both internally and externally. There were different views held within the staff group about the appropriate clinical approach, with some more strongly affirmative and some more cautious and concerned about the use of physical intervention. The complexity of the cases had also increased, so clinical decision making had become more difficult. There was also a high staff

[33] Gender Identity Development Service. Referrals to GIDS, financial years 2010-11 to 2020-21.

turnover, and accounts from staff concerned about the clinical care, which were picked up in both mainstream and social media. This culminated in 2018 with an internal report by a staff governor.

3.14. Following that report, a review was carried out in 2019 by the Trust's medical director. This set out the need for clearer processes for the service's referral management, safeguarding, consent, and clinical approach, and an examination of staff workload and support, and a new Standard Operating Procedure (SOP) was put in place.

NHS England Policy Working Group

3.15. In January 2020, a Policy Working Group (PWG) was established by NHS England to undertake a review of the published evidence on the use of puberty blockers and feminising/masculinising hormones in children and young people with gender dysphoria to inform a policy position on their future use. Given the increasingly evident polarisation among clinical professionals, Dr Cass was asked to chair the group as a senior clinician with no prior involvement or fixed views in this area. The PWG comprised an expert group including endocrinologists, child and adolescent psychiatrists and paediatricians representing their respective Royal Colleges, an ethicist, a GP, senior clinicians from the NHS GIDS, a transgender adult and parents of gender-questioning young people. The process was supported by a public health consultant and policy, pharmacy and safeguarding staff from NHS England.

3.16. NHS England uses a standardised protocol for developing clinical policies. The first step of this involves defining the PICO (the Population being treated, the Intervention, a Comparator treatment, and the intended Outcomes). This of itself was challenging, with a particular difficulty being definition of the intended outcomes of puberty blockers, and suitable comparators for both hormone interventions. However, agreement was reached on what should be included in the PICO and subsequently the National Institute for Health and Care Excellence (NICE) was commissioned to review the published evidence,[34,35] again following a standardised protocol which has strict criteria about the quality of studies that can be included.

3.17. Unfortunately, the available evidence was not strong enough to form the basis of a policy position. Some of the challenges and outstanding uncertainties are summarised as follows.

[34] National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria.
[35] National Institute for Health and Care Excellence (2020). Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria.

Feminising/masculinising hormones

3.18. Sex hormones have been prescribed for transgender adults for several decades, and the long-term risks and side effects are well understood. These include increased cardiovascular risk, osteoporosis, and hormone-dependent cancers.

3.19. In young people, consideration also needs to be given to the impact on fertility, with the need for fertility counselling and preservation.

3.20. The additional physical risk of starting these treatments at age 16+ rather than age 18+ is unlikely to add significantly to the total lifetime risk, although data on this will not be available for many years. However, as evidenced by take-up of treatment with feminising/masculinising hormones, where there is a high level of certainty that physical transition is the right option, the child or young person may be more accepting of these risks, which can seem remote from the immediate gender distress.

3.21. The most difficult question in relation to feminising/masculinising hormones therefore is not about long-term physical risk which is tangible and easier to understand. Rather, given the irreversible nature of many of the changes, the greatest difficulty centres on the decision to proceed to physical transition; this relies on the effectiveness of the assessment, support and counselling processes, and ultimately the shared decision making between clinicians and patients. Decisions need to be informed by long-term data on the range of outcomes, from satisfaction with transition, through a range of positive and negative mental health outcomes, through to regret and/or a decision to detransition. The NICE evidence review demonstrates the poor quality of these data, both nationally and internationally.

3.22. Regardless of the nature of the assessment process, some children and young people will remain fluid in their gender identity up to early to mid-20s, so there is a limit as to how much certainty one can achieve in late teens. This is a risk that needs to be understood during the shared decision making process with the young person.

3.23. It is also important to note that any data that are available do not relate to the current predominant cohort of later-presenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people may not reach a settled gender expression until their mid-20s, it is too early to assess the longer-term outcomes of this group.

Puberty blockers

3.24. The administration of puberty blockers is arguably more controversial than administration of the feminising/masculinising hormones, because there are more uncertainties associated with their use.

3.25. There has been considerable discussion about whether the treatment is 'experimental'; strictly speaking an experimental treatment is one that is being given as part of a research protocol, and this is not the case with puberty blockers, because the GIDS research protocol was stopped in 2014. At that time, the treatment was experimental and innovative, because the drug was licensed for use in children, but specifically for children with precocious puberty. This was therefore the first time it was used 'off-label' in the UK for children with gender dysphoria. If a drug is used 'off-label' it means it is being used for a condition that is different from the one for which it was licensed. The many uncertainties around the 'off-label' use were recognised, but given that this was not a new drug, it did not need Medicines and Healthcare products Regulatory Agency (MHRA) approval at that time.

3.26. The important question now, as with any treatment, is whether the evidence for the use and safety of the medication is strong enough as judged by reasonable clinical standards.

3.27. One of the challenges that NHS England's PWG faced in considering this question was the lack of clarity about intended outcomes, several of which have been proposed including:

- providing time/space for the young person to make a decision about continuing with transition;
- reducing or preventing worsening of distress;
- improving mental health; and
- stopping potentially irreversible pubertal changes which might later make it difficult for the young person to 'pass' in their intended gender role.

3.28. Proponents for the use of puberty blockers highlight the distress that young people experience through puberty and the risk of self-harm or suicide.[36] However, some clinicians do not feel that distress is actually alleviated until children and young people are able to start feminising/masculinising hormones. The Review will seek to gain a better understanding of suicide data and the impact of puberty blockers through its research programme.

3.29. On the other hand, it has been asserted that starting puberty blockers at an older age provides children and young people with more time to achieve fertility preservation. In the case of birth-registered males, there is an argument that it also

[36] Turban JL, King D, Carswell JM, et al (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. Pediatrics 145 (2): e20191725. DOI: 10.1542/peds.2019-1725.

allows more time to achieve adequate penile growth for successful vaginoplasty.

3.30. In the short-term, puberty blockers may have a range of side effects such as headaches, hot flushes, weight gain, tiredness, low mood and anxiety, all of which may make day-to-day functioning more difficult for a child or young person who is already experiencing distress. Short-term reduction in bone density is a well-recognised side effect, but data is weak and inconclusive regarding the long-term musculoskeletal impact.[37]

3.31. The most difficult question is 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. Data from both the Netherlands[38] and the study conducted by GIDS[39] demonstrated that almost all children and young people who are put on puberty blockers go on to sex hormone treatment (96.5% and 98% respectively). The reasons for this need to be better understood.

3.32. A closely linked concern is the unknown impacts on development, maturation and cognition if a child or young person is not exposed to the physical, psychological, physiological, neurochemical and sexual changes that accompany adolescent hormone surges. It is known that adolescence is a period of significant changes in brain structure, function and connectivity.[40] During this period, the brain strengthens some connections (myelination) and cuts back on others (synaptic pruning). There is maturation and development of frontal lobe functions which control decision making, emotional regulation, judgement and planning ability. Animal research suggests that this development is partially driven by the pubertal sex hormones, but it is unclear whether the same is true in humans.[41] If pubertal sex hormones are essential to these brain maturation processes, this raises a secondary question of whether there is a critical time window for the processes to take place, or whether catch up is possible when oestrogen or testosterone is introduced later.

---

[37] National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria.
[38] Brik T, Vrouenraets LJJJ, de Vries MC, Hannema SE (2020). Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. Arch Sex Behav 49: 2611–8. DOI: 10.1007/s10508-020-01660-8.
[39] Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLoS One. 16(2):e0243894. DOI:10.1371/journal.pone.0243894.
[40] Delevichab K, Klinger M, Nana OJ, Wilbrecht L (2021). Coming of age in the frontal cortex: The role of puberty in cortical maturation. Semin Cell Dev Biol 118: 64–72. DOI: 10.1016/j.semcdb.2021.04.021.
[41] Goddings A-L, Beltz A, Jiska S, Crone EA, Braams BR (2019). Understanding the role of puberty in structural and functional development of the adolescent brain. J Res Adolesc 29(1): 32–53. DOI: 10.1111/jora.12408.

3.33. An international interdisciplinary panel[42] has highlighted the importance of understanding the neurodevelopmental outcomes of pubertal suppression and defined an appropriate approach for investigating this further. However, this work has not yet been undertaken.

Initiation of Cass Review

3.34. Dr Cass' own reflections on the PWG process, the available literature, and the issues it highlighted were as follows:

- Firstly, that hormone treatment is just one possible outcome for gender-questioning children and young people. A much better understanding is needed about: the increasing numbers of children and young people with gender-related distress presenting for help; the appropriate clinical pathway for each individual; their support needs; and the full range of potential treatment options.
- Secondly, there is very limited follow-up of the subset of children and young people who receive hormone treatment, which limits our understanding about the long-term outcomes of these treatments and this lack of follow up data should be corrected.
- Thirdly, the assessment process is inconsistent across the published literature. The outcome of hormone treatment is highly influenced by whether the assessment process accurately selects those children and young people most likely to benefit from medical treatment. This makes it difficult to draw conclusions from published studies.

3.35. In light of the above, NHS England commissioned this independent review to make recommendations on how the clinical management and service provision for children and young people who are experiencing gender incongruence or gender-related distress can be improved.

CQC inspection

3.36. In October and November 2020, the Care Quality Commission (CQC) inspectors carried out an announced, focused inspection of GIDS due to concerns reported to them by healthcare professionals and the Children's Commissioner for England. Concerns related to clinical practice, safeguarding procedures, and assessments of capacity and consent to treatment.

[42] Chen D, Strang JF, Kolbuck VD, Rosenthal SM, Wallen K, Waber DP, et al (2020). Consensus parameter: research methodologies to evaluate neurodevelopmental effects of pubertal suppression in transgender youth. Transgender Health 5(4). DOI: 10.1089/trgh.2020.0006.

3.37. The CQC report, published in January 2021,[43] gave the service an overall rating of inadequate. The report noted the high level of commitment and caring approach of the staff but identified a series of issues that needed improvement. In addition to the growing waiting list pressures, the CQC identified problems in several other areas including: the assessment and management of risk; the variations in clinical approach; the lack of clarity and consistency of care plans; the lack of any clear written rationale for decision making in individual cases; and shortfalls in the multidisciplinary mix required for some patient groups. Recording of capacity, competency and consent had improved since the new SOP in January 2020; however, there remained a culture in which staff reported feeling unable to raise concerns.

3.38. The CQC reported that when it inspected GIDS, there did not appear to be a formalised assessment process, or standard questions to explore at each session, and it was not possible to tell from the notes why an individual child might have been referred to endocrinology whilst another had not. Current GIDS data demonstrate that a majority of children and young people seen by the service do not get referred for endocrine treatment, but there is no clear information about what other diagnoses they receive, and what help or support they might need.

3.39. Since the CQC report, NHS England and The Tavistock and Portman NHS Foundation Trust management team have been working to address the issues raised. However, whilst some problems require a focused Trust response, the waiting list requires a system-wide response. This was noted in the letter from the Review to NHS England in May 2021 (**Appendix 2**).

Legal background

3.40. This section sets out the chronology of recent case law. In October 2019, a claim for Judicial Review was brought against The Tavistock and Portman NHS Foundation Trust. The claimants' case was summarised by the High Court as follows: "The claimants' case is that children and young persons under 18 are not competent to give consent to the administration of puberty blocking drugs. Further, they contend that the information given to those under 18 by the defendant [GIDS] is misleading and insufficient to ensure such children or young persons are able to give informed consent. They further contend that the absence of procedural safeguards, and the inadequacy of the information provided, results in an infringement of the rights of such children and young persons under Article 8 of the European Convention

[43] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

for the Protection of Human Rights and Fundamental Freedoms."[44]

3.41. In December 2020, three judges in the High Court of England and Wales handed down judgment in *Bell v Tavistock.*[45] (Most cases in the High Court are heard by a single judge sitting alone, and when a case is heard by more than one judge in the High Court, it is described as the Divisional Court.) The Divisional Court recognised that the Tavistock's policies and practices as set out in the service specification were not unlawful. However, the Court made a declaration that set out in detail a series of implications of treatment that a child would need to understand to be *Gillick* competent[46] to consent to puberty blockers. Specifically, because most children put on puberty blockers go on to have feminising/masculinising hormones, the judgment said a child would need to understand not only the full implications of puberty blocking drugs, but also the implications of the full pathway of medical and surgical transition. The judges concluded that it will be "very doubtful" that 14-15 year-olds have such competence, and "highly unlikely" that children aged 13 or under have competence for that decision. Under the Mental Capacity Act 2005, 16-17 year-olds are presumed to have capacity, and they are effectively treated as adults for consent to medical treatment under the Family Law Reform Act 1969 section 8, but the judges suggested that it would be appropriate for clinicians to involve the court in any case where there were doubts as to whether the proposed treatment would be in the long term best interests of a 16-17 year-old.

3.42. Following the Divisional Court judgment in *Bell v Tavistock*, a claim was brought against the Tavistock in the High Court Family Division by the mother of a child for a declaration that she and the child's father had the ability in law to consent on behalf of their child to the administration of puberty blockers *(AB v CD)*.[47] The Court concluded that "the parents' right to consent to treatment on behalf of the child continues even when the child is *Gillick* competent to make the decision, save where the parents are seeking to override the decision of the child" [para 114] and that there is no "general rule that puberty blockers should be placed in a special category by which parents are unable in law to give consent" [para 128].

---

[44] Bell v Tavistock. [2020] EWHC 3274 (Admin).
[45] Ibid.
[46] Gillick v West Norfolk and Wisbech AHA [1986] AC 112.
[47] AB v CD & Ors [2021] EWHC 741.

3.43. Subsequently, the Tavistock appealed the Divisional Court's earlier decision in *Bell v Tavistock* and was successful.[48] The Court of Appeal held that it was not appropriate for the Divisional Court to provide the guidance about the likelihood of having *Gillick* competence at particular ages, or about the need for court approval [para 91]. The Court of Appeal went on to say "The Divisional Court concluded that Tavistock's policies and practices (as expressed in the service specification and the SOP) were not unlawful and rejected the legal criticism of its materials. In those circumstances, the claim for judicial review is dismissed." [para 91]. However, clinicians should "take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed" [para 92].

3.44. The Court of Appeal in *Bell v Tavistock* recognised the lawfulness of treating children for gender dysphoria in this jurisdiction. Recognising the divergences in medical opinion, morality and ethics, it indicated that the question of whether treatment should be made available is a matter of policy "for the National Health Service, the medical profession and its regulators and Government and Parliament" [para 3].

3.45. Following the Divisional Court decision in *Bell v Tavistock*, new referrals for puberty blockers were suspended and a requirement was put in place that children currently on puberty blockers were reviewed with a view to court proceedings for a judge to determine the best interests for children in whom these medications were considered essential. This requirement was changed following *AB v CD*, with the reinstatement of the hormone pathway in March 2021. However, an external panel, the Multi Professional Review Group (MPRG), was established to ensure that procedures for assessment and for informed consent had been properly followed. The outcome of the *Bell* appeal has not changed this requirement, which is contingent not just on the legal processes but on the concerns raised by CQC regarding consent, documentation and clarity about decision making within the service.[49]

[48] EWCA [2021] Civ 1363.
[49] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

The Multi-Professional Review Group

3.46. NHS England has established a Multi-Professional Review Group (MPRG) to review whether the agreed process has been followed for a child to be referred into the endocrinology clinic and to be prescribed treatment. The Review has spoken directly to the MPRG, which has reported its observations of current practice.

3.47. The MPRG has stated that its work has been impeded by delays in the provision of clinical information, the lack of structure in the documentation received, and gaps in the necessary evidence. This means that when reviewing the documents provided it is not always easy to determine if the process for referral for endocrine treatment has been fully or safely followed for a particular child or young person.

3.48. The MPRG indicates that there does not appear to be a standardised approach to assessment. They are particularly concerned about safeguarding shortfalls within the assessment process. There is also limited evidence of systematic, formal mental health or neurodevelopmental assessments being routinely documented, or of a discipline of formal diagnostic formulation in relation to co-occurring mental health difficulties. This issue was also highlighted by the Care Quality Commission (CQC).[50]

3.49. Additionally, there is concern that communications to GPs and parents regarding prescribed treatment with puberty blockers sometimes come from non-medical staff.

[50] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

4. What the review has heard so far



Listening sessions

4.1. Since its establishment, the Review has met with an extensive range of stakeholders, including professionals, their respective governing organisations and those with lived experience, both directly and through support and advocacy groups, to understand the broad range of views and experiences surrounding the delivery of gender identity services.

What we have heard from service users, their families and support and advocacy groups

Issues for children and young people

4.2. What we understand most clearly from all we have heard is that at the centre of a difficult and complex debate are children, young people and families in great distress. We have heard concerns about children and young people facing the stress of being on a prolonged waiting list with limited support available from statutory services, lack of certainty about when and if they might reach the top of that list and subsequent impacts on mental health. Also, the particular issues that have followed the *Bell v Tavistock* litigation.

4.3. We have heard about the anxiety that birth-registered males face as they come closer to the point where they will grow facial hair and their voice drops, and the fear that it will make it harder for them to pass as a transgender woman in later life. We have also heard about the distress experienced by birth-registered females as they reach puberty, including the use of painful, and potentially harmful, binding processes to conceal their breasts.

4.4. When children and young people are able to access the service, there is often a sense of frustration with what several describe as the "gatekeeping" medical model and a "clinician lottery". This can feel like a series of barriers and hurdles designed to add to, rather than alleviate, distress. Most children and young people seeking help do not see themselves as having a medical condition; yet to achieve their desired intervention they need to engage with clinical services and receive a medical diagnosis of gender dysphoria. By the time they are seen in the GIDS clinic, they may feel very certain of their gender identity and be anxious to start hormone treatment as quickly as possible. However, they can then face a period of what can seem like intrusive, repetitive and unnecessary questioning. Some feel that this undermines their autonomy and right to self-determination.

4.5. We have heard that some young people learn through peers and social media what they should and should not say to therapy staff in order to access hormone treatment; for example, that they are advised not to admit to previous abuse or trauma, or uncertainty about their sexual orientation. We have also heard that many of those seeking NHS support identify as non-binary, gender non-conforming, or gender fluid. We understand that some

young people who identify as non-binary feel their needs are not met by clinical services unless they give a binary narrative about their gender preferences.

Issues for parents

4.6. We have also heard about the distress parents may feel as they try to work out how best to support their children and how tensions and conflict may arise where parents and their children have different views. For example, some parents have highlighted the importance of ensuring that children and young people are able to keep their options fluid until such time as it becomes essential to commit to a hormonal course of action, whilst their children may want more rapid hormone intervention.

4.7. We have heard about families trying to balance the risks of obtaining unregulated and potentially dangerous hormone supplies over the internet or from private providers versus the ongoing trauma of prolonged waits for assessment.

4.8. Parents have also raised concerns about the vulnerability of neurodiverse children and young people and expressed that the communication needs of these children and young people are not adequately reflected during assessment processes or treatment planning.

4.9. GIDS has always required consent/assent from both the child and parents/carers and has sought ways to resolve family conflict, which in the worst-case scenario can lead to family breakdown. It has been highlighted to us that the future service model should provide more targeted support for parents and carers.

Service issues

4.10. Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria. This issue is compounded by the waiting list, which means that there can be a significant period of time without appropriate assessment, treatment or care.

4.11. Stakeholders have spoken of the need for appropriate assessment when first accessing NHS services to aid both the exploration of the child or young person's wellbeing and gender distress and any other challenges they may be facing.

Information

4.12. We have also heard about the lack of access to accurate, balanced information upon which children, young people and their families/carers can inform their decisions.

4.13. We have heard that distress may be exacerbated by pressure to identify with societal stereotyping and concerns over the influence of social media, which can be seen to perpetuate unrealistic images of gender and set unhealthy expectations, especially given how long

children and young people are waiting to access services.

Other issues

4.14. Several issues that were raised with us are not explored further in this interim report, but we have taken note of them. These will be considered further during the lifetime of the Review and include:

- The important role of schools and the challenges they face in responding appropriately to gender-questioning children and young people.
- The complex interaction between sexuality and gender identity, and societal responses to both; for example, we have heard from young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as gay rather than transgender. We have also heard from adults who identified as transgender through childhood, and then reverted to their birth-registered gender in teen years.
- The issues faced by detransitioners highlight the need for better services and pathways for this group, many of whom are living with irreversible effects of transition but for whom there is no clear access to services as they fall outside the responsibility of NHS gender identity services.
- The age at which adult gender identity clinics can receive referrals, with concerns about the inclusion of 17-year-olds. The service offer in adult services is perceived to be quite different from that of GIDS, and young people presenting later may therefore not be afforded the same level of therapeutic input under the adult service model. There is also concern about the impact on the young person of changing clinicians at a crucial point in their care. The movement of young people with special educational needs between children's and adult services raises particular concerns.

What we have heard from healthcare professionals

Lack of professional consensus

4.15. Clinicians and associated professionals we have spoken to have highlighted the lack of an agreed consensus on the different possible implications of gender-related distress – whether it may be an indication that the child or young person is likely to grow up to be a transgender adult and would benefit from physical intervention, or whether it may be a manifestation of other causes of distress. Following directly from this is a spectrum of opinion about the correct clinical approach, ranging broadly between those who take a more gender-affirmative approach to those who take a more cautious, developmentally-informed approach.

4.16. Speaking to current and ex-GIDS staff, we have heard about the pressure on GIDS clinicians, many of whom feel overwhelmed by the numbers of children and young people being referred and who are demoralised by the media coverage of their service. Although the clinical team attempt to manage risk on the waiting list by engaging with local services, there is limited capacity and/or capability to respond appropriately to the needs of this group in primary and secondary care. The Review has already referred to this issue as the most pressing priority in its letter to NHS England (**Appendix 2**), alongside potential risks relating to safeguarding and/or mental health issues, and diagnostic overshadowing.

4.17. With respect to GIDS, we have been told that although there are forums for staff to discuss difficult cases with senior colleagues, it is still difficult for staff to raise concerns about the clinical approach. Also that many individuals who are more cautious and advocate the need for an exploratory approach have left the service.

Consistency and standards

4.18. GIDS staff have confirmed that judgements are very individual, with some clinicians taking a more gender-affirmative approach and others emphasising the need for caution and for careful exploration of broader issues. The Review has been told that there is considerable variation in the approach taken between the London, Leeds and Bristol teams.

4.19. Speaking to professionals outside GIDS, we have heard widespread concern about the lack of guidance and evidence on how to manage this group of young people.

4.20. Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person's problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach. Some clinicians feel that they are not supported by their professional body on this matter. Hence the practice of passing referrals straight through to GIDS is not just a reflection of local service capacity problems, but also of professionals' practical concerns about the appropriate clinical management of this group of children and young people.

4.21. GPs have expressed concern about being pressurised to prescribe puberty blockers or feminising/masculinising hormones after these have been initiated by private providers.

4.22. This also links to professional concerns about parents being anxious for hormone treatment to be initiated when the child or young person does not seem ready.

Other issues

4.23. We have also heard that parents and carers play a huge role and are instrumental in helping young people

to keep open their developmental opportunities. In discussion with social workers, we heard concerns about how looked after children are supported in getting the help and support they need.

4.24. Therapists who work with detransitioners and people with regret have highlighted a lack of services and pathways and a need for services to support this population. There is also the need for more research to understand what factors contribute to the decision to detransition.

4.25. The importance of broad holistic interventions to help reduce distress has been emphasised to the Review, with therapists and other clinicians advocating the importance of careful developmentally informed assessment and of showing children and young people a range of different narratives, experiences and outcomes.

4.26. Clinicians have raised concerns about children and young people's NHS numbers being changed inconsistently, as there is no specific guidance for GPs and others as to when this should be done for this population and under what consent. This has implications for safeguarding and clinical management of these children and young people and it also makes it difficult to do research exploring long-term outcomes.

4.27. As with the comments made by service users, their families and support and advocacy groups, we have heard similar views from professionals about the transition from children's to adult services, and the role of schools.

Structured engagement with primary, secondary and specialist clinicians

4.28. The Review's letter to NHS England (**Appendix 2**) set out some of the immediate issues with the current provision of gender identity services for children and young people and suggested how its work might help with the challenging problem of establishing an infrastructure outside GIDS. This included looking at the capacity, capability and confidence of the wider workforce and how this could be built and sustained, and the establishment of potential assessment frameworks for use in primary and/or secondary care.

Professional panel – primary and secondary care

4.29. In order to understand the challenges and establish a picture of current competency, capacity and confidence among the workforce outside the specialist gender development service, an online professional panel was established to explore issues around gender identity services for children and young people. The role of the panel was aimed at better comprehending how it looks and feels for clinicians and other professionals working with these young people, as well as any broader thoughts about the work, and to start exploring how the care of these

children and young people can be better managed in the future.

4.30. The project was designed to capture a broad mix of professional views and experiences, recruiting from the professional groups that are most likely to have a role in the care pathway – GPs, paediatricians, child psychiatrists, child psychologists and child psychotherapists, nurses and social workers.

4.31. A total of 102 clinicians and other professionals were involved in the panel. The panel represented a balanced professional mix, and participant ages and gender were broadly representative of the overall sector workforce. Participants were self-selecting and were recruited via healthcare professional networks and Royal Colleges.

4.32. Each week the panel was set an independent activity comprised of two or more tasks. Additionally, a sub-set of the panel was invited to participate in focus groups at the midway and endpoint of the project. Activities were designed to capture an understanding of:

- experiences of working with gender-questioning children and young people and panel members' confidence and competence to manage their care;
- changes they may have experienced in the presentation of children and young people with gender-related distress;
- areas where professionals feel they require more information in order to support gender-questioning children and young people;
- where professionals currently go to find that information;
- the role of different professions in the care pathway;
- the role of professionals in the assessment framework; and
- what participants felt should be included in an assessment framework across the whole service pathway.

Gender specialist questionnaire

4.33. Having concluded the professional panel exercise, we wanted to triangulate what we had heard with the thoughts and views of professionals working predominantly or exclusively with gender-questioning children and young people.

4.34. To do this in a systematic way, we conducted an online survey which contained some service-specific questions, but also reflected and sought to test some of what we had heard from primary and secondary care professionals.

Findings

4.35. This structured engagement has yielded valuable insights from clinicians and professionals with experience working with gender-questioning children and young people both within and outside the specialist gender service. It has contributed to the thinking of the Review and informed some of the interim advice set out in this report.

4.36. There are a number of consistent messages arising from these activities:

- The current long waiting lists that gender-questioning children and young people and their families/carers face are unacceptable for all parties involved, including professionals.
- Many professionals in our sample said that not only are gender-questioning children and young people having to wait a long time before receiving treatment, but they also do not receive appropriate support during this waiting period.
- Another impact of the long wait that clinicians reported is that when a child or young person is seen at GIDS, they may have a more fixed view of what they need and are looking for action to be taken quickly. This reportedly can lead to frustration with the assessment process.
- When considering the more holistic support that children and young people may need, gender specialists further highlighted the difficulties that children and young people face accessing local support, for example, from CAMHS, whilst being seen at GIDS.
- It is clear from the professionals who took part in these activities that there is a strong professional commitment to provide quality care to gender-questioning children and young people and their families/carers. However, this research indicates that levels of confidence and competence do vary among primary and secondary care professionals in our sample.
- Concerns were expressed by professionals who took part in this research about the lack of consensus among the clinical community on the right clinical approach to take when working with a gender-questioning child or young person and their families/carers.
- In order to support clinicians and professionals more widely, participants felt there is a need for a robust evidence base, consistent legal framework and clinical guidelines, a stronger assessment process and different pathway options that holistically meet the needs of each gender-questioning child or young person and their families/carers.

4.37. There are also several areas where further discussion and consensus is needed:

- There is not a consistent view among the professionals participating in the panel and questionnaire about the nature of gender dysphoria and therefore the role of assessment for children and young people experiencing gender dysphoria.

- Some clinicians felt that assessment should be focused on whether medical interventions are an appropriate course of action for the individual. Other clinicians believe that assessment should seek to make a differential diagnosis, ruling out other potential causes of the child or young person's distress.
- There are different perspectives on the roles of primary, secondary and specialist services in the care pathway(s) and what support or action might best be provided at different levels.
- While there was general consensus that diagnostic or psychological formulation needs to form part of the assessment process, there were differing views as to whether a mental state assessment is needed, and should it be, where in the pathway and by whom this should be done.

4.38. It is important to note that the information gathered represents the views and insights of the panel participants and survey respondents at a moment in time and findings should be read in the context of a developing narrative on the subject, where perspectives may evolve. This relates to both the experiences of professionals, but also the extent to which this subject matter is discussed in the public sphere.

4.39. The Review is grateful to all the participants for their time and high level of engagement. The Review will build on the work we have undertaken and, alongside our academic research, will continue with a programme of engagement with professionals, service users and their families, which will help to further develop the evidence base.

The full reports from the professional panel and gender specialist questionnaire are on the Review's website (https://cass.independent-review.uk/).

5. Principles of evidence based service development



Evidence based service development

5.1. This chapter integrates the information regarding the development of the current service (see Chapter 3) with the views we have heard to date (see Chapter 4) and sets this in the context of how evidence is routinely used to develop and improve services in the NHS.

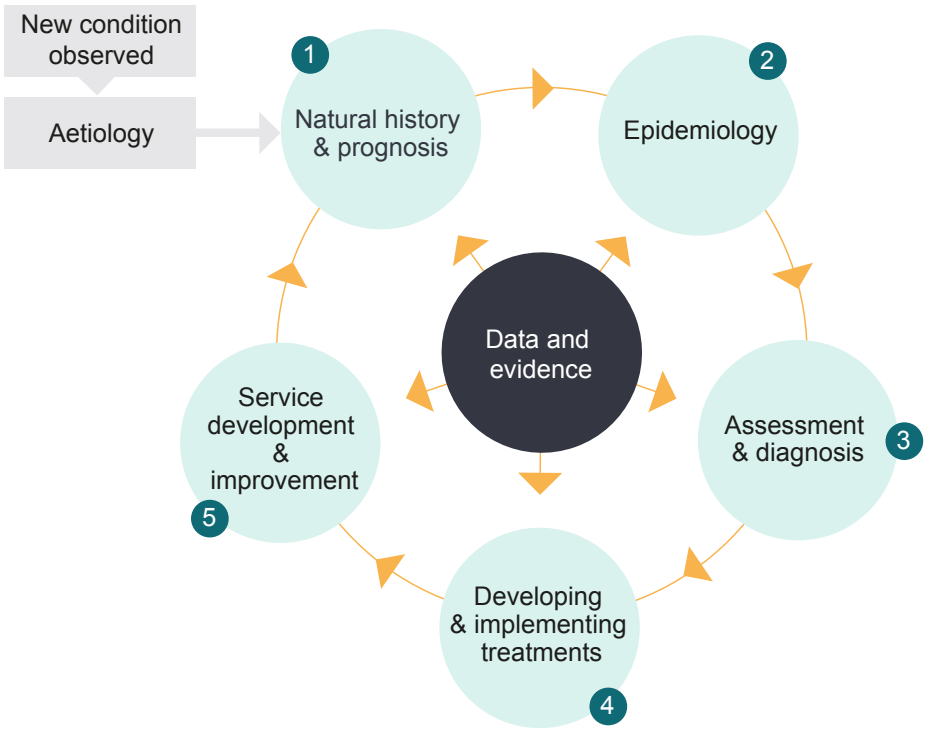
5.2. Some earlier information is necessarily repeated here, but this is with the intention of providing a more accessible explanation of the standards and processes which govern clinical service development. This is essential to an understanding of the rationale for the Review's recommendations.

5.3. Because the specialist service has evolved rapidly and organically in response to demand, the clinical approach and overall service design has not been subjected to some of the normal quality controls that are typically applied when new or innovative treatments are introduced. This Review now affords everyone concerned the opportunity to step back and consider from first principles what this cohort of children and young people now need from NHS services, based on the evidence that exists, or additional evidence that the Review hopes to collect.

5.4. In **Appendix 4** we have described the service development process for three different conditions which may help to illustrate what would be expected to happen at each different stage of developing a clinical service. The steps may proceed in a different sequence for different conditions, but each step is important in the development of evidence based care.

5.5. We recognise that for some of those reading this report it may feel wrong to compare gender incongruence or dysphoria to clinical conditions, and indeed this approach would not be justified if individuals presenting with these conditions did not require clinician intervention. However, where a clinical intervention is given, the same ethical, professional and scientific standards have to be applied as to any other clinical condition.

Key stages of service development



New condition observed: This often begins with a few case reports and then clinicians begin to recognise a recurring pattern and key clinical features, and to develop fuller descriptions of the condition.

Aetiology: Clinicians and scientists try to work out the cause of the condition or the underlying physical or biological basis. Sometimes the answers to this are never found.

Natural history and prognosis: It is important to understand how a condition usually evolves over time, with or without treatment. The latter is important if treatment has limited efficacy and the condition is 'self-limiting' (that is, it resolves without treatment), because otherwise there is a risk that treatments create more difficulties than the condition itself.

5.6. The first UK service for gender-questioning children and young people was established in 1989. At that time there were very few children and young people being seen by medical services internationally. The most common presentation in the early years of the service was of birth-registered

boys who had demonstrated gender incongruence from an early age.[51,52,53]

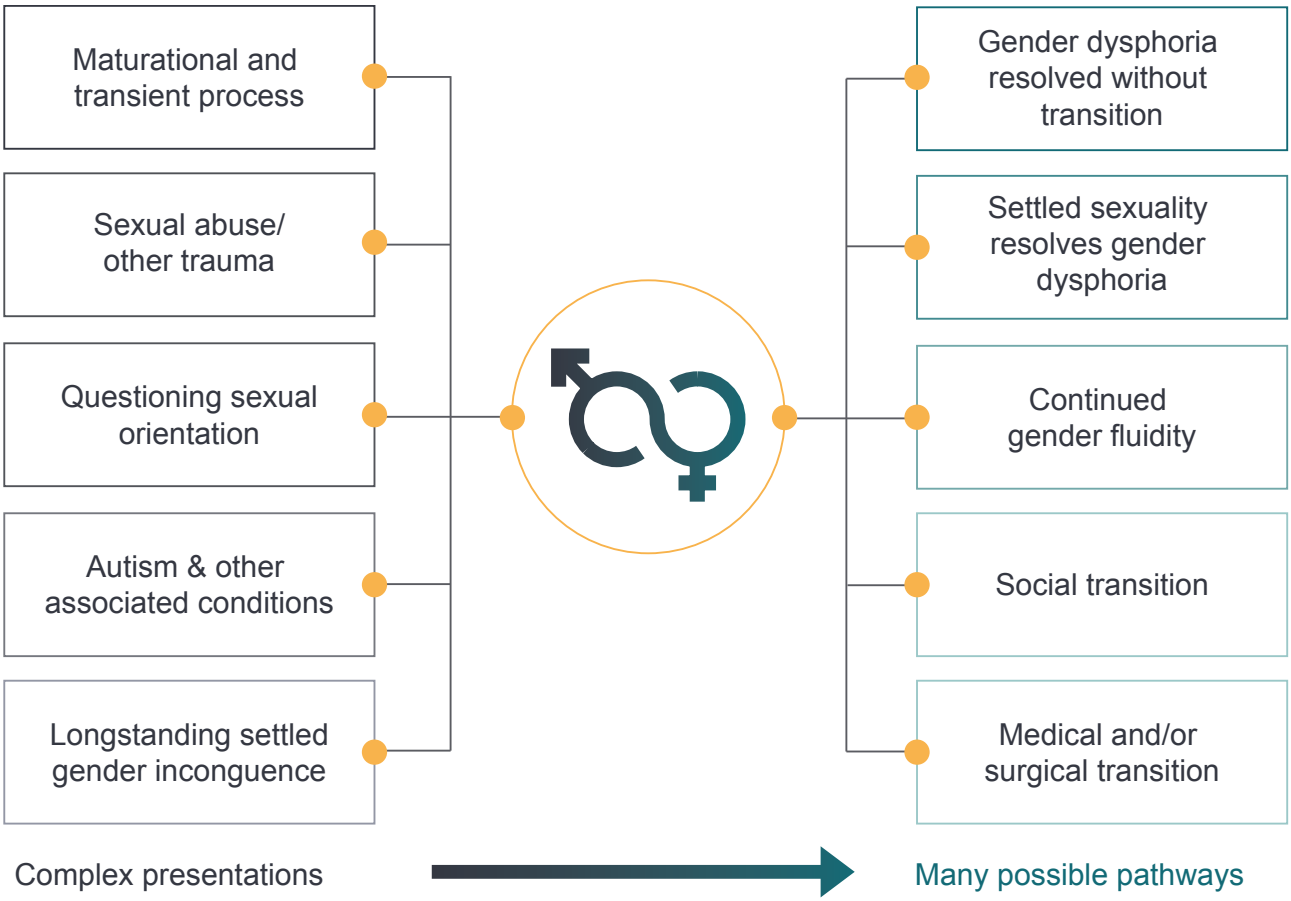
5.7. There is extensive literature discussing the possible aetiology of gender incongruence. Based on the available evidence, many authors would suggest that it is likely that biological, cultural, social and psychological factors all contribute. The examples in **Appendix 4** show that this is not an uncommon situation; many conditions do not have a single clear causation – they are in other words 'multifactorial'.

5.8. Regardless of aetiology, the more contentious and important question is how fixed or fluid gender incongruence is at different ages and stages of development, and whether, regardless of aetiology, can be an inherent characteristic of the individual concerned. There is a spectrum of academic, clinical and societal opinion on this. At one end are those who believe that gender identity can fluctuate over time and be highly mutable and that, because gender incongruence or gender-related distress may be a response to many psychosocial factors, identity may sometimes change or the distress may resolve in later adolescence or early adulthood, even in those whose early incongruence or distress was quite marked. At the other end are those who believe that gender incongruence or dysphoria in childhood or adolescence is generally a clear indicator of that child or young person being transgender and question the methodology of some of the desistance studies. Previous literature has indicated that if gender incongruence continues into puberty, desistance is unlikely.[54,55] However, it should be noted that these older studies were not based on the current changed case-mix or the different socio-cultural climate of recent years, which may have led to different outcomes. Having an open discussion about these questions is essential if a shared understanding of how to provide appropriate assessment and treatment is to be reached.

---

[51] Zucker KJ (2017). Epidemiology of gender dysphoria and transgender identity. Sex Health 14(5): 404–11. DOI:10.1071/SH1.
[52] Zucker KJ, Lawrence AA (2009). Epidemiology of gender identity disorder: recommendations for the Standards of Care of the World Professional Association for Transgender Health. Int J Transgend 11(1): 8-18. DOI: 10.1080/15532730902799946.
[53] de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009-2016). Arch Sex Behav 47(5): 1301–4.
[54] Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clin Child Psychol Psychiatry 16(4): 485-97. DOI: 10.1177/135910451037803.
[55] Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. J Am Acad Child Adolesc Psychiatry 52: 582-590. DOI: 10.1016/j.jaac.2013.03.016.

Complex presentations and complex pathways – exemplars, not comprehensive lists



Epidemiology: Epidemiologists collect data to find out how common a condition is, who is most likely to be affected, what the age distribution is and so on. This allows health service planners to work out how many services are needed, where they should be established, and what staff are needed.

They also report on changes in who is most affected, which may mean that either the disease is changing, or the susceptibility of the population is changing.

5.9. As previously indicated, the epidemiology of gender dysphoria is changing, with an increase in the numbers of birth-registered females presenting in early teens.[56,57] In addition, the majority of children and young people presenting to GIDS have other complex mental health issues and/or neurodiversity.[58] There is also an over-representation of looked after children.[59]

5.10. There are several implications arising from the change in epidemiology:

- Firstly, the speed of change in the numbers presenting means that services have not kept pace with demand.
- Secondly, the cohort that the original Dutch Approach was based on is different from the current more complex NHS cohort, and also from the current case-mix internationally, and therefore it is difficult to extrapolate from older literature to this current group.
- Thirdly, different subgroups may have quite different needs and outcomes, and these must be built into any service design, so that it works for all children and young people.

5.11. At present we have the least information for the largest group of patients – birth-registered females first presenting in early teen years. Since the rapid increase in this group began around 2015, they will not reach late 20s for another 5+ years, which would be the best time to assess longer-term wellbeing.

[56] Steensma TD, Cohen-Kettenis PT, Zucker KJ (2018). Evidence for a change in the sex ratio of children referred for gender dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam (1988-2016). Journal of Sex & Marital Therapy 44(7): 713–5. DOI: 10.1080/0092623X.2018.1437580.
[57] de Graaf NM, Carmichael P, Steensma TD, Zucker KJ (2018). Evidence for a change in the sex ratio of children referred for Gender Dysphoria: Data from the Gender Identity Development Service in London (2000–2017). J Sex Med 15(10): 1381–3. DOI: 10.1016/j.jsxm.2018.08.002.
[58] Van Der Miesen AIR, Hurley H, De Vries ALC (2016). Gender dysphoria and autism spectrum disorder: A narrative review. Int Rev Psychiatry 28: 70-80. DOI: 10.3109/09540261.2015.1111199.
[59] Matthews T, Holt V, Sahin S, Taylor A, Griksaitis (2019). Gender Dysphoria in looked-after and adopted young people in a gender identity development service. Clinical Child Psychol Psychiatry 24: 112-128. DOI: 10.1177/1359104518791657.

Assessment and diagnosis: Clinicians will usually take a history from (that is, of their symptoms) and examine the patient (that is, for signs and symptoms), and where appropriate undertake a series of investigations or tests, to help them reach an accurate diagnosis.

Sometimes the whole process of making a diagnosis through talking to the patient and asking them to complete formal questionnaires, examining them and/or undertaking investigations is called 'clinical assessment'.

As well as diagnosing and ruling out a particular condition, clinicians often need to consider and exclude other, sometimes more serious, conditions that present in a similar way but may need quite different treatment – this process is called 'differential diagnosis'.

5.12. For children and young people with gender-related distress, many people would dispute the notion that 'making a diagnosis' is a meaningful concept, arguing that gender identity is a personal, internal perception of oneself. However, there are several reasons to why a diagnostic framework is used:

- Firstly, the clinician will seek to determine whether the child or young person has a stable transgender identity, or whether there might be other causes for the gender-related distress.
- Secondly, the clinician will determine whether there are other issues or diagnoses that might be having an impact on the young person's mental health. The Dutch Approach suggesting that these should be addressed prior to or alongside initiation of any medical treatments.
- Thirdly, in any situation where life-altering treatments are being administered, the clinician holds the responsibility for ensuring that they are being administered based on an appropriate decision making process. Therefore, it is usual practice for a diagnosis of gender dysphoria to be made prior to referring for any physical treatments.

5.13. When the word 'diagnosis' is used, people often associate this with the use of blood tests, X-rays, or other laboratory tests. As set out in the **Appendix 4**, the public is very familiar with diagnosis of Covid-19 and understands that there need to be tests that give a high degree of certainty about whether an individual is Covid-19 positive or not. False positive lateral flow tests are rare, but caused problems for schools, while PCR has been treated as the 'gold standard' test for accuracy.

5.14. When it comes to gender dysphoria, there are no blood tests or other laboratory tests, so assessment and diagnosis in children and young people with gender-related distress is reliant on the judgements of experienced clinicians. Because medical, and subsequently possibly surgical treatments will follow, it may be argued that a highly sensitive and specific assessment process is required. The assessment should be able to accurately identify those children or young people for whom physical intervention is going to be the best course of action, but it is equally important that it identifies those who need an alternative pathway or treatment.

5.15. The formal criteria for diagnosing gender dysphoria (DSM-5) are listed in **Appendix 3**. However, there are two problems associated with the use of these criteria:

- Firstly, several of the criteria are based on gender stereotyping which may not be deemed relevant in current society, although the core criteria remain valid.
- Secondly, and more importantly, these criteria give a basis on which to make a diagnosis that a young person is clinically distressed by the incongruence between their birth-registered and their experienced gender, but they do not help in determining which factors may have led to this distress and how they might best be resolved.

5.16. At present, the assessment process varies considerably, dependent on the perceptions, experience and beliefs of different clinicians. There are some existing measurement tools, but it is suggested that these have substantial limitations.[60]

5.17. The challenges are similar to the early difficulties in diagnosing autism, as set out in **Appendix 4**. As with autism, the framework for assessment needs to become formalised so there are clearer criteria for diagnosis and treatment pathways which are shared more widely. These should incorporate not just whether the child or young person meets DSM-5 criteria for gender dysphoria, but how a broader psychosocial assessment should be conducted and evaluated, and what other factors need to be considered to gain a holistic understanding of the child or young person's experience. Professional judgement and experience will still be important, but if the frameworks and criteria for assessment and diagnosis were more consistent and reproducible, there would be a greater likelihood that two different people seeing the same child or young person would come to the same conclusion. This would also mean that any research on interventions or long-term outcomes would be more reliable because the criteria on which a diagnosis was made, and hence the patients within the sample, would have the same characteristics.

[60] Bloom TM, Nguyen TP, Lami F, Pace CC, Poulakis Z, Telfer N (2021). Measurement tools for gender identity, gender expression, and gender dysphoria in transgender and gender-diverse children and adolescents: a systematic review. Lancet Child Adolescent Health. 5: 582-588. DOI: 10.1016/s2352-4642(21)00098-5.

5.18. As outlined above, it is standard clinical practice to undertake a process called differential diagnosis. This involves summarising the main points of the clinical assessment, the most likely diagnosis, other possible diagnoses and the reasons for including or excluding them, as well as any further assessments that may be required to clarify the diagnosis and the treatment options and plan. This is important when a medical intervention is being provided on the basis of the assessment, so the process is robust, explicit and reproducible. These considerations need to be applied to the assessment of children and young people presenting with gender-related distress. In mental health services, practitioners may also undertake a diagnostic or psychological formulation, which is a holistic summary of how the patient is feeling and why, and how to make sense of it, and a plan for moving forward with management or treatment.

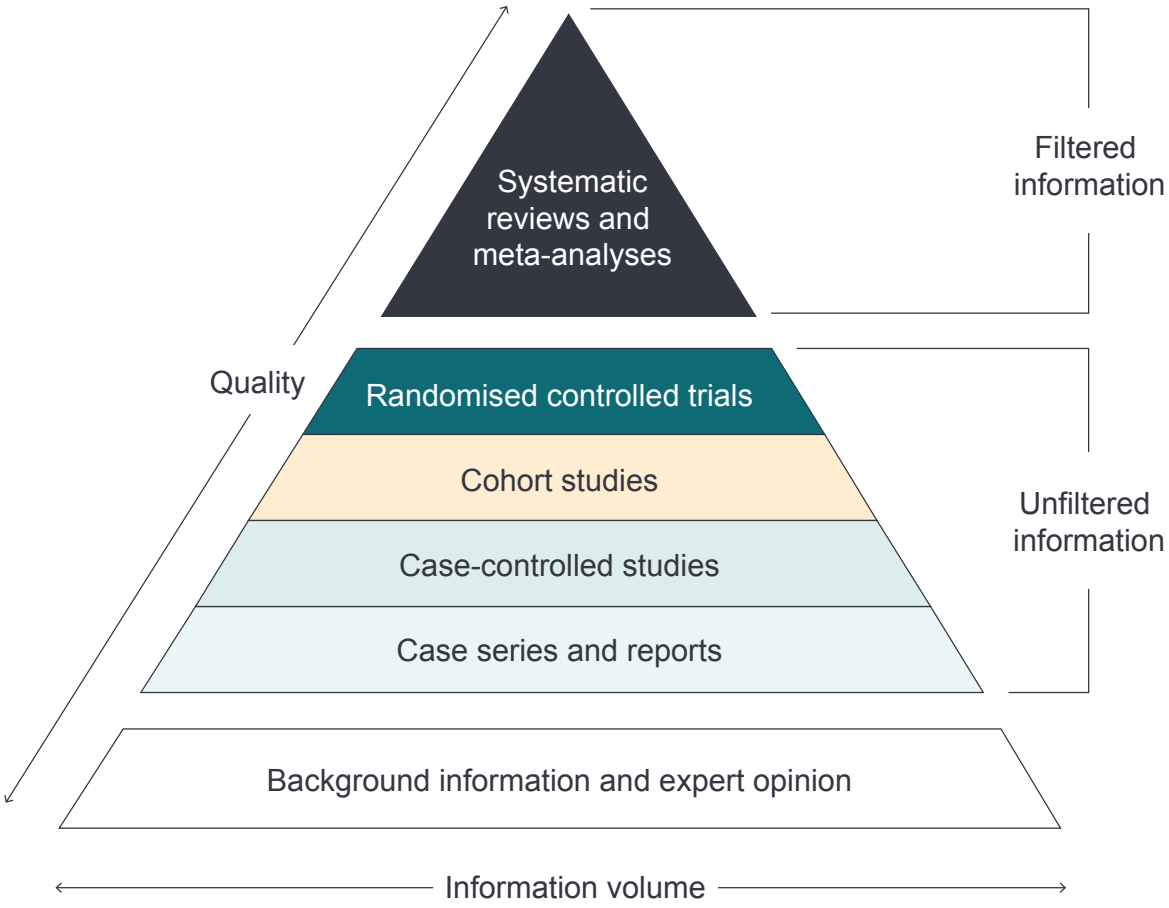
Developing and implementing new treatments: Clinicians and scientists work on developing treatments. This involves clinical trials and, where there are new treatments, comparing them to any existing treatments. Questions include: What are the intended outcomes or benefits of treatment? What are the complications or side effects? What are the costs? To initiate a new treatment, it must be both safe and effective. Questions of affordability can sometimes become controversial.

The best type of single study is considered to be the randomised controlled trial (RCT), but sometimes this is not feasible. Even where RCTs are not available, it is usual to at least have data on the outcomes of sufficient cases or cohorts to understand the risk/benefit of the treatment under consideration. As demonstrated in Fig. 4, the highest level of evidence is when the results of several different studies are pooled, but this is only useful if the individual studies themselves are of high quality.

In many instances, evidence is not perfect and difficult decisions have to be made. Where treatments are innovative or life-changing, the whole multi-disciplinary team will usually meet to consider the available options, and how to advise the child or young person and family so that a shared decision can be made. Sometimes an ethics committee is involved. This is one of the most challenging areas of medicine and is underpinned by GMC guidance.[61,62]

[61] General Medical Council (2020). Decision making and consent.
[62] National Institute for Health and Care Excellence (2021). Shared decision making.

Figure 3: Pyramid of standards of evidence



Source: Levels of evidence pyramid, OpenMD. Reproduced with permission[63]

5.19. There are three types of intervention or treatment for children and young people with gender-related distress, which may be introduced individually or in combination with one another:

- **Social transition** – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning.[64,65] There are different views on the benefits versus the harms of early social transition. Whatever position one

[63] OpenMD (2021). New Evidence in Medical Research.
[64] Sievert EDC, Schweizer K, Barkmann C, Fahrenkrug S, Becker-Hebly I (2020). Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria.Clin Child Psychol Psychiatry 26(1): 79–95. DOI: 10.1177/1359104520964530
[65] Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Colton K-M (2018). Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens. Int J Transgend 19(2): 251–68. DOI: 10.1080/15532739.2017.1414649.

takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes.

- **Counselling, social or psychological interventions** – these may be offered before, instead of, or alongside physical interventions. Again, they should be viewed as active interventions which require robust evaluation in their own right.
- **Physical treatments** – these comprise puberty blockers and feminising/masculinising hormones (administered by endocrinologists) and surgery. The latter is not considered as part of this Review since it is not available to those under age 18.

5.20. It should also be recognised that 'doing nothing' cannot be considered a neutral act.

5.21. The lack of available high-level evidence was reflected in the recent NICE review into the use of puberty blockers and feminising/masculinising hormones commissioned by NHS England, with the evidence being too inconclusive to form the basis of a policy position.[66,67] Assessing treatments for gender dysphoria has many of the same problems as assessing treatment for children with autism – it can take many years to get a full appreciation of outcomes and there may be other complicating factors in the child or young person's life during this period. However, this of itself is not an adequate reason for the major gaps in the international literature.

5.22. It is still common that drugs are not specifically licensed for children because the trials have only taken place on adults. This does not preclude their use or make their use inherently unsafe, particularly if they are used very commonly in children. However, where their use is innovative, patients receiving the drug should ideally do so under trial conditions.

5.23. The same considerations apply to 'off-label' drugs, where the drug is used for a condition different to the one for which it was licensed. This is the case for puberty blockers, which are licensed for use in precocious puberty, but not for puberty suppression in gender dysphoria. Again, it is important that it is not assumed that outcomes for, and side effects in, children treated for precocious puberty will necessarily be the same in children or young people with gender dysphoria.

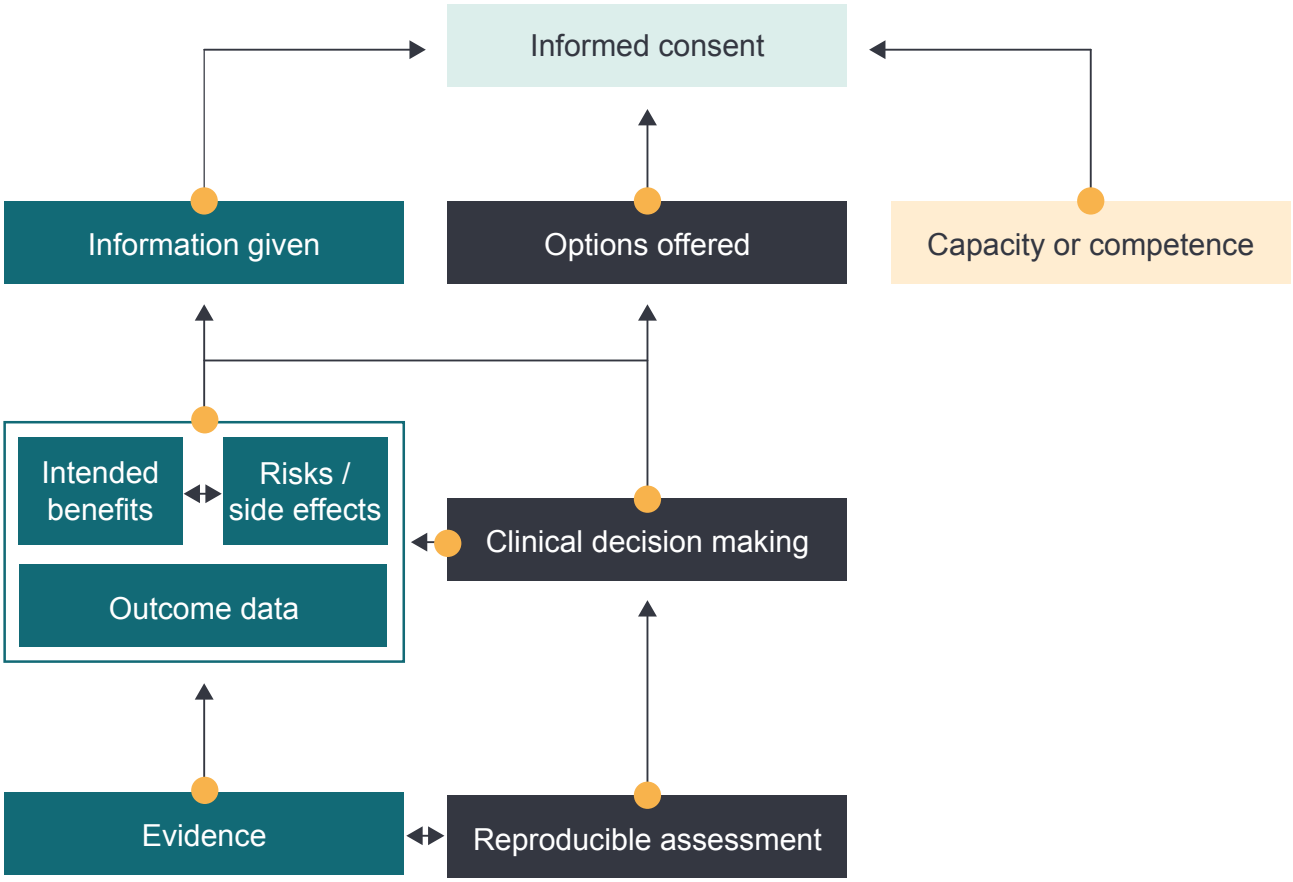
5.24. As outlined above, in other areas of practice where complex or potentially life-altering treatment is being considered for a child or young person, it is usual for the case to be discussed by an MDT including all professionals involved in their care. In gender services for children and young people in the Netherlands, as well as a number of other countries, there are full

[66] National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria
[67] National Institute for Health and Care Excellence (2020). Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria.

MDT meetings, including psychiatrists and endocrinologists, to make decisions about suitability for hormone intervention and to review progress.[68,69]

5.25. Recent legal proceedings have examined the question of the competence and capacity of children and young people to consent to hormone treatment. However, there are some essential components that underpin informed consent; the robustness of the options offered to the patient, the information provided to them about those options, and their competence and capacity to consider them. The courts have given consideration to competence and capacity, and it is incumbent on this Review to consider the soundness of the decision making which underpins the options offered, and the quality and accuracy of the information provided about those options.

Elements of informed consent



[68] Kyriakou A, Nicolaides NC, Skordis N (2020). Current approach to the clinical care of adolescents with gender dysphoria. Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.
[69] Cohen-Kettenis PT, Steensma TD, de Vries ALC. Treatment of adolescents with gender dysphoria in the Netherlands. Child Adolesc Psychiatr Clin N Am 20. 689–700. 2001. DOI: 10.1016/j.chc.2011.08.001.

Service development and service improvement: Central to any service improvement is the systematic and consistent collection of data on outcomes of treatment. There is a process of continuous service improvement as new presentations or variations on the original condition are recognised, diagnosis or screening improves and/or trials on new treatments or variations on existing treatments are ongoing.

There should be consistent treatment protocols or guidelines in place, in order to make sense of variations in outcomes. Where possible, these should be compared between and across multiple different centres.

As time passes, services need to be changed or extended based on patient need, and on what resources are needed to deliver the available treatments. They need to be accessible where the prevalence of the condition is highest. The relevant workforce to deliver the service needs to be recruited and trained, contingent on the type of treatments or therapy that is required.

5.26. When a pioneering treatment or specialist service starts, it is often delivered in a single centre. Thereafter, additional centres take on the work as increasing numbers of patients need to access the treatment. Current provision of NHS specialist gender identity services for children and young people has remained concentrated within a single organisation, but demand has grown dramatically.

5.27. The situation has been exacerbated because there are not many local services seeing gender-questioning children at an earlier stage in their journey, which means that GIDS is carrying an unsustainable workload of increasingly complex young people.

5.28. As a condition evolves, rigorous data collection and quantitative research is an essential prerequisite to refining understanding and treatment. Historically, The Tavistock and Portman NHS Foundation Trust built its international reputation as the home of psychoanalysis, psychotherapy and family therapy, with a strong track record of publishing qualitative rather than quantitative research; consequently its approach to quantitative data collection about this important group of children and young people has been weak.

5.29. A further anomaly is a public perception that The Tavistock and Portman NHS Foundation Trust is the responsible organisation for leading the management of children receiving hormone treatment for their gender dysphoria. In reality, the hormone treatment is delivered by paediatric services in University College London Hospitals NHS Foundation Trust and The Leeds Teaching Hospitals NHS Trust.

5.30. In practice, it is important that for children and young people who need physical intervention, paediatric and mental health services are seen as equal partners, with seamless joint working and shared responsibility. When there were very small numbers of patients, it was easier for this to be achieved, but cross-site working with a very large caseload has made this more difficult to achieve, despite the best intentions of the staff.

5.31. Over the last two years there have been strong efforts on the part of The Tavistock and Portman NHS Foundation Trust to make practice within GIDS more consistent, with tighter procedures for case management, consent, and safeguarding. However, although this has resulted in better documentation, variations and inconsistencies in clinical decision making remain. In responding to a changing legal framework, some processes have become more cumbersome and complex, and the team are working hard to streamline the process.

5.32. Overall, GIDS faces a daunting task as a single provider in managing risk on the waiting list, seeing new referrals, reviewing and supporting those on hormone treatment, undertaking an ongoing transformation programme, recruiting and training new staff and trying to retain existing staff. This suggests that the current model is not sustainable and that another model is needed.

6. Interim advice, research programme and next steps



Dealing with uncertainty

6.1. As outlined throughout this report, there are major gaps in the research base underpinning the clinical management of children and young people with gender incongruence and gender dysphoria, including the appropriate approaches to assessment and treatment.

6.2. As with any other area of medicine, where there are gaps in the evidence base and uncertainties about the correct clinical approach, three tasks must be undertaken:

- Clinical services must be run as safely and effectively as possible, within the constraints of current knowledge; treatment options must be weighed carefully; and treatment decisions must be made in partnership between the clinicians and the children, young people and their families and carers, based on our current understanding about outcomes.
- Consistent data must be collected by clinical services, for both audit and research purposes so that knowledge gaps can be filled, alongside an active research programme.
- Where there is not an immediate prospect of filling research gaps, professional consensus should be developed on the correct way to proceed pending clearer research evidence, supported by input from service users.

6.3. The additional problem with the current service model is that safety and access are further compromised by the pace at which referrals have grown and outstripped capacity at tertiary level, and the lack of service availability at local level.

6.4. The Review's approach to these tasks is as follows:

- Our **interim advice** focuses on the issues of capacity, safety, and standards around treatment decisions, as well as data and audit.
- Our **research streams** will provide the Review with an independent collation of published evidence relevant to epidemiology, clinical management, models of care, and outcomes, as well as delivering qualitative and quantitative research relevant to the Terms of Reference of the Review. This offers a real opportunity to contribute to the international evidence base for this service area.
- There will be an ongoing and wide-ranging **programme of engagement** to address areas on which we will not be able to obtain definitive evidence during the lifetime of the Review.

Interim advice

6.5. The Review considers that there are some areas where there is sufficient clarity about the way forward and we are therefore offering some specific observations and interim advice. The Review will work with NHS England, providers and the broader stakeholder community to progress action in these areas.

Service model

6.6. It has become increasingly clear that a single specialist provider model is not a safe or viable long-term option in view of concerns about lack of peer review and the ability to respond to the increasing demand.

6.7. Additionally, children and young people with gender-related distress have been inadvertently disadvantaged because local services have not felt adequately equipped to see them. It is essential that they can access the same level of psychological and social support as any other child or young person in distress, from their first encounter with the NHS and at every level within the service.

6.8. A fundamentally different service model is needed which is more in line with other paediatric provision, to provide timely and appropriate care for children and young people needing support around their gender identity. This must include support for any other clinical presentations that they may have.

6.9. The Review supports NHS England's plan to establish regional services, and welcomes the move from a single highly specialist service to regional hubs.

6.10. Expanding the number of providers will have the advantages of:

- creating networks within each area to improve early access and support;
- reducing waiting times for specialist care;
- building capacity and training opportunities within the workforce;
- developing a specialist network to ensure peer review and shared standards of care; and
- providing opportunities to establish a more formalised service improvement strategy.

Service provision

6.11. The primary remit of NHS England's proposed model is for the regional hubs to provide support and advice to referrers and professionals. However, it includes limited provision for direct contact with children and young people and their families.

1: The Review advises that the regional centres should be developed, as soon as feasibly possible, to become direct service providers, assessing and treating children and young people who may need specialist care, as part of a wider pathway. The Review team will work with NHS England and stakeholders to further define the proposed model and workforce implications.

2: Each regional centre will need to develop links and work collaboratively with a range of local services within their geography to ensure that appropriate clinical, psychological and social support is made available to children and young people who are in early stages of experiencing gender distress.

3: Clear criteria will be needed for referral to services along the pathway from primary to tertiary care so that gender-questioning children and young people who seek help from the NHS have equitable access to services.

4: Regional training programmes should be run for clinical practitioners at all levels, alongside the online training modules developed by Health Education England (HEE). In the longer-term, clearer mapping of the required workforce, and a series of competency frameworks will need to be developed in collaboration with relevant professional organisations.

Data, audit and research

6.12. A lack of routine and consistent data collection means that it is not possible to accurately track the outcomes and pathways children and young people take through the service. Standardised data collection is required in order to audit service standards and inform understanding of the epidemiology, assessment and treatment of this group. This, alongside a national network which brings providers together, will help build knowledge and improve outcomes through shared clinical standards and systematic data collection. In the longer-term, formalisation of such a network into a learning health system[70] with an academic host would mean that there was systematised use of data to produce a continuing research programme with rapid translation into clinical practice and a focus on training.

5: The regional services should have regular co-ordinated national provider meetings and operate to shared standards and operating procedures with a view to establishing a formal learning health system.

6: Existing and future services should have standardised data collection in order to audit standards and inform understanding of the epidemiology, assessment and treatment of this group of children and young people.

[70] Scobie S, Castle-Clarke S (2019). Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics. Learning Health Systems 4(1): e10209. DOI:10.1002/lrh2.10209.

7: Prospective consent of children and young people should be sought for their data to be used for continuous service development, to track outcomes, and for research purposes. Within this model, children and young people put on hormone treatment should be formally followed up into adult services, ideally as part of an agreed research protocol, to improve outcome data.

Clinical approach

Assessment processes

6.13. We have heard that there are inconsistencies and gaps in the assessment process. Our work to date has also demonstrated that clinical staff have different views about the purpose of assessment and where responsibility lies for different components of the process within the pathway of care. The Review team has commenced discussions with clinical staff across primary, secondary and tertiary care to develop a framework for these processes.

8: There needs to be agreement and guidance about the appropriate clinical assessment processes that should take place at primary, secondary and tertiary level.

9: Assessments should be respectful of the experience of the child or young person and be developmentally informed. Clinicians should remain open and explore the patient's experience and the range of support and treatment options that may best address their needs, including any specific needs of neurodiverse children and young people.

Hormone treatment

6.14. The issues raised by the Multi-Professional Review Group echo several of the problems highlighted by the CQC. It is essential that principles of the General Medical Council's Good Practice in Prescribing and Managing Medicine's and Devices[71] are closely followed, particularly given the gaps in the evidence base regarding hormone treatment. Standards for decision making regarding endocrine treatment should also be consistent with international best practice.[72,73,74]

---

[71] General Medical Council (2021). Good practice in prescribing and managing medicines and devices (76-78).
[72] Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, et al (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab 102(11): 3869–903. DOI: 10.1210/jc.2017-01658.
[73] Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). Treatment of adolescents with gender dysphoria in the Netherlands. Child Adolesc Psychiatr Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.
[74] Kyriakou A, Nicolaides NC, Skordis N (2020). Current approach to the clinical care of adolescents with gender dysphoria. Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.

10: Any child or young person being considered for hormone treatment should have a formal diagnosis and formulation, which addresses the full range of factors affecting their physical, mental, developmental and psychosocial wellbeing. This formulation should then inform what options for support and intervention might be helpful for that child or young person.

11: Currently paediatric endocrinologists have sole responsibility for treatment, but where a life-changing intervention is given there should also be additional medical responsibility for the differential diagnosis leading up to the treatment decision.

6.15. Paediatric endocrinologists develop a wide range of knowledge within their paediatric training, including safeguarding, child mental health, and adolescent development. Being party to the discussions and deliberations that have led up to the decision for medical intervention supports them in carrying out their legal responsibility for consent to treatment and the prescription of hormones.

12: 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.

6.16. Given the uncertainties regarding puberty blockers, it is particularly important to demonstrate that consent under this circumstance has been fully informed and to follow GMC guidance[75] by keeping an accurate record of the exchange of information leading to a decision in order to inform their future care and to help explain and justify the clinician's decisions and actions.

13: Within clinical notes, the stated purpose of puberty blockers as explained to the child or young person and parent should be made clear. There should be clear documentation of what information has been provided to each child or young person on likely outcomes and side effects of all hormone treatment, as well as uncertainties about longer-term outcomes.

[75] General Medical Council (2020). Decision making and consent.

14: In the immediate term the Multi-Professional Review Group (MPRG) established by NHS England should continue to review cases being referred by GIDS to endocrine services.

Research programme

6.17. The Review's formal academic research programme, comprising a literature review, quantitative analysis and primary qualitative research, has been based on the identified gaps in the evidence and the feasibility of filling them within the lifetime of the Review.

6.18. Initial work has identified the existing evidence base on epidemiology, natural history, and the treatment and outcomes of children and young people with gender dysphoria/gender-related distress. It has also assessed the feasibility of linking data between local, regional or national datasets in order to assess intermediate and longer-term outcomes.

Literature review

6.19. A literature review is being undertaken, which will interface with evidence gathering from the professional community (see qualitative research section below). Its aim is to systematically identify, collate and synthesise the existing evidence on the changing epidemiology of gender-related distress in children and young people and the appropriate social, clinical, psychological and medical management of that distress.

6.20. The literature review will capture primary studies of any design, including experimental, observational, survey and qualitative, and is looking to answer the following questions:

1. How has the population of children and young people presenting with gender dysphoria and/or gender-related distress changed over time?
2. What are the appropriate referral, assessment and treatment pathways for children and young people with gender dysphoria and/or gender-related distress?
3. What are the short-, medium- and long-term outcomes for children and young people with gender dysphoria and/or gender-related distress?
4. How do children and young people and their families negotiate distress, present this distress to services, and what are their expectations, following presentation?
5. How do children, young people and their families/carers experience referral, assessment and treatment? And how are these negotiated among children and young people, parents/carers, families and healthcare professionals?

6.21. A separate synthesis for each question will be undertaken. The systematic review has been registered on PROSPERO [ID:289659].

Quantitative research

6.22. The National Institute for Health and Care Excellence (NICE) recently published two evidence reviews.[76,77] These highlight shortcomings in the follow-up data collected about children and young people, when they are referred to a specialist gender identity service. The quantitative research will therefore focus on the collection and analysis of data to uncover patterns and quantify problems, thereby helping the Review to address some of these shortcomings.

6.23. The aim of the quantitative study is to supplement the material collected by the literature review, further examining the changing epidemiology of gender-related distress in children and young people, in addition to exploring the appropriate social, clinical, psychological and medical management. Its objectives are to:

a) describe the clinical and demographic characteristics of this population of children and young people and their clinical management in the GIDS service; and

b) assess the intermediate and longer-term outcomes of this population of children and young people utilising national healthcare data.

6.24. This research will provide an evidence base to facilitate informed decision making among children and young people and their families. It will also provide an evidence base for those responsible for commissioning, delivering and managing services.

Qualitative research

6.25. The qualitative research will capture a diverse range of trajectories experienced by gender-questioning children and young people, exploring a range of different experiences and outcomes. This will include talking to children and young people and their families/carers who are currently negotiating gender-related distress, young adults who have gone through the process of resolving their distress and care professionals.

[76] National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria.
[77] National Institute for Health and Care Excellence (2020). Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria.

The objectives of the qualitative research are to:

1. Explore how children and young people understand, respond and negotiate gender-related distress within the context of their social networks, alongside the perspectives of young adults who experienced gender distress as children.
2. Examine the perspectives, understandings and responses of parents (or carers), including how they support their child.
3. Investigate how children, young people, young adults and their families experience(d) and negotiate(d) referral, assessment and possible treatment and intervention options.
4. Understand the role and experiences of care professionals who offer support, including identifying shared and potentially divergent views among care professionals, children and young people, and parents of what constitutes optimal care.

Progress

6.26. The literature review is already underway and is identifying relevant studies. Initial meetings have also taken place with voluntary organisations and other researchers working in the area to ensure there is no duplication and in recognition of research fatigue among this population.

6.27. Children and young people and young adults who have experienced gender-related distress are involved in the research programme. Their advice has been, and will continue to be, sought throughout this work, including in relation to the focus of the research and interpretation of findings and the design and content of dissemination materials.

6.28. Three research protocols have been produced setting out how the research will be undertaken, and the research team is currently gaining the necessary ethical and governance approvals to progress the study. The systematic review is published on the PROSPERO website and will be published on the Review website in due course, along with the qualitative and quantitative research proposals once ethical and governance approvals have been received.

6.29. The research findings will be subject to peer review through the publication process and various summaries, aimed at different audiences, will be available on the project website and distributed via support organisations. These summaries will also be made available on the Review website.

Ongoing engagement

6.30. In recognition that not all the published evidence is likely to be of high enough quality to form the sole basis for our recommendations, a consensus development approach will be used to synthesise the published evidence and research outputs of the academic work with stakeholder submissions and expert opinion.

6.31. Over the coming months, the Review will build on its engagement to date and, alongside the academic research programme, will continue informal and structured engagement with service users, their families, support and advocacy groups and professionals to test emerging thinking, provide opportunities for challenge and further develop the evidence base.

6.32. This review is an iterative process and we will share important findings when they become available. For the latest updates, please visit our website: https://cass.independent-review.uk/

6.33. We thank those who have participated in the Review to date and welcome engagement with us as work progresses towards final recommendations.

Glossary



Glossary

There is sometimes no consensus on the best language to use relating to this subject. The language surrounding this area has also changed rapidly and young people have developed varied ways of describing their experiences using different terms and constructs that are relevant to them.

The Review tries as far as possible to use language and terms that are respectful and acknowledge diversity, but that also accurately illustrate the complexity of what we are trying to describe and articulate.

The terms we have used may not always feel right to some; nevertheless, it is important to emphasise that the language used is not an indication of a position being taken by the Review. The glossary below sets out a description of some of the terms we have used in the Review.

Term		Description
Affirmative model		A model of gender healthcare that originated in the USA[78,79,80,81] which affirms a young person's subjective gender experience while remaining open to fluidity and changes over time. This approach is used in some key child and adolescent clinics across the Western world.
Assent		To agree to or approve of something (idea, plan or request), especially after thoughtful consideration.
Autonomy		Personal autonomy is the ability of a person to make their own decisions. In health this refers specifically to decisions about their care.

[78] Hidalgo MA, Ehrensaft D, Tishelman AC, Clark LF, Garofalo R, Rosenthal SM, et al (2013). The gender affirmative model: What we know and what we aim to learn [Editorial]. Human Dev 56(5): 285–290. DOI:10.1159/000355235.
[79] Chen D, Abrams M, Clark L, Ehrensaft D, Tishelman AC, Chan YM, et al (2021). Psychosocial characteristics of transgender youth seeking gender-affirming medical treatment: baseline findings from the trans youth care study. J Adol Health 68(6): 1104–11.
[80] Olson-Kennedy J, Chan YM, Rosenthal S, Hidalgo MA, Chen D, Clark L, et al (2019). Creating the Trans Youth Research Network: A collaborative research endeavor. Transgend Health 4(12): 304–12. DOI: 10.1089/trgh.2019.0024.
[81] Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Colton K-M (2018). Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens. Int J Transgend 19(2): 251–68. DOI: 10.1080/15532739.2017.1414649.

Term		Description
Best interests		Clinicians and the courts seek to act in the best interests of children and young people. For the Mental Capacity Act (MCA) 2005, decisions for someone who cannot decide for themselves must be made in their best interests. Under the Children Act 1989, in any decision of the court about a child (under 18), the welfare of the child must be paramount. For these purposes, there is little or no material difference between the welfare and best interests, and we have used "best interests" throughout the report. Although there is no standard definition of "best interests of the child," the General Medical Council advises that an assessment of best interests will include what is clinically indicated as well as additional factors such as the child or young person's views, the views of parents and others close to the child or young person and cultural, religious and other beliefs and values of the child or young person.[82]
		The MCA s4,[83] and extensive Court of Protection case law, deals with the approach to best interests under that legislation. Whether in the Court of Protection or the High Court, when the court is asked to make an assessment of a child or young person's best interests, it will consider their welfare/best interests in the widest sense. This will include not just medical factors but also social and psychological factors.
Case-mix		The mix of patients within a particular group.
Child and adolescent mental health services	CAMHS	NHS children and young people's mental health services.[84]

[82] General Medical Council (2018). 0-18 years – guidance for all doctors.
[83] Mental Health Law Online. MCA 2005 s4.
[84] Young Minds. Guide to CAMHS: a guide for young people.

Term		Description
Child and/or young person		In law, everyone under 18 years of age is a child (Children Act 1989) but we recognise that it may be more appropriate to refer to those approaching the age of 18 as a young person, and that such young people may not recognise themselves as a "child". In places, we have referred only to "young person", or only to "child", for example where treatment in question is only given towards the later stages of childhood, closer to the age of 18, or in reference to the parent/child relationship, in which they remain the parents' child, regardless of their age. Otherwise, we have used the phrase "child and/or young person" throughout the report for this reason only, and do not intend there to be a material difference between them other than that.
Cognitive		Relating to, or involving, the process of thinking and reasoning.
Consent		Permission for a clinical intervention (such as an examination, test or treatment) to happen. For consent to be 'informed', information must be disclosed to the person about relevant risks, benefits and alternatives (including the option to take no action), and efforts made to ensure that the information is understood. In legal terms, consent is seen as needing: 1 – capacity (or *Gillick* competence under 16) to make the relevant decision; 2 – to be fully informed (ie the information provided about the available options, the material risks and benefits of each option, and of doing nothing, "material" meaning (per the Montgomery Supreme Court judgment in 2015) what a reasonable patient would want to know, and what this patient actually wants to know, NOT what a reasonable doctor would tell them); and 3 – to be freely given (that is,without coercion).
Contraindications		A condition or circumstance that suggests or indicates that a particular technique or drug should not be used in the case in question.

Term		Description
Court of Appeal		(England and Wales) The Court of Appeal hears appeals against both civil and criminal judgments from the Crown Courts, High Court and County Court. It is second only to the Supreme Court.
Detransition/ detransitioners		Population of individuals who experienced gender dysphoria, chose to undergo medical and/or surgical transition and then detransitioned by discontinuing medications, having surgery to reverse the effects of transition, or both.[85]
Diagnostic and Statistical Manual of Mental Disorders Fifth edition	DSM-5	The American diagnostic manual used to diagnose mental health disorders, and commonly used in UK practice. See **Appendix 3**.
Diagnostic formulation		The comprehensive assessment that includes a patient's history, results of psychological tests, and diagnosis of mental health difficulties.
Divisional Court		(England and Wales) When the High Court of Justice of England and Wales hears a case with at least two judges sitting, it is referred to as the Divisional Court. This is typically the case for certain judicial review cases (as well as some criminal cases).
Dutch Approach		Protocol published in 1998 by the Amsterdam child and adolescent gender identity clinic.[86]
Endocrine treatment		In relation to this clinical area, this term is used to describe the use of gonadotropin-releasing hormones (see below) and feminising and masculinising hormones (see below).
Endocrinologist		An endocrinologist is a medical doctor specialising in diagnosing and treating disorders relating to problems with the body's hormones.
Endocrinology		The study of hormones.

[85] Littman L (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners. Arch Sex Abuse 50: 3353–69. DOI: 10.1007/s10508-021-02163-w

[86] de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. J Homosex 59: 301-320. DOI: 10.1080/00918369.2012.653300.

Term		Description
Epidemiology		Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.[87]
Exploratory approaches		Therapeutic approaches that acknowledge the young person's subjective gender experience, whilst also engaging in an open, curious, non-directive exploration of the meaning of a range of experiences that may connect to gender and broader self-identity.[88,89,90,91]
Feminising and masculinising hormones (also known as cross-sex hormones, and gender affirming hormones).		Hormones given as part of a medical transition for gender dysphoric individuals, where sex hormones (testosterone for transgender males and oestrogen for transgender females).
Gender dysphoria		Diagnostic term used in DSM-5.[92] Gender dysphoria describes "a marked incongruence between one's experienced/expressed gender and assigned gender of at least 6 months duration" which must be manifested by a number of criterion – see **Appendix 3** for further detail.
Gender fluid		An experience of gender that is not fixed, but changes between two or more identities.
Gender identity		This term is used to describe an individual's internal sense of being male or female or something else.
Gender identity development		The developmental experience of a child or young person in seeking to understand their gender identity over time.
Gender Identity Development Service	GIDS	The service that NHS England commissions for children and adolescents with gender dysphoria.

[87] Centers for Disease Control and Prevention (2012). Principles of Epidemiology in Public Health Practice: An introduction to Applied Epidemiology and Biostatistics, 3rd ed.
[88] Di Ceglie D (2009). Engaging young people with atypical gender identity development in therapeutic work: A developmental approach. J Child Psychother 35(1): 3–12. DOI: 10.1080/00754170902764868.
[89] Spiliadis A (2019). Towards a gender exploratory model: Slowing things down, opening things up and exploring identity development. Metalogos Systemic Ther J 35: 1–9.
[90] Churcher Clarke A, Spiliadis A (2019). 'Taking the lid off the box': The value of extended clinical assessment for adolescents presenting with gender identity difficulties. Clin Child Psychol Psychiatry 24(2): 338–52. DOI:10.1177/1359104518825288.
[91] Bonfatto M, Crasnow E (2018). Gender/ed identities: an overview of our current work as child psychotherapists in the Gender Identity Development Service. J Child Psychother 44(1): 29–46. DOI:10.1080/007541 7X.2018.1443150.
[92] American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Health Disorders: DSM-5™, 5th ed.

Term		Description
Gender incongruence		Diagnostic term used in ICD-11.[93] Gender incongruence is characterised by "a marked and persistent incongruence between an individual's experienced gender and the assigned sex". See **Appendix 3** for further detail.
Gender-questioning		A broader term that might describe children and young people who are in a process of working out how they want to present in relation to their gender.
Gender-related distress		A way of describing distress that may arise from a broad range of experiences connected to a child or young person's gender identity development. Often used for young people whereby any formal diagnosis of gender dysphoria has not yet been made.
Gillick competence/ Fraser guidelines		A term derived from *Gillick v West Norfolk And Wisbech AHA*, 1984 that is used to decide whether a child or young person up to the age of 16 years is able to consent to their own medical treatment, without the need for parental permission or knowledge. A child or young person will be 'Gillick competent' for that decision if they have the necessary maturity and understanding to make the decision.
Gonadotropin-releasing hormone analogues (also known as the hormone blocker/s and puberty blocker/s)	GnRH	GnRH analogues competitively block GnRH receptors to prevent the spontaneous release of two gonadotropin hormones, Follicular Stimulating Hormone (FSH) and Luteinising Hormone (LH) from the pituitary gland. This arrests the progress of puberty.
General Practitioner	GP	GPs deal with a whole range of health problems and manage the care of their patients, referring onto specialists as appropriate.[94]
High Court		The third highest court in the UK. It deals with all high value and high importance civil law (non-criminal) cases and appeals of decisions made in lower courts. When the High Court sits with more than one judge, as required for certain kinds of cases, it is called the Divisional Court.
International Classification of Diseases, Version 11	ICD-11	ICD-11[95] is the World Health Organization (WHO) mandated health data standard used for medical diagnosis.

[93] World Health Organization (2022). International Classification of Diseases Eleventh Revision.
[94] NHS. GP services.
[95] World Health Organization (2022). International Classification of Diseases Eleventh Revision.

Term		Description
Looked after children		Children who are in the care of their Local Authority who may be living with foster parents or in a residential care setting.
Multi-disciplinary-team	MDT	The identified group of professional staff who provide a clinical service.
Neurodiverse		Displaying or characterised by autistic or other neurologically atypical patterns of thought or behaviour; not neurotypical.
Non-binary		A gender identity that does not fit into the traditional gender binary of male and female.[96]
Paediatrics		The branch of medicine dealing with children and their medical conditions.
Pass/passing		A person's gender being seen and read in the way they identify.
Precocious puberty		This is when a child's body begins changing into that of an adult (puberty) too soon – before age 8 in girls and before age 9 in boys.
Primary care		Primary care includes general practice, community pharmacy, dental and optometry (eye health) services. This tends to be the first point of access to healthcare.
Psychological formulation		A structured approach to understanding the factors underlying distressing states in a way that informs the changes needed and the therapeutic intervention for these changes to occur.
Psychosocial		Describes the psychological and social factors that encompass broader wellbeing.
Puberty blockers		See gonadotropin-releasing hormone above.
Secondary care		Hospital and community health care services that do not provide specialist care and are usually relatively close to the patient. For children this will include Child and Adolescent Mental Health Services (CAMHS), child development and general paediatric services.
Tanner Stage		Classification of puberty by stage of development. This ranges from Stage 1, before physical signs of puberty appear, to Stage 5 at full maturity.

[96] Twist J, de Graaf NM (2019). Gender diversity and non-binary presentations in young people attending the United Kingdom's National Gender Identity Development Service. Clin Child Psychol Psychiatry 24(2): 277–90. DOI: 10.1177/1359104518804311.

Term		Description
Tertiary care		Tertiary care is the specialist end of the NHS. These services relate to complex or rare conditions. Services are usually delivered in a number of hospitals/centres.
Transgender	trans	This is an umbrella term that includes a range of people whose gender identity is different from the sex they were registered at birth.
Transition		These are the steps a person may take to live in the gender in which they identify. This may involve different things, such as changing elements of social presentation and role and/or medical intervention for some.

Appendix 1

Terms of reference



TERMS OF REFERENCE FOR REVIEW OF GENDER IDENTITY DEVELOPMENT SERVICE FOR CHILDREN AND ADOLESCENTS

INTRODUCTION

1. NHS England is the responsible commissioner for specialised gender identity services for children and adolescents. The Gender Identity Development Service for children and adolescents is currently managed by the Tavistock and Portman NHS Foundation Trust.

2. In recent years there has been a significant increase in the number of referrals to the Gender Identity Development Service, and this has occurred at a time when the service has moved from a psychosocial and psychotherapeutic model to one that also prescribes medical interventions by way of hormone drugs. This has contributed to growing interest in how the NHS should most appropriately assess, diagnose and care for children and young people who present with gender incongruence and gender identity issues.

3. It is in this context that NHS England and NHS Improvement's Quality and Innovation Committee has asked Dr Hilary Cass to chair an independent review, and to make recommendations on how to improve services for children and young people experiencing issues with their gender identity or gender incongruence, and ensure that the best model/s for safe and effective services are commissioned.

REVIEW SCOPE

The independent review, led by Dr Cass, will be wide ranging in scope and will conduct extensive engagement with all interested stakeholders. The review is expected to set out findings and make recommendations in relation to:

i. Pathways of care into local services, including clinical management approaches for individuals with less complex expressions of gender incongruence who do not need specialist gender identity services;
ii. Pathways of care into specialist gender identity services, including referral criteria into a specialist gender identity service; and referral criteria into other appropriate specialist services;
iii. Clinical models and clinical management approaches at each point of the specialised pathway of care from assessment to discharge, including a description of objectives, expected benefits and expected outcomes for each clinical intervention in the pathway;
iv. Best clinical approach for individuals with other complex presentations.
v. The use of gonadotropin-releasing hormone analogues and gender affirming drugs, supported by a review of the available evidence by the National Institute for Health and Care Excellence; any treatment recommendations will include a description of treatment objectives, expected benefits and expected outcomes, and potential risks, harms and effects to the individual;
vi. Ongoing clinical audit, long term follow-up, data reporting and future research priorities;
vii. Current and future workforce requirements;
viii. Exploration of the reasons for the increase in referrals and why the increase has disproportionately been of natal females, and the implications of these matters; and,

TERMS OF REFERENCE FOR REVIEW OF GENDER IDENTITY DEVELOPMENT SERVICE FOR CHILDREN AND ADOLESCENTS

ix. Any other relevant matters that arise during the course of the review

4. In addition, and with support from the Royal College of Paediatrics and Child Health and other relevant professional associations, the Chair will review current clinical practice concerning individuals referred to the specialist endocrine service. It is expected that findings and any recommendations on this aspect of the review will be reported early in 2021 with the review's wider findings and recommendations delivered later in 2021.

5. The review will not immediately consider issues around informed consent as these are the subject of an ongoing judicial review. However, any implications that might arise from the legal ruling could be considered by the review if appropriate or necessary.

Appendix 2

Letter to NHS England from Dr Cass – May 2021





Dr Hilary Cass
Chair
Review of GIDS for Children and Young People

John Stewart
National Director
Specialised Commissioning
NHS England and NHS Improvement

Sent by email

10 May 2021

Dear John

INDEPENDENT REVIEW INTO GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE

I am writing to update you on my current approach to the work of the independent review into gender identity services for children and young people. However, the most pressing issue is how we augment the immediate support for children and young people currently needing assessment and treatment, some of whom have already been waiting for an extended period for an appointment. I will therefore also make some suggestions about interim arrangements and ways in which the review team could help to support and strengthen these.

Commissioned research programme

As you know, a key principle of the review is that it should be evidence-based, and that final conclusions will be developed through a consensus development process contingent on the synthesised evidence.

I am pleased to see that the National Institute for Health and Care Excellence (NICE) evidence reviews of gonadotrophin releasing hormone analogues and gender affirming hormones for children and adolescents with gender dysphoria have now been published. Although this is a helpful starting point, despite following a standard and robust process the NICE review findings are not conclusive enough to inform policy decisions. As part of my review, I am therefore exploring other methodologies to give increased confidence and clarity about the optimal treatment approaches.

My team is commissioning a broader literature review of the existing evidence base on the epidemiology, management and outcomes of children with gender dysphoria. We are also commissioning qualitative and quantitative research, including considering other approaches which might be employed to understand the intermediate and longer-term outcomes of children with gender dysphoria. We intend to include a review of international models and data in this programme of work.

Addressing the immediate situation

Recognising that the outcome of the review is going to take some time, I have been reflecting on the recent court rulings on puberty blockers and consent and the Care Quality Commission (CQC) report on the Gender Identity Development Service (GIDS) run by the Tavistock and Portman NHS Foundation Trust. These significant developments have changed the context in which the review is taking place, and further added to the service pressures.

I note the proposal to establish an independent multidisciplinary professional review group to confirm decision-making has followed a robust process, which seems an appropriate interim measure pending further clarification of the legal situation.

I know that everyone concerned with the delivery of services – both commissioners and providers – are worried about the increasing number of children on the waiting list for assessment by the GIDS service and the resulting distress for the children and young people and their families. The difficulty in managing risk for those on the waiting list is exacerbated by the staff vacancies at GIDS, the increasing volume of new referrals, and the fact that the support and engagement from local services is highly variable and, in some cases, very limited.

Having a single provider may have been a logical position when the GIDS service was first set up, given that this is a highly specialised service that was seeing a relatively small number of cases each year. As the epidemiology has changed and there has been an exponential increase in numbers of children with gender incongruence or dysphoria, concentration of expertise within a single service has become unsustainable. At the same time, local services have not developed the skills and competencies to provide support for children on the waiting list and those with lesser degrees of gender incongruence who may not wish to pursue specialist medical intervention, and / or to provide help for children with additional complex needs.

I know from discussions we have had that your team is working hard to find some practical alternative arrangements, and that you have been in discussion with relevant professional bodies to come up with creative interim solutions while awaiting the outcome of my review.

The review team has also been in discussion with CQC, with the Tavistock and Portman NHS Foundation Trust and with colleagues within and external to NHS England and NHS Improvement to consider which aspects of this situation we can help with in the short to medium term, whilst keeping our focus on the longer-term questions of the appropriate clinical management and whole care pathway for these children and young people. In the past months I have also met with many groups and individuals with expertise and lived experience relevant to the review, including charities and support groups, Royal Colleges and healthcare professionals.

Recommendations to NHS England and NHS Improvement

I would encourage you to consider the following when developing an interim pathway for children and young people experiencing gender dysphoria:

- **Access and referral:** Children and young people need ready access to services. However, it is unusual for a specialist service to take direct referrals. The risk of having a national service as the first point of access is that assessment and treatment of children and young people who have the greatest need for specialist care is delayed because of the lack of differentiation of those on the waiting list. In addition, many children and

young people have complex needs, but once they are identified as having gender dysphoria, other important healthcare issues which would normally be managed by local services can sometimes be overlooked.

- **Assessment and management:** All children and young people who are referred to specialist services should have a competent local multi-disciplinary assessment and should remain under active holistic local management until they are seen at a specialist centre.

  I recognise that developing capacity and capability outside of the existing GIDS service to provide such initial assessment and support will be difficult to achieve at speed and will be incremental. This means that there will likely be a range of different models and options around the country, dependent on local resources, with some of the work being delivered through existing secondary service teams, and some being delivered at regional level. The support of wider services is vital.

- **Data:** The lack of systematic data collection is a significant issue. Therefore, when employing interim measures, I would suggest that particular attention is paid to the gathering of good quality data, which can then be used to inform the evidence base and future model of provision.

Actions for the review team

I would like to suggest how the review team might help with the challenging problem of growing an infrastructure outside of GIDS. From my conversations to date, I believe there are three barriers to the involvement of local services:

- **Capacity** – the staff most appropriately trained to be involved in initial assessment are those who are already most stretched within Child and Adolescent Mental Health Services (CAMHS) and paediatric services, and this situation has been significantly worsened through the impact of the Covid-19 pandemic on children's mental health. However, I know that there is substantial investment in CAMHS services, so close engagement with the relevant national policy teams at NHS England and NHS Improvement and at Health Education England (HEE) will be crucial.

- **Capability and confidence** – clinical teams outside of GIDS do not feel confident in initial assessment and support of children and young people with gender incongruence and dysphoria, in large part because they have not had the necessary training and experience, but also because of the societal polarisation and tensions surrounding the management of this group.

- **Lack of an explicit assessment framework** – currently expertise in assessment of children and young people presenting to GIDS is held in a small body of clinicians and their assessment processes have not been made explicit. The CQC report drew attention to the lack of structured assessment in the GIDS notes, and this is something that the Tavistock and Portman NHS Foundation Trust is already working to address internally. However, it is equally important to develop an initial assessment approach that can be used by first contact professionals, not just those working in the specialist service.

In the first instance, it is important that we test these assumptions with a range of clinical staff and ascertain whether there are other barriers that are preventing local engagement in this work. Then we would plan to prioritise a series of workshops, in collaboration with relevant professional groups, service users and close engagement with HEE. The purpose of these workshops would be to address identified barriers and develop:

- A framework for initial assessment of children and young people presenting with gender dysphoria.

- An approach to training for professionals at local and regional level.

- Some preliminary workforce recommendations, which will be particularly important in meeting the timelines of the three-year Comprehensive Spending Review.

These workshops will serve multiple purposes – firstly to support NHS England and NHS Improvement in the establishment of local and / or regional teams; secondly as an essential component of the work needed to inform the questions that the review is tackling; and thirdly to form the professional networks that will be needed to underpin future service and research networks.

Timelines

As you will recognise, setting up a complex national review is difficult and time consuming at the best of times. It requires a team to support the work and mechanisms for stakeholders to engage safely and with confidence. Starting a review in the midst of a pandemic is even more challenging.

I have committed to a review approach which is participative, consensus-based, evidence-based, transparent, and informed by lived and professional experience. This requires extensive engagement. Pending the appointment of our research team, the review has now launched its website and I have been proactively engaging with the stakeholder community.

It is critical that we get the approach right, particularly the engagement, the evidence review and the quantitative research given the gaps in the evidence highlighted through the NICE review, and this will take time.

My intention is that an interim report will be delivered in the summer, with a report next year setting out my final recommendations.

Yours sincerely



Dr Hilary Cass
Chair, Independent Review into Gender Identity Services for Children and Young People

Cc: Care Quality Commission
Health Education England
Tavistock and Portman NHS Foundation Trust

Appendix 3

Diagnostic criteria for gender dysphoria



DSM-5 diagnostic criteria for gender dysphoria

Gender Dysphoria in Children

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as congenital adrenal hyperplasia or androgen insensitivity syndrome).

Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as congenital adrenal hyperplasia or androgen insensitivity syndrome).

Specify if:

Post transition: the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen – namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

ICD-11: HA60 Gender incongruence of adolescence or adulthood

Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

Exclusions:

Paraphilic disorders.

ICD-11: HA61 Gender incongruence of childhood

Gender incongruence of childhood is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

Exclusions:

Paraphilic disorders.

Appendix 4

The standard approach to clinical service development



The standard approach to clinical service development

The three examples below illustrate the usual process of developing a clinical service: Covid-19 is included because this is a new condition that everyone is familiar with; childhood epilepsy because it is a complex condition with physical manifestations; and autism because it is a condition with neuro-behavioural manifestations.

By comparing these examples of clinical service development, it is possible to demonstrate some of the challenges in developing services for children and young people with gender incongruence or dysphoria, and to identify where there are gaps and questions that need to be addressed for this population, in order to ensure any future service model delivers the highest possible standards of care.

The stages below may proceed in a different sequence for different conditions, but each stage is important in the development of evidence based care.

Stage	Covid-19	Childhood Epilepsy	Autism
New condition is observed This often begins with a few case reports and then clinicians begin to recognise a recurring pattern and key clinical features, and to develop fuller descriptions of the condition.	Covid-19 is an example of a recent new condition that we all recognise, and this started with a few unusual cases of respiratory illness being described in Wuhan.	Childhood epilepsy has been recognised for centuries, but over the last century there has been growing understanding of the many different subtypes.	Individuals with autism have probably also existed for an indefinite period, but it wasn't until 1943 and 1944 that Leo Kanner and Hans Asperger wrote the first scientific accounts about the condition.

Stage	Covid-19	Childhood Epilepsy	Autism
Aetiology Clinicians and scientists try to work out the cause of the condition or the underlying physical or biological basis. Sometimes the answers to this are never found.	The cause of Covid-19 was identified at a very early stage as being due to a novel coronavirus, although it remains unclear where and how this originated.	It is now known that there are numerous different types of epilepsy, with many different causes – for example, epilepsy can be caused by specific epilepsy genes, by birth trauma, by metabolic conditions, by brain tumours and many other mechanisms. Epilepsies due to a change in the brain structure which occur after birth are called 'symptomatic' – they are a symptom of something else. Epilepsies for which there is no identified cause are called 'idiopathic'.	The first theory about the aetiology of autism was that it was caused by so called 'refrigerator parents'. This was inaccurate and damaging. It has subsequently been shown that there are many complex genetic and physical or chemical brain changes underpinning this condition.
Natural history and prognosis It is important to understand how a condition usually evolves over time, with or without treatment. The latter is important if treatment has limited efficacy and the condition is 'self-limiting' (that is, it resolves without treatment), because otherwise there is a risk that treatments create more difficulties than the condition itself.	Covid-19 is an example of a condition where there are quite polarised views about management based on its prognosis and natural history. A relatively small proportion of people are seriously affected and need treatment, and for the majority the natural history is that it will get better by itself. This has led some people to question the need for lockdowns, vaccinations and other measures which they see as impacting personal freedoms.	In epilepsy the natural history is very important. Some epilepsies get better through puberty and into adulthood, and some can get worse with hormonal changes. This is important to know when monitoring and reviewing drug treatment.	

Stage	Covid-19	Childhood Epilepsy	Autism
Epidemiology Epidemiologists collect data to find out how common a condition is, who is most likely to be affected, what the age distribution is and so on. This allows health service planners to work out how many services are needed, where they should be established, and what staff are needed. They also report on changes in who is most affected, which may mean that either the disease is changing, or the susceptibility of the population is changing.	Epidemiologists have been crucial in supporting the management of Covid-19 because they have extracted and analysed the data on which patients are at greater risk from the virus. This has been fundamental to planning a vaccination strategy and other protective measures.		The epidemiology of autism has changed considerably, with a dramatic increase in the numbers of children diagnosed over the last 20 years. This has had major implications for service provision. There is ongoing debate about the cause of the increase – whether it is because of greater awareness and better diagnosis, or because there are more children with autism. Current opinion favours the first option.

Stage	Covid-19	Childhood Epilepsy	Autism
Assessment and diagnosis Clinicians will usually take a history from (that is, of their symptoms) and examine the patient (that is, for signs and symptoms), and where appropriate undertake a series of investigations or tests, to help them reach an accurate diagnosis. Sometimes the whole process of making a diagnosis through talking to the patient and asking them to complete formal questionnaires, examining them and/or undertaking investigations is called 'clinical assessment'. As well as diagnosing and ruling out a particular condition, clinicians often need to consider and exclude other, sometimes more serious, conditions that present in a similar way but may need quite different treatment – this process is called 'differential diagnosis'.	PCR has been used as a 'gold standard' test for diagnosis of Covid-19 since the beginning of the pandemic. Lateral flow testing was developed to provide a quicker and cheaper option, but it demonstrates the limitations of testing; it is 99.68% specific, which is a very high specificity. This means there are only a tiny number of false positives. It has lower sensitivity at 76.8%, which means it will miss about a quarter of all cases, so giving many more false negatives, BUT it will only miss 5% of cases with high viral load.	Epilepsy can only be definitively diagnosed by either getting a really clear description of the events from a parent or carer, or seeing the child or young person having a seizure on a video. An EEG (brain wave tracing) and other tests can provide information about the type of epilepsy, but unless a seizure happens during the recording, it does not demonstrate that they actually have seizures – only that they may be susceptible to seizures.	In autism there are no blood tests or X-rays to make the diagnosis. It is a 'clinical' diagnosis, which means it is dependent on taking a standardised history from the parents, and performing standardised assessments on the child or young person to distinguish between autism and other possible diagnoses (for example, language disorder, social anxiety). In the early days, these standardised measures did not exist; the diagnosis was very dependent on experts who were used to diagnosing autism by making a clinical judgement about each child. This made it difficult to teach new people how to do this without a long apprenticeship, and also made it difficult to know whether two different experts would come to the same conclusion about the same child or young person. Standardisation of the questions and process made diagnosis more reliable and consistent, as did an improved evidence base. At the same time, because children with autism all present differently, the assessment had to be flexible enough to accommodate, for example, non-verbal children with severe learning disability, as well as high-functioning children with strong verbal skills.

Stage	Covid-19	Childhood Epilepsy	Autism
Differential diagnosis As well as making a positive diagnosis, clinicians often need to exclude other, sometimes more serious conditions that present in a similar way, but may need quite different treatment.		There are conditions that can be mistaken for epilepsy, so it is important to accurately diagnose whether seizures are happening and exclude other conditions (differential diagnoses) by carrying out relevant tests.	There are many conditions that may be mistaken for autism – for example, children who have language disorders, learning disability, severe social anxiety for other reasons, or ADHD can all appear to have autism. It is important to exclude these other conditions as well as making a positive diagnosis of autism. Sometimes these conditions can exist alongside autism, and management must then be planned to address all the child's difficulties.

Stage	Covid-19	Childhood Epilepsy	Autism
Developing and implementing new treatments Clinicians and scientists work on developing treatments. This involves clinical trials and, where there are new treatments, comparing them to any existing treatments. Questions include: What are the intended outcomes or benefits of treatment? What are the complications or side effects? What are the costs? To initiate a new treatment, it must be both safe and effective. Questions of affordability can sometimes become controversial. The best type of single study is considered to be the randomised controlled trial (RCT), but sometimes this is not feasible. Even where RCTs are not available, it is usual to at least have data on the outcomes of sufficient cases or cohorts to understand the risk/benefit of the treatment under consideration. As demonstrated in Fig. 3, the highest level of evidence is when the results of several different studies are pooled, but this is only useful if the individual studies themselves are of high quality.	Developing treatments for Covid-19 has been possible at speed because of the large numbers of patients, and the fact that outcomes can be observed on each patient within a matter of days to weeks. Because Covid-19 was a new condition, clinicians also started in a position of 'equipoise' which means that they did not have reason to believe any one treatment might be more effective than another; this made it ethical to have one group having a treatment and another group having a different treatment or a placebo. There are also really clear outcome measures, such as whether or not patients survive or need hospitalisation. This has facilitated a high level of evidence through randomised controlled trials (see diagram below).	Similar considerations apply to the treatment of epilepsy in that there are 'hard' outcome measures (for example, frequency of seizures), but it can take several months to determine whether a new drug is better than an existing one for any one patient, and some side effects may be longer-term, so trials can take several years. In addition, children with epilepsy may have very different conditions causing their seizures which can also make trials more challenging. In the most severe cases of epilepsy, surgery may be the best option for controlling seizures. This can be very radical in certain cases and have lifelong implications for how they function. These options, which have a cost as well as a benefit to the child, will only be offered after a multi-disciplinary team meeting, including the paediatricians, therapists, neuropsychologists, radiologists, neurophysiologists and neurosurgeons have all discussed whether the benefits will outweigh the costs.	Evaluating interventions for autism is the most difficult of these three examples. This is because it can take many years to see developmental outcomes; it is hard to get uniform groups of children; outcomes are extremely sensitive to the social (and historical) response of others; and many other things happen in children's lives (such as changes of school, other medications, new diets). Isolating the effect of the target treatment is therefore challenging.

Stage	Covid-19	Childhood Epilepsy	Autism
In many instances, evidence is not perfect and difficult decisions have to be made. Where treatments are innovative or life-changing, the whole multi-disciplinary team will usually meet to consider the available options, and how to advise the child or young person and family so that a shared decision can be made. Sometimes an ethics committee is involved. This is one of the most challenging areas of medicine and is underpinned by GMC guidance.[97, 98]	The UK has been internationally recognised for its Recovery Trial, led by Oxford University. This has recruited over 46,000 participants, and resulted in several treatments being approved. A key factor in this success was the willingness of patients to participate in these studies – with over 46,000 being recruited and consented.		

[97] General Medical Council (2020). Decision making and consent.
[98] National Institute for Health and Care Excellence (2021). Shared decision making.

Stage	Covid-19	Childhood Epilepsy	Autism
Service development and service improvement Central to any service improvement is the systematic and consistent collection of data on outcomes of treatment. There is a process of continuous service improvement as new presentations or variations on the original condition are recognised, diagnosis or screening improves and/or trials on new treatments or variations on existing treatments are ongoing. There should be consistent treatment protocols or guidelines in place, in order to make sense of variations in outcomes. Where possible, these should be compared between and across multiple different centres. As time passes, services need to be changed or extended based on patient need, and on what resources are needed to deliver the available treatments. They need to be accessible where the prevalence of the condition is highest. The relevant workforce to deliver the service needs to be recruited and trained, contingent on the type of treatments or therapy that is required.	Service development to manage Covid-19 has been on a scale unlike any normal new service development ever experienced. It has also demonstrated how other non-Covid services have had to evolve alongside, including the need for isolation, and/or PCR testing prior to routine clinical appointments, use of remote consultation and an array of other changes across the NHS. Continuous audit and monitoring of outcomes has resulted in major improvements in survival – for example, changing ventilation approach to include 'proning' (putting patients on their front while on the ventilator) and delaying fully intubated ventilation by giving mask ventilation for as long as possible.	Paediatric epilepsy is a good example of how a national approach can be taken to service improvement through the Epilepy12 programme.[99] This is a nationally co-ordinated audit which collects a standardised dataset, incorporating NICE standards, and is used to drive up standards of care for children and young people with epilepsy.	Improvement in autism services has been driven by the changing epidemiology, NICE standards, extensive training of the workforce and attempts to improve public understanding. Where previously diagnosis was undertaken in a few specialist centres, the rising waiting times and NICE standards on access, assessment and appropriate multi-professional provision have led to almost every community child development service having an autism assessment clinic or team. Services are able to self-assess against national standards to inform local improvement strategies.

[99] Royal College of Paediatrics and Child Health (2021). Epilepsy 12 – national organisational audit and clinical audit.

References

AB v CD & Ors [2021] EWHC 741.

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Health Disorders: DSM-5TM, 5th ed.

Bell v Tavistock [2020] EWHC 3274 (Admin).

Bloom TM, Nguyen TP, Lami F, Pace CC, Poulakis Z, Telfer N (2021). Measurement tools for gender identity, gender expression, and gender dysphoria in transgender and gender-diverse children and adolescents: a systematic review. Lancet Child Adolescent Health. 5: 582-588. DOI: 10.1016/s2352-4642(21)00098-5.

Bonfatto M, Crasnow E (2018). Gender/ed identities: an overview of our current work as child psychotherapists in the Gender Identity Development Service. J Child Psychother 44(1): 29–46. DOI:10.1080/0075417X.2018.1443150.

Brik T, Vrouenraets LJJJ, de Vries MC, Hannema SE (2020). Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. Arch Sex Behav 49: 2611–8. DOI: 10.1007/s10508-020-01660-8.

Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLoS One. 16(2):e0243894. DOI:10.1371/journal.pone.0243894.

Centers for Disease Control and Prevention (2012). Principles of Epidemiology in Public Health Practice: An introduction to Applied Epidemiology and Biostatistics, 3rd ed.

Chen D, Abrams M, Clark L, Ehrensaft D, Tishelman AC, Chan YM, et al (2021). Psychosocial characteristics of transgender youth seeking gender-affirming medical treatment: baseline findings from the trans youth care study. J Adol Health 68(6): 1104–11.

Chen D, Strang JF, Kolbuck VD, Rosenthal SM, Wallen K, Waber DP, et al (2020). Consensus parameter: research methodologies to evaluate neurodevelopmental effects of pubertal suppression in transgender youth. Transgender Health 5(4). DOI: 10.1089/trgh.2020.0006.

Churcher Clarke A, Spiliadis A (2019). 'Taking the lid off the box': The value of extended clinical assessment for adolescents presenting with gender identity difficulties. Clin Child Psychol Psychiatry 24(2): 338–52. DOI:10.1177/1359104518825288.

Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). Treatment of adolescents with gender dysphoria in the Netherlands. Child Adolesc Psychiatr Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.

Cohen-Kettenis PT, Van Goozen S (1998). Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. Eur Child Adolesc Psychiatry 7: 246–8. DOI: 10.1007/s007870050073.

de Graaf NM, Carmichael P, Steensma TD, Zucker KJ (2018). Evidence for a change in the sex ratio of children referred for Gender Dysphoria: Data from the Gender Identity Development Service in London (2000–2017). J Sex Med 15(10): 1381–3. DOI: 10.1016/j.jsxm.2018.08.002.

de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009-2016). Arch Sex Behav 47(5): 1301–4.

de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.

Delemarre-van de Wall HA, Cohen-Kettinis PT (2006). Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. Eur J Endocrinol 155 (Suppl 1): S131–7. DOI: 10.1530/eje.1.02231.

Delevichab K, Klinger M, Nana OJ, Wilbrecht L (2021). Coming of age in the frontal cortex: The role of puberty in cortical maturation. Semin Cell Dev Biol 118: 64–72. DOI: 10.1016/j.semcdb.2021.04.021.

Di Ceglie D (2009). Engaging young people with atypical gender identity development in therapeutic work: A developmental approach. J Child Psychother 35(1): 3–12. DOI: 10.1080/00754170902764868.

Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Colton K-M (2018). Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens. Int J Transgend 19(2): 251–68. DOI: 10.1080/15532739.2017.1414649.

EWCA [2021] Civ 1363.

Gender Identity Clinic, The Tavistock and Portman NHS Foundation Trust. Waiting times.

Gender Identity Development Service. Referrals to GIDS, financial years 2010-11 to 2020-21.

General Medical Council (2018). 0-18 years – guidance for all doctors.

General Medical Council (2020). Decision making and consent.

General Medical Council (2021). Good practice in prescribing and managing medicines and devices (76-78).

Gillick v West Norfolk and Wisbech AHA [1986] AC 112.

Goddings A-L, Beltz A, Jiska S, Crone EA, Braams BR (2019). Understanding the role of puberty in structural and functional development of the adolescent brain. J Res Adolesc 29(1): 32–53. DOI: 10.1111/jora.12408.

Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, et al (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab 102(11): 3869–903. DOI: 10.1210/jc.2017-01658.

Hidalgo MA, Ehrensaft D, Tishelman AC, Clark LF, Garofalo R, Rosenthal SM, et al (2013). The gender affirmative model: What we know and what we aim to learn [Editorial]. Human Dev 56(5): 285–290. DOI:10.1159/000355235.

Kyriakou A, Nicolaides NC, Skordis N (2020). Current approach to the clinical care of adolescents with gender dysphoria. Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.

Littman L (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners. Arch Sex Abuse 50: 3353–69. DOI: 10.1007/s10508-021-02163-w

Matthews T, Holt V, Sahin S, Taylor A, Griksaitis (2019). Gender Dysphoria in looked-after and adopted young people in a gender identity development service. Clinical Child Psychol Psychiatry 24: 112-128. DOI: 10.1177/1359104518791657.

Mental Health Law Online. MCA 2005 s4.

National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria.

National Institute for Health and Care Excellence (2020). Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria.

National Institute for Health and Care Excellence (2021). Shared decision making.

NHS. GP services.

Office for National Statistics (2019). What is the difference between sex and gender?

Olson-Kennedy J, Chan YM, Rosenthal S, Hidalgo MA, Chen D, Clark L, et al (2019). Creating the Trans Youth Research Network: A collaborative research endeavor. Transgend Health 4(12): 304–12. DOI: 10.1089/trgh.2019.0024.

OpenMD (2021). New Evidence in Medical Research.

Royal College of Paediatrics and Child Health (2021). Epilepsy 12 – national organisational audit and clinical audit – 2021.

Scobie S, Castle-Clarke S (2019). Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics. Learning Health Systems 4(1): e10209. DOI:10.1002/lrh2.10209.

Sievert EDC, Schweizer K, Barkmann C, Fahrenkrug S, Becker-Hebly I (2020). Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria.Clin Child Psychol Psychiatry 26(1): 79–95. DOI: 10.1177/1359104520964530

Spiliadis A (2019). Towards a gender exploratory model: Slowing things down, opening things up and exploring identity development. Metalogos Systemic Ther J 35: 1–9.

Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clin Child Psychol Psychiatry 16(4): 485-97. DOI: 10.1177/135910451037803.

Steensma TD, Cohen-Kettenis PT, Zucker KJ (2018). Evidence for a change in the sex ratio of children referred for gender dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam (1988-2016). Journal of Sex & Marital Therapy 44(7): 713–5. DOI: 10.1080/0092623X.2018.1437580.

Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. J Am Acad Child Adolesc Psychiatry 52: 582-590. DOI: 10.1016/j.jaac.2013.03.016.

Turban JL, King D, Carswell JM, et al (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. Pediatrics 145 (2): e20191725. DOI: 10.1542/peds.2019-1725.

Twist J, de Graaf NM (2019). Gender diversity and non-binary presentations in young people attending the United Kingdom's National Gender Identity Development Service. Clin Child Psychol Psychiatry 24(2): 277–90. DOI: 10.1177/1359104518804311.

Van Der Miesen AIR, Hurley H, De Vries ALC (2016). Gender dysphoria and autism spectrum disorder: A narrative review. Int Rev Psychiatry 28: 70-80. DOI: 10.3109/09540261.2015.1111199.

Vrouenraets LJ, Fredriks AM, Hannema SE, Cohen-Kettenis PT, de Vries MC (2015). Early medical treatment of children and adolescents with gender dysphoria: an empirical ethical study. J Adolesc Health 57(4): 367-73. DOI: 10.1016/.2015.04.004.

World Health Organization (2022). International Classification of Diseases Eleventh Revision.

Wren B (2019). Notes on a crisis of meaning in the care of gender-diverse children. In: Hertzmann L, Newbigin J (eds) Sexuality and Gender Now: Moving Beyond Heteronormativity. Routledge.

Young Minds. Guide to CAMHS: a guide for young people.

Zucker KJ (2017). Epidemiology of gender dysphoria and transgender identity. Sex Health 14(5): 404–11. DOI:10.1071/SH1.

Zucker KJ, Lawrence AA (2009). Epidemiology of gender identity disorder: recommendations for the Standards of Care of the World Professional Association for Transgender Health. Int J Transgend 11(1): 8-18. DOI: 10.1080/15532730902799946.

We use cookies on this site to enhance your user experience. OK More info

Current debates

Young people are understanding gender in an increasingly diverse way. For example, Facebook now allows users to choose from an “extensive list” of pre-populated gender identities, or to enter their own preferred terms(read about this on Facebook (https://www.facebook.com/facebookdiversity/posts/774221582674346)). Each individual can add up to 10 terms describing their gender to their profile and can customise how public this information is made. Young people who we meet at GIDS have often familiarised themselves with a large range of different identity labels in discussions online or with their peers.

Young people are also talking about the people they are attracted to or have relationships with in diverse and nuanced ways. There are a many different terms in common use to describe sexuality including lesbian, gay, bisexual, pansexual, omnisexual, asexual, heteroromantic, questioning, fluid, queer-identified, men who have sex with men, same-gender loving, polyamorous and more (see a list of LGBTQ+ vocabulary definitions (http://itspronouncedmetrosexual.com/2013/01/a-comprehensive-list-of-lgbtq-term-definitions/)).

We recognise that sexual orientation and gender identity are distinct concepts. However, we also acknowledge that whilst some people experience them as entirely separate, others experience them as overlapping or intertwined to varying degrees. We also recognise that there is a degree of overlap in the language that has been available to think about them, and the shared histories of marginalisation, community and activism. This can be a contentious issue and there are a wide variety of different viewpoints on how closely transgender people and lesbian, gay and bisexual people should be grouped together and how far their goals and priorities align.

The possible links between how we see sexuality and how we see gender identity have received much academic attention. Drescher (2010) provides a review of how gender identity and sexual orientation have been linked in scientific and medical literature, as well as in wider society, and discusses parallels between the classification of homosexuality and gender identity disorder as psychiatric diagnoses and the debates around this. Read the review (http://dx.doi.org/10.1007/s10508-009-9531-5)

It is sometimes suggested that there may be some people who align with trans identity, rather than as lesbian or gay, perhaps because in some social groups homosexuality is still seen as unacceptable. We have no way of knowing if this is ever the case. However, on this page we look at some of the ways that we try to open up exploratory conversations on these matters, while not favouring one outcome over another.

How we consider referrals where sexuality may be the presenting issue

When we receive a referral it is screened by clinicians in our intake team. At our intake meetings we look for information about distress related to gender identity. Occasionally, we receive referrals which appear to be related specifically to sexual orientation rather than gender identity. In these cases, we liaise with referrers (http://gids.nhs.uk/referrals#intake) to understand whether the young person is also experiencing issues related to their gender identity. If this is not the case, we would recommend other services or sources of support.

Our approach with younger children

For younger children, we encourage parents to support their child to safely explore their interests, allegiances and preferred activities, whilst keeping a range of options open to them. We recommend keeping an open mind about how a child's interests and identity might develop over time.

Our approach to discussing sexuality and distress around gender with adolescents

We discuss sexuality with young people and their families in our assessments (http://www.gids.nhs.uk/about-us#support-that-we-offer), as part of the broader discussions we have about relationships and bodily feelings. We work with each individual to find the best way forward for them, remaining mindful that feelings and priorities may change over time. Adolescence is a stage of life when people are working out in all sorts of ways who they are and who they want to be.

At a developmentally appropriate age, and in an appropriate fashion, we also have conversations with young people about sexual and romantic relationships, safer sex and sexual health (http://genderedintelligence.co.uk/trans-youth/resources), and their relationships with others. We might also discuss with teenagers their relationship to their own body and sexual feelings. We would consider with them how this might relate to their hopes for transition and the impact of potential physical interventions (http://www.gids.nhs.uk/puberty-and-physical-intervention), if they are considering starting these. We aim to empower young people to make informed decisions about their futures, and recognise that sexuality – in the broadest sense – is an important aspect of life for many people as they approach young adulthood.

We understand that this can be an embarrassing topic to discuss in front of parents. Whilst some young people talk quite freely with their families about who they are attracted to, for others the very thought of doing so makes them cringe. We therefore let young people know that we can have these discussions in one-to-one sessions with us, without their parents in the room: this is something we routinely offer.

We also discuss, where appropriate, any perceived connections between sexuality, sexual orientation, and gender. We realise that whilst sexuality and gender are different and for some people feel very distinct, for others they can overlap and it might not always be helpful or possible to think of them as entirely separate.

For some young people, it may seem quite difficult to untangle sexuality and gender identity or to figure out what is the best path for them. We encourage them to safely explore and experiment and let them know that we will support them however they come to identify, and we will help them over time to make choices that they feel are the best for them. Others may feel that their gender identity and sexual orientation have already settled and that this kind of exploration is less relevant to them.

As you would expect in any large group of people, we see people of all different sexualities: some describe themselves as heterosexual or straight, others as gay or lesbian, as bisexual, pansexual or queer. In our clinical experience, many trans young people have spent a period of time identifying as lesbian, gay or bisexual before identifying as trans. But for some adolescents it can be frustrating or invalidating that people often confuse their sexuality and their gender, or assume that they are the same thing.

Homophobia, transphobia and bullying

We pay attention to and explore experiences of homophobia and biphobia, just as we do for young people's experiences of transphobia. We are acutely aware of the pervasive nature of transphobia, homophobia, biphobia, and sexism throughout society, as well as within and between marginalised communities. The young people we see frequently have repeated, first-hand experience of this from others. We also work with young people to address feelings of internalised stigma and shame that many people experience.

We believe that bullying is never acceptable and that young people should not have to accept this as normal. If bullying is taking place, we work with families and schools to address this.

Sexuality of young people coming to GIDS

The question of how to 'measure' or record the sexual orientation of a population has long raised a host of questions for researchers. For example, are you asking how people identify, who they are attracted to, or about sexual behaviour? This is of course even harder to measure in children, and indeed some would question whether it is ever either possible or appropriate to describe a child in terms of their sexual orientation. At GIDS, we simply record the gender(s) a young person says they are currently attracted to for use in our anonymised data-sets.

In our most recent statistics (2015), of the young people seen in our service who were assigned male at birth and for whom we have data, around 30% were attracted to males, 30% to females, and 30% to both males and females (or other genders). The remaining approximately 10% of those for whom we have data described themselves as not being attracted to either males or females, or as asexual.

For young people assigned female at birth for whom we have data: over half were attracted to females, a quarter were attracted to males, just under 20% were to both males and females (or other genders), and a small percentage described themselves as asexual or as not being attracted to either males or females.

How do these figures relate to the general population of adolescents? It is hard to say. Estimates of sexual orientation (https://www.theguardian.com/politics/reality-check/2013/oct/03/gay-britain-what-do-statistics-say) at the population-level can vary widely. A YouGov survey (https://yougov.co.uk/news/2015/08/16/half-young-not-heterosexual/) in 2015 found that almost half of 18 to 24 year olds reported at least some level of same-sex attraction, although 83% of all respondents also described themselves as heterosexual. 10% described themselves as gay or lesbian. Many people report their sexual orientation continuing to develop into their adult lives so we do not know how the young people in our service will identify in terms of sexuality in 5, 10, or 15 years' time.

As we noted above, at GIDS we see young people of all different sexualities: some speak of themselves as heterosexual or straight, others as gay or lesbian, bisexual, pansexual or queer.

We see quite a lot of young people who identify as trans for a period of time before coming to understand themselves in terms of a (cisgender) gay or lesbian identity instead. We also see a number of people who have a trans identity but who do not wish to have physical interventions, such as hormone blockers, testosterone, or oestrogen. And there are of course many more levels of nuance and complexity to people's evolving identities and the terms they use for their experiences than our numerical data can describe. Whilst apparently neat categories for both sexuality and gender can sometimes provide a useful shorthand, for many people this does not adequately reflect their full experience.

Conversion therapy

Conversion therapy – defined as therapy which aims to attempt to change an individual's gender identity or sexual orientation – is unethical and damaging (http://www.psychotherapy.org.uk/UKCP_Documents/policy/MoU-conversiontherapy.pdf) to both individuals and communities. There is no credible evidence that such attempts do anything to change an individual's underlying feelings or their sense of self, although these may result in people trying to hide these feelings from others and can lead to psychological distress. The Gender Identity Development Service rejects the idea of conversion therapy in the strongest possible terms. We would consider all appropriate steps to protect a child's safety if we believed they were at risk of this from anyone else.

Our approach: empowering young people

Whilst we would never attempt to change a child or young person's gender identity or sexual orientation, we acknowledge that a child or young person's perceived gender identity or sexual orientation may change or develop during the time that they are with our service. This may be so even when at any one time they feel very sure that their identity or orientation is fixed.

For this reason we discuss collaboratively with young people and families the many possible identities and outcomes that their futures may hold in store. We think carefully with young people and parents about informed consent and we see our role in helping young people to make their own sense of who they are and what their priorities might be. This can sometimes include sensitively asking constructively challenging questions. Our supportive and neutral stance is affirmative towards however a young person has come to understand themselves (and however they will do so in the future) without seeking to confirm, reject, or impose upon them any of the options which are available.

Search

GIDS

Young people (/young-people)

Parents (/parents-and-carers)

Professionals (/professionals)

News & events (/news)

About us (/about-us)

Feedback and complaints (/about-us#feedback-and-complaints)

Contact us

Are you a service user or potential service user? If so use the details below:

Find us here (/contact-us)

T: 020 8938 2030/1 (tel:02089382030/1)

E: gids@tavi-port.nhs.uk (mailto:gids@tavi-port.nhs.uk)

Share

Privacy policy (https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/privacy-and-your-data/) | Cookies (/cookies) | The Tavistock and Portman NHS Foundation Trust © 2022

We consider the proposal that an "excuse" is necessary to contribute to public debate is an unacceptable assault on the freedom of expression.

Consultation Question 2.
7.3 We provisionally propose that the offence should cover the sending or posting of any letter, electronic communication, or article (of any description). It should not cover the news media, broadcast media, or cinema. Do consultees agree?

No. The distinction made here is artificial and unhelpful. Many journalists communicate through media such as Twitter. Conversely, non-journalists may express views through news or broadcast media. This distinction serves no useful purpose.

Consultation Question 3.
7.4 We provisionally propose that the offence should require that the communication was likely to cause harm to someone likely to see, hear, or otherwise encounter it. Do consultees agree?

Clearly no compassionate person would wish to cause harm. However, the term 'harm' is open to personal interpretation and people should not be required to modulate their language in order to avoid upsetting the most sensitive person in their audience. LGB Alliance is frequently told on Twitter that our communications cause harm to trans people. When we state biological facts (humans are a sexually dimorphic species; it is not possible to change sex; someone with a penis is not a woman; a man cannot become a lesbian) we are told that these communications seek to eliminate trans people from the face of the earth; that they are hate speech that deny the existence of trans people. This means that the 'likely to cause harm' test causes serious problems in the defence of scientific fact, women's rights, and LGB rights. Enacting legislation that would suppress discussion of such issues in the 'public square' would have a chilling effect on public debate. It could also have the effect of forcing gays and lesbians back into the closet and allowing unscientific theories to go unchallenged.

As Christopher Ferguson, Professor of Psychology at Stetson University, Florida, puts it: "These emotional attempts to suppress controversial or unpopular speech have increasingly made use of what I call the "Mourner's Veto"—individuals will say that a speaker or a piece of writing has caused them to become distressed or sad or angry or frightened, and they will support these claims with allegations of "harm" or even threats to their "right to exist." Reasonable debate and discussion then becomes impossible as activists make unfalsifiable but furiously emotive claims about alleged threats to their safety and wellbeing amid much weeping and claims of exhaustion and mental fragility. It is not healthy for the limits of permissible speech to be dictated by the most sensitive person in the room, nor to allow emotional appeals to supplant robust argument as the most effective strategy in a debate.' https://quillette.com/2020/12/03/resisting-the-mourners-veto/

Consultation Question 4.
7.5 We provisionally propose that the offence should require that the communication was likely to cause harm. It should not require proof of actual harm. Do consultees agree?

No. See the reply to point 7.4 above. The subjectivity of 'harm' is highly problematic, and these problems will be much amplified if there is no need to prove any sort of impact on a single person.

Consultation Question 5.
7.6 "Harm" for the purposes of the offence should be defined as emotional or psychological harm, amounting to at least serious emotional distress. Do consultees agree?

7.7 If consultees agree that "harm" should be defined as emotional or psychological harm, amounting to at least serious emotional distress, should the offence include a list of factors to indicate what is meant by "serious emotional distress"?

The law already provides protection from malicious communications that provoke serious emotional distress. What arises here is a major problem in the potential for claims of distress from those who are distressed by factual assertions, such as that only women menstruate, only women get pregnant, and that mothers breastfeed.

The reasonableness of the distress must surely be part of this. If anyone can claim 'serious emotional distress' with tears, claims of suicidal ideation and other responses that are not open to verification, such a clause is likely to become a tool of censorship. See the quotation from Ferguson at Question 3.

Consultation Question 6.
7.8 We provisionally propose that the offence should specify that, when considering whether the communication was likely to cause harm, the court must have regard to the context in which the communication was sent or posted, including the characteristics of a likely audience. Do consultees agree?

While this may seem reasonable, it creates major difficulties on such platforms as Twitter which are open to all. The likely audience is everyone in the world. Given the ease of mass communication, it is a simple matter for a lobby group, such as those asserting the importance of gender identity theory, to organise as part of any audience – making them a 'likely' part of that audience. If they so desire, they can assert the right of transwomen to be potential partners for lesbians and claim that those who disagree are harming them. This is not a fictitious example: it occurs on a regular basis.

Consultation Question 7.
7.9 We provisionally propose that the new offence should not include a requirement that the communication was likely to cause harm to a reasonable person in the position of a likely audience. Do consultees agree?

This question highlights the problems inherent in this proposal. Even the adjective 'reasonable' no longer has an agreed meaning. Some will say it is reasonable for a person to be able to declare whether they are a man or a woman, regardless of biology. Others (such as LGB Alliance) find that completely unreasonable. We again refer you to the quotation from Ferguson in our response to Question 3.

Consultation Question 8.
7.10 We provisionally propose that the mental element of the offence should include subjective awareness of a risk of harm, as well as intention to cause harm. Do consultees agree?

No. Again, there is far too much subjectivity here, and far too much potential for censorship and the weaponizing of a perceived "victim" status.

Consultation Question 9.
7.11 Rather than awareness of a risk of harm, should the mental element instead include awareness of a likelihood of harm?

No. The only sensible 'mental element' would be a clear and demonstrable intention to cause harm.

Consultation Question 10.
7.12 Assuming that there would, in either case, be an additional requirement that the defendant sent or posted the communication without reasonable excuse, should there be:
(1) one offence with two, alternative mental elements (intention to cause harm or awareness of a risk of causing harm); or
(2) two offences, one with a mental element of intention to cause harm, which would be triable either-way, and one with a mental element of awareness of a risk of causing harm, which would be a summary only offence?

We cannot answer this since we reject the premise that a 'reasonable excuse' should be required.

Consultation Question 11.
7.13 We provisionally propose that the offence should include a requirement that the communication was sent or posted without reasonable excuse, applying both where the mental element is intention to cause harm and where the mental element is awareness of a risk of harm. Do consultees agree?

Consultation Question 12.
7.14 We provisionally propose that the offence should specify that, when considering whether the communication was sent or posted without reasonable excuse, the court must have regard to whether the communication was or was meant as a contribution to a matter of public interest. Do consultees agree?

Clearly a remark on a matter of public interest deserves more protection than a personal comment aimed at an individual. Those posting malicious comments aimed at individuals can already be prosecuted under existing legislation.

We are very concerned by the Commission's example regarding the tweets posted by JK Rowling further to 5.185:
'We do not doubt that these Tweets had the capacity to cause distress, especially to transgender people. For example, the LGBT+ organisation GLAAD responded to J K Rowling saying: "We stand with trans youth, especially those Harry Potter fans hurt by her inaccurate and cruel tweets."'
The Commission's comment that 'a court would very likely find that [these tweets] were sent or posted with reasonable excuse' is shockingly timid. This is a serious step towards draconian censorship. We strongly object to any attempt to stifle perfectly reasonable views because they are met with reactions we consider irrational and frankly absurd.

Consultation Question 13.
7.15 We invite consultees' views as to whether the new offence would be compatible with Article 10 of the European Convention on Human Rights.

Article 10 of the ECHR protects freedom of expression. It is our view that the proposed criminalisation would not be compatible with Article 10.

Consultation Question 14.
7.16 We invite consultees' views as to whether the new offence would be compatible with Article 8 of the European Convention on Human Rights.

Consultation Question 15.
7.17 In addition to our proposed new communications offence, should there be a specific offence covering threatening communications?

This is the only addition that we feel would be a helpful step forwards. People in high-profile positions, especially parliamentarians and academics and especially women, receive rape and death threats on a daily basis. Although these are already covered by existing legislation, we do think it is worthwhile considering adding a specific offence covering such threats.

Consultation Question 16.
7.18 Do consultees agree that the offence should not be of extra-territorial application?

We oppose the general tenor of the proposed offence. But given the international nature of social media such as Twitter, we believe that ruling out extra-territorial application makes no sense.

Consultation Question 17.
7.19 We provisionally propose that section 127(2)(c) should be repealed and replaced with a specific offence to address hoax calls to the emergency services. Do consultees agree?

Consultation Question 18.
7.20 We provisionally propose that section 127(2)(a) and (b) of the Communications Act 2003 should be repealed and replaced with a new false communications offence with the following elements:
(1) the defendant sent a communication that he or she knew to be false;
(2) in sending the communication, the defendant intended to cause non-trivial emotional, psychological, or physical harm to a likely audience; and
(3) the defendant sent the communication without reasonable excuse.
(4) For the purposes of this offence, definitions are as follows:
(a) a communication is a letter, electronic communication, or article (of any description); and
(b) a likely audience is someone who, at the point at which the communication was sent by the defendant, was likely to see, hear, or otherwise encounter it.
Do consultees agree?

Consultation Question 19.
7.21 We provisionally propose that the conduct element of the false communications offence should be that the defendant sent a false communication, where a communication is a letter, electronic communication, or article (of any description).
Do consultees agree?

Consultation Question 20.
7.22 We provisionally propose that the mental element of the false communications

offence should be:
(1) the defendant knew the communication to be false; and
(2) the defendant, in sending the message, intended to harm a likely audience,
where harm is defined as any non-trivial emotional, psychological, or physical harm.
Do consultees agree?

We have already answered this question in the replies to questions 8 and 9.

Consultation Question 21.
7.23 We provisionally propose that the false communications offence should include a requirement that the communication was sent without reasonable excuse. Do consultees agree?

No. The notion that communications that may upset someone must have a 'reasonable excuse' amounts to censorship.

Consultation Question 22.
7.24 Should there be a specific offence of inciting or encouraging group harassment?

No. This would be far too difficult to prove

Consultation Question 23.
7.25 Should there be a specific offence criminalising knowing participation in uncoordinated group ("pile-on") harassment?

See the reply to question 22.

Consultation Question 24.
7.26 We provisionally propose that section 66 of the Sexual Offences Act 2003 should be amended to include explicitly the sending of images or video recordings of one's genitals. Do consultees agree?

Yes. We consider this a sensible proposal.

Consultation Question 25.
7.27 Assuming that section 66 of the Sexual Offences Act 2003 is amended to include explicitly the sending of images or video recordings of one's genitals, should there be an additional cyber-flashing offence, where the conduct element includes sending images or video recordings of the genitals of another?

Consultation Question 26.
7.28 Assuming that section 66 of the Sexual Offences Act 2003 is amended to include explicitly the intentional sending of images or video recordings of one's genitals, should there be an additional cyber-flashing offence, where a mental or fault element includes other intended consequences or motivations, beyond causing alarm or distress?
7.29 Further, should the defendant's awareness of the risk of causing harm (whether alarm or distress, or otherwise) be sufficient to establish this mental or fault element of the cyber-flashing offence?

Consultation Question 27.
7.30 Should there be a specific offence of glorification of violence or violent crime? Can consultees provide evidence to support the creation of such offence?

Yes. Women known abusively as 'TERFs' are frequently targeted with violent images and words seeking to glorify such violence. A very large number of examples are catalogued at https://terfisaslur.com/

Consultation Question 28.
7.31 Can consultees suggest ways to ensure that vulnerable people who post nonsuicide self-harm content will not be caught by our proposed harm-based offence?

Consultation Question 29.
7.32 Should there be a specific offence of encouragement of self-harm, with a sufficiently robust mental element to exclude content shared by vulnerable people for the purposes of self-expression or seeking support? Can consultees provide evidence to support the creation of such an offence?

Consultation Question 30.
7.33 We welcome consultees' views on the implications for body modification content of the possible offences of:
(1) glorification of violence or violent crime; and
(2) glorification or encouragement of self-harm.

Final List of Consultation Responses Submitted by LGBA

1. Committee on Standards in Public Life

Consultation Title: Inquiry into APPGs

Date: 20.11.20

Link to Call for Evidence:

https://committees.parliament.uk/call-for-evidence/268/allparty-parliamentary-groups/

LGBA Submission:



Committe on Standards - inquiry in

2. Women and Equalities Committee

Consultation Title: The Government's response to GRA reform

Date: 27.11.20

Link to Call for Evidence:

https://committees.parliament.uk/call-for-evidence/291/reform-of-the-gender-recognition-act/

LGBA Submission:

https://committees.parliament.uk/writtenevidence/17828/html/ Link to our submission on WESC website



WESC Reform of the GRA.pdf

3. Law Commission

Consultation Title: Reforms to hate crime laws to make them fairer, while also protecting freedom of expression

Date: 24.12.20

Link to Consultation:

https://www.lawcom.gov.uk/project/hate-crime/#hate-crime-consultation-paper

LGBA Submission:

https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2021/12/CS-Redactions-1501-1700new-DONE.pdf (from p. 948)



Law Commission Hate Crime Consultati

4. Digital, Culture, Media and Sport Committee

Consultation Title: Sport in our communities Inquiry

Date: 11.12.20

Link to Call for Evidence:

https://committees.parliament.uk/work/647/sport-in-our-communities/

LGBA Submission:

https://committees.parliament.uk/writtenevidence/19033/html/

DCMS Sport in our Communities.pdf

5. Law Commission

Consultation Title: Consultation on reform of the communications offences

Date: 18.12.20

Link to Consultation:

https://consult.justice.gov.uk/law-commission/online_comms/

LGBA Submission:

Final - Law Commission Commur

6. Ofsted

Consultation Title: Changes to the publication of statistics on further education and skills inspections and outcomes

Date: 22.01.21

Link to Consultation:

https://www.gov.uk/government/consultations/changes-to-the-publication-of-statistics-on-further-education-and-skills-inspections-and-outcomes

LGBA Submission:

Ofsted data consultation 22nd jan

7. Committee on Standards in Public Life

Consultation Title: Standards Matter 2: Public Consultation and Public Sector Survey

Date: 29.01.21

Link to Consultation:

https://www.gov.uk/government/consultations/standards-matter-2-public-consultation-and-public-sector-survey

LGBA Submission:

SM2_Public_Consultaton_Submissions_Redacted_V2.pdf (publishing.service.gov.uk) (Submission No. 87)



Submission standards in public lif

8. Joint Committee on Human Rights

Consultation Title: Freedom of expression Inquiry

Date: 31.01.21

Link to Call for Evidence:

https://committees.parliament.uk/call-for-evidence/307/freedom-of-expression/

LGBA Submission:

https://committees.parliament.uk/writtenevidence/22175/html/



JCHR Freedom of Expression Consultati

9. Women and Equalities Committee

Consultation Title: The role of the GEO: embedding equalities across government

Date: 17.02.21

Link to Call for Evidence:

https://committees.parliament.uk/call-for-evidence/368/the-role-of-the-geo-embedding-equalities-across-government/

LGBA Submission:

https://committees.parliament.uk/writtenevidence/22894/html/



GEO Embedding Equalities accross Gov

10. UK Statistics Authority

Consultation Title: UK Statistics Authority Inclusive Data Consultation

Date: 26.03.21

Link to Consultation:

UK Statistics Authority Inclusive Data Consultation - Office for National Statistics - Citizen Space

Review of how inclusive data and evidence are across the UK. To help support the work of the Inclusive Data Taskforce

LGBA Submission:

The consultation response was submitted as an online form. The content of the submission can be found in the attached Word document.

UK Statistics Authority - Inclusive D

11. Digital, Culture, Media and Sport Committee

Consultation Title: Influencer Culture Inquiry

Date: 07.05.21

Link to Call for Evidence:

Influencer culture - Committees - UK Parliament

LGBA Submission:

DCMS Influencer consultation - Final M

12. Digital, Culture, Media and Sport Committee

Consultation Title: Major cultural and sporting events Inquiry

Date: 14.05.21

Link to Call for Evidence:

Major cultural and sporting events - Committees - UK Parliament

LGBA Submission:

DCMS Major cultural and sporting May 202

13. Department of Health and Social Care

Consultation Title: Women's Health Strategy: Call for Evidence

Date: 13.06.21

Link to Call for Evidence:

Women's Health Strategy: Call for Evidence - GOV.UK (www.gov.uk)

LGBA Submission:



Final LGB Alliance, Women's Health Strat

14. Foreign Affairs Committee

Consultation Title: Tech and the future of UK foreign policy Inquiry

Date: 22.06.21

Link to Call for Evidence:

Tech and the future of UK foreign policy - Committees - UK Parliament

LGBA Submission:



FAC - Tech and the future foreign policy -

15. Welsh Government

Consultation Title: Curriculum for Wales guidance and code for Relationships and Sexuality Education (RSE)

Date: 16.07.21

Link to Call for Evidence:

Curriculum for Wales guidance and code for Relationships and Sexuality Education (RSE) | GOV.WALES

LGBA Response:



LGB Alliance, response to Welsh RS

16. Department of Health and Social Care

Consultation Title: Consultation on the appointment and operation of the Patient Safety Commissioner

Date: 05.08.21

Link to Call for Evidence:

Consultation on the appointment and operation of the Patient Safety Commissioner - GOV.UK (www.gov.uk)

LGBA Submission:



Patient Safety Commissioner consul

17. Scottish Government - Equalities, Human Rights and Civil Justice Committee

Consultation Title: Views on 'End Conversion Therapy' Petition

Date: 13.08.21

Link to Call for Evidence:

Views on the 'End Conversion Therapy' petition - Scottish Parliament - Citizen Space

LGBA Submission:

Response 112727299 to Views on the 'End Conversion Therapy' petition - Scottish Parliament - Citizen Space



Scottish Gov Conversion Therapy p

18. Digital, Culture, Media and Sport Committee

Consultation Title: Online Safety and online harms Inquiry

Date: 03.09.21

Link to Call for Evidence:

Online safety and online harms - Committees - UK Parliament

LGBA Submission:

https://committees.parliament.uk/writtenevidence/38745/html/



DCMS Online Safety and Online Harms.pdf

19. Joint Committee on Draft Online Safety Bill

Consultation Title: Draft Online Safety Bill

Date: 16.09.21

Link to Call for Evidence:

Draft Online Safety Bill - Committees - UK Parliament
*Special committee set up to scrutinise this Bill**. We were invited to make a submission**.*

LGBA Submission:

Joint Committee on draft Online Safety Bil

20. Health and Social Care Committee

Consultation Title: NHS Litigation reform Inquiry

Date: 20.10.21

Link to Call for Evidence:

NHS litigation reform - Committees - UK Parliament

LGBA Submission:

NHS litigation reform - Oct 2021.pdf

21. Welsh Government

Consultation Title: LGBTQ+ Action Plan

Date: 22.10.21

Link to Call for Evidence:

LGBTQ+ Action Plan | GOV.WALES

LGBA Submission:

Welsh Gov LGBTQ+ Action Plan - LGBA Re

22. Financial Conduct Authority

Consultation Title: Diversity and inclusion on company boards and executive committees

Date: 20.10.21

Link to Consultation:

CP21/24: Diversity and inclusion on company boards (fca.org.uk)

LGBA Submission:

LGBA Response to Financial Conduct Aut

23. Joint Committee on Human Rights

Consultation Title: Protecting human rights in care settings

Date: 02.11.21

Link to Consultation:

Protecting human rights in care settings - Committees - UK Parliament

LGBA Submission:

JCHR Protecting human rights in a care

24. UN Human Rights Office of the High Commissioner

Consultation Title: Invitation to submit inputs to the OHCHR's "Report to the Human Rights Council on the realisation of the right of persons affected by violence and discrimination based on sexual orientation and gender identity to the enjoyment of the highest attainable standard of physical and mental health, in relation to SDG3"

Date: 25.02.22

Link to Consultation:

https://www.ohchr.org/en/issues/sexualorientationgender/pages/index.aspx

LGBA Submission:

OHCHR Feb 2022 - The Independent Expe

25. Government Equalities Office

Consultation Title: Banning Conversion Therapy

Date: 04.02.22

Link to Consultation:

Banning conversion therapy - GOV.UK (www.gov.uk)
Annex A: Consultation questions - GOV.UK (www.gov.uk)

LGBA Submission:



GEO Banning Conversion Therapy -

26. Health and Social Care Committee

Consultation Title: Impact of body image on physical and mental health

Date: 22.01.22

Link to Consultation:

The impact of body image on physical and mental health - Committees - UK Parliament
Includes a section on impact of cosmetic surgery and whether there is adequate advice/support for people considering cosmetic surgery.

LGBA Submission:



Final body image submission.pdf

Additional Consultations where we submitted a response but don't have the submissions to hand

1. **UN Human Rights Office of the High Commissioner**

Consultation Title: Call for input to a thematic report: Gender, sexual orientation and gender identity

Date: 28.02.21

Link to Call for Input:

OHCHR | Gender theory

2. **Home Office**

Consultation Title: Violence against women and girls (VAWG) Call for Evidence

Date: 19.02.21

Link to Call for Evidence:

https://www.gov.uk/government/consultations/violence-against-women-and-girls-vawg-call-for-evidence

3. **Department for Education**

Consultation Title: Keeping children safe in education: proposed revisions 2021

Date: 04.03.21

Link to Consultation:

https://consult.education.gov.uk/safeguarding-in-schools-team/keeping-children-safe-in-education-schools-and-col/

Seeking views on revisions to statutory guidance which sets out what schools are required to comply with to keep children safe.

4. **Women and Equalities Committee**

Consultation Title: Gender Sensitive Parliament Inquiry

Date: 31.03.21

Link to Call for Evidence:

Gender Sensitive Parliament - Committees - UK Parliament

Inquiry to make recommendations to create a more "gender-sensitive" parliament.

5. **Office for Statistics Regulation**

Consultation Title: Collecting and reporting data about sex in official statistics

Date: 06.04.21

Link to Consultation:

Draft Guidance: Collecting and reporting data about sex in official statistics – Office for Statistics Regulation (statisticsauthority.gov.uk)

6. **Home Office**

Consultation Title: Independent review: Political violence and disruption

Date: 14.05.21

Link to Consultation:

Independent review: Political violence and disruption - GOV.UK (www.gov.uk)

7. **Equality and Human Rights Commission**

Consultation Title: Strategic Plan for 2022 to 2025

Date: 30.09.21

Link to Consultation:

Our strategic plan for 2022 to 2025: have your say | Equality and Human Rights Commission (equalityhumanrights.com)

8. **Women and Equalities Committee**

Consultation Title: Equality and the UK asylum process

Date: 08.11.21

Link to Consultation:

Equality and the UK asylum process - Committees - UK Parliament

Relationships and sexuality education (RSE) statutory guidance and code

Consultation response form

Your name:

Organisation (if applicable): LGB Alliance

e-mail/telephone number:

Your address: Kemp House 152-160 City Road London EC1V 2NX

Responses should be returned by **16 July 2021** to:

Curriculum and Assessment Division
The Education Directorate
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

or completed electronically and sent to:

e-mail: curriculumforwales@gov.wales

Respondent type (please select one from the following)

Child or young person	☐	Employer/business representative	☐
Parent/carer	☐	Professional body/interest group	☐
Schools governor or member of school management committee	☐	Voluntary sector (community group, volunteer, self-help group, social or co-operative enterprise, religious, not for profit organisation)	✓
Mainstream school practitioner (head, teacher, teaching assistant, etc.)	☐	Regional consortium	☐
EOTAS provider (PRU staff, independent school staff, other provider, etc.)	☐	Local authority	☐
Higher education (including universities/academic institutions)	☐	Further education	☐
Politician (Senedd member, county councillors, MP, etc.)	☐	Other respondent group not listed above, please specify:	☐
Lobbyist	☐	Prefer not to say	☐

Question 1 – Do you agree that the explanation of the definition of RSE is clear?

Strongly disagree	☐	**Disagree**	✓	**Neither agree nor disagree**	☐	**Agree**	☐	**Strongly agree**	☐

Please explain your answer:

The definition uses the term ‘sexuality’ which is defined in the glossary as including ‘gender identities and rôles’. While this is (sadly) a WHO definition, ‘gender identity’ is a queer theory concept, a much-contested idea that is about some inner sense of the ‘gender’ with which one ‘identifies’. It is a queer theory idea that this can be included in ‘sexuality’, a word that is generally understood to refer to sexual feelings and responses. The definition of RSE obfuscates these issues.

The way the term ‘sexuality’ is commonly understood relates to sexual desire, and not what parents want their young children to be taught about.

The absence of specific mention of gay and lesbian sexuality is concerning.

As described in the glossary, the term ‘gender’ is used in several different ways, which makes understanding difficult. It is used as a synonym for sex (biology); as a reference to ‘identity; relating to social norms; and concerning harmful stereotypes.

It is a matter of considerable concern that unscientific terms from gender ideology/queer theory are given throughout the document. 'Gender identity', 'assigned sex' and 'non-binary' have no scientific validity, are not neutral and should not be presented as factual.

Question 2 – Do you agree that the principles for embedding RSE are clear?

Strongly disagree	☐	**Disagree**	☐	**Neither agree nor disagree**	✓	**Agree**	☐	**Strongly agree**	☐

Please explain your answer:

Some aspects seem entirely reasonable, but far too much is vague and undefined. Sadly, the bias inherent in the terms used (see response to Question 1) make it impossible to feel that the principles for embedding RSE are transparent. There is a dogma, a theory, a belief system being promoted here.

It is worrying that despite the Guidance stating that "Effective RSE requires specialist expertise, time and resources" and "Provision should draw on specialist services and expertise" there is no advice or guidance to schools concerning appropriate sources of such services and expertise. Until the DfE issued statutory guidance for English schools, some of the material in use compromised safeguarding obligations and even failed to state the law accurately. This is liable to happen in Wales unless clear advice and guidance is given to prevent it.

Question 3 – Do you agree that the structure and content of the guidance clear?

Strongly disagree	☐	**Disagree**	✓	**Neither agree nor disagree**	☐	**Agree**	☐	**Strongly agree**	☐

Please explain your answer:

Given the conflation of 'sex' and 'gender', and the confusing definitions given in the glossary (which do not match up with common understandings), there is a considerable risk of misunderstandings. The failure to properly identify safeguarding issues and appropriate expertise on this matter leaves staff without clarity about such key issues as the frequency with which children on the autism spectrum, who often experience gender dysphoria, are led to believe they 'are transgender' and hence embark on a course potentially leading to sterility.

The lack of specified content concerning same-sex attraction means that this aspect of human sexuality may not be effectively included in the curriculum, and the danger of same-sex attraction being conflated with 'gender identity', such that e.g. young lesbians are led to believe they are 'really' boys, is considerable. It is essential that the absolute distinction between same-sex attraction and 'gender identity' is properly covered and that the myth of 'same-gender' attraction is not promulgated.

Question 4 – We propose that the content set out in the three broad stages of the guidance will become mandatory as part of the RSE code. Do you agree that they encompass what is important about RSE for all learners' ages and developmental stages?

Strongly	☐	**Disagree**	✓	**Neither agree**	☐	**Agree**	☐	**Strongly**	☐

disagree				**nor disagree**				**agree**	

Please explain your answer:

We are concerned that without proper safeguarding advice and support, it is possible that the curriculum guidance will encompass matters in ways that few parents would expect, understand or support.

One strand concerns 'kindness'. It is hard to object to the idea that one should 'be kind', but unfortunately this is used by groomers and abusers, and particularly disadvantages girls who are too often expected to 'be kind' to their own disadvantage, even to acquiescing to sexual abuse.

The failure to make explicit mention of lesbian and gay sexuality, and to make efforts to explicitly counter the homophobia to which many are subjected and the way the terms 'lesbian' and 'gay' are used as terms of abuse among schoolchildren, means that this guidance does not serve lesbian, gay and bisexual children in schools.

Question 5 – Do you agree that the RSE code section of the guidance is clear and appropriate?

Strongly disagree	☐	**Disagree**	✓	**Neither agree nor disagree**	☐	**Agree**	☐	**Strongly agree**	☐

Please explain your answer:

Once again, the lack of clarity about the definitions of terms used makes the guidance itself unclear.

Question 6 – Do you agree that the mandatory elements of the guidance (the RSE code) are the right ones? Is anything missing that should be included?

Strongly disagree	☐	**Disagree**	✓	**Neither agree nor disagree**	☐	**Agree**	☐	**Strongly agree**	☐

Please explain your answer:

Where is the information about sexism, sex discrimination and sexual harassment; grooming and how to recognise this, online and offline; such sex-based matters as FGM; the problem of drugs (both legal and illegal)? While there are a few mentions of LGBTQ+, the specific need to talk about lesbians and gay men, homophobia, and the distinction between LGB and 'transgender' is nowhere to be found. This should not be left up to the awareness of the individual school.

Question 7 – Do you agree that the guidance offers relevant information to support practitioners when designing their school curriculum for RSE?

Strongly	✓	**Disagree**	☐	**Neither agree**	☐	**Agree**	☐	**Strongly**	☐

disagree				**nor disagree**				**agree**	

Please explain your answer:

As mentioned previously, the lack of guidance for sources of information is of considerable concern, given the many ideologically-driven groups providing such information to schools from the viewpoint of queer theory/gender identity ideology. There is no effective guidance on safeguarding or sources of such support. The failure to provide links to balanced sources of help and support for children experiencing gender confusion leaves schools liable to influence from biased lobby groups.

It is also puzzling that a curriculum intended to be consistent across Wales leaves so much to the vagaries of individual schools, their knowledge and expertise (or lack thereof) and the possibility of biased sources of materials being promoted.

Question 8 – We would like to know your views on the effects that the RSE draft statutory guidance would have on the Welsh language, specifically on:

i) opportunities for people to use Welsh
ii) treating the Welsh language no less favourably than the English language.

What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

Supporting comments

Question 9 – Please also explain how you believe the proposed RSE draft statutory guidance could be formulated or changed so as to have:

i) positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language
ii) no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

Supporting comments

Question 10 – We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them.

Responses to consultations are likely to be made public, on the internet or in a report. If you would prefer your response to remain anonymous, please tick here: ☐

Help and advice

WordPress <wordpress@lgballiance.org.uk> 2 February 2022 at 14:55
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Help and advice

Message Body:
Hello LGB Alliance, my name is [redacted] I hope this reaches you as I don't know who else to turn to. I'm 17 years old and I recently realised I was gay. When I told my parents about it, I thought they'd understand, but my mum is Christian and my dad yells at me and tells me it's not natural. He's banned me from going on the computer and taken my phone away. I'm not allowed to see my friends outside of college. I feel so lonely and isolated. I can't turn to the police because it's not like they hit me or anything. I've thought about running away but I have nowhere to go I'd be on the street. What should I do? I've seen other charities like stonewall being criticised for taking extremist stances I don't really understand it but I know I don't wish I was a woman or whatever. But I can't keep going like this my friends talk to me less and I don't know what to do. Thank you.

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

New Message From LGB Alliance

2 messages

[redacted] <mail@lgballiance.org.uk> 22 January 2021 at 01:27
Reply-To: "[redacted]
To: lgballiancefuture@gmail.com

Hi, I'm sorry to be contacting you over a question that seems so trivial but I don't know who to turn to anymore. I recently objected to the word queer being used and was shamed for it. This word for me personally has such negativity and so many bad memories attached to it that upon hearing it I have panic attacks. I was told that the word had now been reclaimed and that it was fine to be used now and was shocked to hear my friend, a lesbian, using it to refer to herself. Has this word been reclaimed? Is this right? Am I so out of touch that I'm over reacting? I hate this word but maybe if this is true maybe I can learn to I've with it. Apologies again for taking this question but there is so much disinformation out there that I just don't know what to believe anymore.
Kindest regards
A lesbian, female homosexual.
[redacted]
Subject: Question re queer

LGB Alliance <lgballiancefuture@gmail.com> 22 January 2021 at 09:36
To: [redacted]

Hi [redacted]

Thanks for getting in touch.

Personally, I can't stand the word "queer", and feel it is unfortunate how many younger people use it to just mean they feel different to "the norm" when it comes to sex, sexuality, gender identity etc.

The word hasn't been "reclaimed" and I think it is fine to stand up and say you don't like the word because of the historical connotations of it's use as a homophobic slur. If others choose to use it to refer to themselves you can say you don't agree but that it's up to them.

If it is in a workplace context you could ask for a meeting with HR to ask their advice, and explain that you understand people wanting to use it to describe themselves but that some recognition is needed of the homophobic nature of how this word has been used, and still is used.

Hope that helps in some way.

thanks again,

James

LGB Alliance Steering Group member.
[Quoted text hidden]

Resources for young people

WordPress <wordpress@lgballiance.org.uk> 16 May 2021 at 21:55
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Resources for young people

Message Body:
Hi, I'm really keen to find some LGB specific info for young people - to give to my daugther's secondary school, I have a meeting with them in June. I know a small group was set up at some point (early days of LGBA) - has that progressed? Can I be part of it?

I also just came across this on Stonewall's site - from the good old days! https://www.stonewall.org.uk/system/files/so_you_think_your_child_is_gay.pdf.

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

Homophobic misinformation at work

WordPress <wordpress@lgballiance.org.uk> 8 June 2021 at 10:03
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Homophobic misinformation at work

Message Body:
Hi, I've no idea if you can help point me to useful resources or give advice but it may just be good for you to know what's happening. I want to challenge this with my employer.

Here goes...! I work at a medium financial services mutual, we signed up to stonewall last year. My colleague has challenged our membership, referencing all the bad press from the last 2 weeks but HR still think it's a good idea.

We have removed references to women and mothers in our maternity policy and have allyship training next month.

Our intranet and internal emails - as of last week - are full of this kind of rhetotic "gay refers to attraction towards or desire for the same gender (or similar genders to one's own). Homosexual and homoromantic can be considered synonyms or subcategories of gay".

Lesbians come off even worse and are "gay women, meaning a woman, woman-aligned or feminine-aligned person who is attracted to women, woman-aligned or feminine-aligned people.

The term is also used by neutral-aligned, abinary or unaligned non-binary people, feminine aligned people and other non-binary people who identify as lesbians.

It is sometimes more broadly defined as non-men attracted non-men...".

It reads like it has been lifted from tumblr by the lgbt+ contingent of the d&i group but is presented uncritically, and is being promoted.

If you can point me to any resources to help me challenge this I would be very grateful. If not, it is another anecdote which demonstrates the terrible state we're in.

Thanks
[redacted]

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

Advice needed

WordPress <wordpress@lgballiance.org.uk> 11 February 2022 at 16:13
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Advice needed

Message Body:
I was hoping someone could ring me to offer some advice please.
I am in complete support of you. Passionately! I recently attended a work meeting for diversity and before I knew it I was declaring myself a proud gay woman and asking them about unisex toilets and if they know the difference between sex and gender or being swept along as society is. I now have a bundle of meetings with directors all very interested in the research I have been doing, my support of you and my own experiences. Very positive. But I regret being recorded in case I become a target too.
I met a few of you at the women's conference in Dalston in 2019 I think it was and have since then been so warmed that I can have allies. I am not on social media but feel I need to return, at least if it is to find out the next conference of yours, but I suspect that will be hush hush due to the venue needing to be kept secret.
I have started donating to you and expressed interest in volunteering. I am more passionate about these issues than my own career and may work towards changing.
I need advice in obtaining correct statistics for the director to take notice etc but also how to join the next event you have.
Thank you!
[redacted]

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

Support groups for academics

1 message

WordPress <wordpress@lgballiance.org.uk> 18 May 2021 at 14:41
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Support groups for academics

Message Body:
Hi there. I would like to know if there is an informal network or support group for LGB-affiliated academics who work in the area of gender and sexuality studies. As you will appreciate, this can be a stressful environment to work in for those who are questioning academic orthodoxies about gender and have reservations with the LGBTQIA+ acronym etc. I'd really like to be able to reach out and build community with other academics who broadly support the aims of the LGB alliance (particularly recognising the importance of biology). I'm unsure what to do, and feel quite lonely as I don't feel I can voice my real thoughts to my immediate colleagues. Your advice / help would be much appreciated. Kind regards, [redacted]

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

Gmail LGB Alliance <lgballiancefuture@gmail.com>

New Message From LGB Alliance

[redacted] <mail@lgballiance.org.uk> 20 April 2021 at 17:26
Reply-To: "\"[redacted]
To: contact@lgballiance.org.uk

Hello there,

My purpose in contacting your group is to inquire whether you would accept a student voice into your team, namely my own. Due to your groups recent progression into charity status, I was surprised.

As someone who is bisexual and has a personal understanding of DSDs, I value the understanding that sex and gender are separate, that sex is binary, and that those ideals are important in the protection of LGB individuals and their rights. So I wish to see this charity succeed in it's goals toward protecting us.

The problem is, I have concerns that holding those opinions will be disregarded due to my age, minimal experience and the fact that I am also transgender. I want to explain why those facts do not matter when it comes to my opinions regarding your group

First of all, at my age I am not yet considered a "Mature Student", however, I am over the age of 18. I believe that given the seriousness of my approach to politics, my right to vote and my history in scouting, joining a charity group is perfectly reasonable even at my young age. Secondly, in college I had involvement in the Student Union and progressed into the role of Student President before I left. I feel that experience has given me a great understanding of how to operate as a representative of student experiences and I plan on continuing to involve myself in the Student Union at University. The final reason why this doesn't matter is that, your group is a charity focused on LGB rights, people view you as an anti-trans hate group and having an inside trans perspective would negate that affect since I would be able to explain how to avoid damaging progression of trans rights while enforcing LGB protections.

I have repeatedly seen quotes from your group, in news articles, speaking against the progression of trans medical rights. As a charity focused on LGB, it is important that you avoid negative involvement in the trans rights movement to remain in good standing.

With all that said, please consider my involvement in your charity. I would love to hear back from you regardless of the answer.

Yours sincerely,
[redacted]
Subject: UK Student Voice for LGB Alliance

Safe resources for LGB youth

WordPress <wordpress@lgballiance.org.uk> 2 February 2022 at 12:53
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Safe resources for LGB youth

Message Body:
I am trying to find safe resources for young people in foster care to link to for an information leaflet, but am drawing a blank. Everything I find is trans focused. Please can you help? There must be something out there for LGB young people.

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

How far you've shifted the Overton Window

1 message

WordPress <wordpress@lgballiance.org.uk> 4 February 2022 at 13:41
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: How far you've shifted the Overton Window

Message Body:
Hello All, A quick email from my real email address, and my real name to let you know the impact you have had in less than a year.

I first sent you a donation not long after your inception from another email and with no name. I was so paranoid I rang afterwards and asked you to check no records would be kept.

Yet yesterday - less than a year later - I attended a work meeting wearing one of your hoddies. (I'd love to say this went down well, but it was not entirely without consequence. I've since been 'invited' to a meeting to 'discuss' my views on sex and gender, which I expect will be a reprimand.)

However, I'm also very happy to attend this 'discussion', because the issues are ones that I believe need to be discussed more and more openly. The best way to bleach bad ideas in the light.

But most strikingly of all, these are no longer views I am frightened to own or share, and thanks in no small part thanks to you all.

So huge thanks and best wishes from me,

[redacted]

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

LGB ALLIANCE

Charity number: 1194148

Recently registered

Charity overview

What, who, how, where

Governance

Trustees

Financial history

Accounts and annual returns

Governing document

Contact information

Governing document

> Details of the type of governing document the charity has and when it was established.
> It is not the full text of the charity's governing document.

MEMORANDUM AND ARTICLES INCORPORATED 28 NOV 2019

Charitable objects

2. OBJECTS THE OBJECTS OF THE COMPANY ARE: 2.1 TO PROMOTE EQUALITY AND DIVERSITY FOR THE PUBLIC BENEFIT, IN PARTICULAR BY: 2.1.1 THE ELIMINATION OF DISCRIMINATION ON THE GROUNDS OF SEXUAL ORIENTATION; 2.1.2 ADVANCING EDUCATION AND RAISING AWARENESS IN EQUALITY AND DIVERSITY IN RESPECT OF LESBIAN, GAY AND BISEXUAL PEOPLE; 2.1.3 CONDUCTING OR COMMISSIONING RESEARCH ON EQUALITY AND DIVERSITY ISSUES AND PUBLISHING THE USEFUL RESULTS TO THE PUBLIC; AND 2.1.4 CULTIVATING A SENTIMENT IN FAVOUR OF EQUALITY AND DIVERSITY FOR LESBIAN, GAY AND BISEXUAL PEOPLE. 2.2 TO PROMOTE HUMAN RIGHTS (AS SET OUT IN THE UNIVERSAL DECLARATION OF HUMAN RIGHTS AND SUBSEQUENT UNITED NATIONS CONVENTIONS AND DECLARATIONS) AND PARTICULARLY THE RIGHTS AND FREEDOMS OF THOSE WHO FACE DISCRIMINATION ON THE GROUNDS OF SEXUAL ORIENTATION, INCLUDING BY: 2.2.1 MONITORING ABUSES OF HUMAN RIGHTS; 2.2.2 OBTAINING REDRESS FOR THE VICTIMS OF HUMAN RIGHTS ABUSES; 2.2.3 RELIEVING NEED AMONG THE VICTIMS OF HUMAN RIGHTS ABUSES; 2.2.4 RESEARCH INTO HUMAN RIGHTS ISSUES; 2.2.5 EDUCATING THE PUBLIC ABOUT HUMAN RIGHTS; 2.2.6 PROVIDING TECHNICAL ADVICE TO GOVERNMENT AND OTHERS ON HUMAN RIGHTS MATTERS; 2.2.7 CONTRIBUTING TO THE SOUND ADMINISTRATION OF THE LAW; 2.2.8 COMMENTING ON PROPOSED HUMAN RIGHTS LEGISLATION; 2.2.9 RAISING AWARENESS OF HUMAN RIGHTS ISSUES; 2.2.10 PROMOTING PUBLIC SUPPORT FOR HUMAN RIGHTS: 2.2.11

PROMOTING RESPECT FOR HUMAN RIGHTS AMONG INDIVIDUALS AND CORPORATIONS; AND 2.2.12 ELIMINATING INFRINGEMENTS OF HUMAN RIGHTS. 2.3 TO PROMOTE ANY OTHER PURPOSE THAT IS CHARITABLE UNDER THE LAW OF ENGLAND AND WALES.

Print charity details

LGB ALLIANCE

LGB Alliance
Kemp House
152-160 City Road
London, EC1V 2NX

Help Line – provide support for LGB young people where none exists today
Draft plan 8 July 2021

Goal: run a free of charge phone and web-based service for LGB young people & their families, providing relevant information and support.

Safeguarding procedures will be set up and monitored by strategic partners Safe Schools Alliance (confirmed) and Samaritans TBC

Operating hours 14.00 - 24.00 7 days a week

Projected costs London base:

Trained staff	£29,500.00	6	£177,000.00
Enhanced DBS checks	£40	6	£240.00
London weighting	£3,366.00	6	£20,196.00.
shift allowance 3.5%	£1,032.50	6	£6,195.00
NI-12%	£3540	6	£21,240.00
Pension-3% (minimum)	£885	6	£5,310.00
Recruitment	£3000	6	£18,000
office space	£24,000.00	1	£24,000.00
office furniture*	£6,000.00		
IT & telecoms	£30,000.00		£30,000.00
TOTAL			£307,971.00

Details:

- a desk, adjustable chair, under-desk set of drawers, meeting chair, one quarter of a meeting table and one fifth of a sofa – all delivered and installed-can buy second hand.
- Consider CCTV /Security
- Employers Liability Insurance
- Building Insurance-check level of cover with building owner/landlord
- Building accessibility
- Energy, utilities, and facilities maintenance costs - are these included in office space?
- Business rates subject to 80% relief **with 20% outstanding**

- Training costs
- Statutory sick pay £96.35 as a minimum. But usually three months on full pay, three months on half pay
- Cover if someone is ill. An additional wage for the duration of sickness absence.
- clinical supervision
- software for logging/tracking calls
- IT equipment if not included in costing

Full set of policies needed including:
DBS
Vulnerable adults
Safeguarding Policy
And others – this is just the beginning.

Apply for funding – perhaps for a smaller grant to scope the proposal first.

---------- Original Message ----------

From: "AFE@tnlcommunityfund.org.uk" <afe@tnlcommunityfund.org.uk>

To: "karen.duncombe@lgballiance.org.uk" <karen.duncombe@lgballiance.org.uk>

CC: "kate.harris@lgballiance.org.uk" <kate.harris@lgballiance.org.uk>

Date: 18/03/2022 13:58

Subject: Good news - you got the funding



Project ID: 20199142

Hello Karen

We're going to fund your idea
We're really happy to tell you we will be funding your project following your application for National Lottery Awards for All. And we want to give LGB Advice Scoping Project £9000 to help your community thrive.

Can you fill in this form so we know more about how the funding is helping your community.

We'll send the funding to your bank account
You should see the funding in your organisation's account in the next couple of weeks. So you can start spending it on the activities you told us about in your application.

Terms and conditions
We talked about how funding from The National Lottery comes with terms and conditions, so you might want to read the terms and conditions again.

Keep your receipts
We could ask to see receipts and invoices related to your funding for at least seven years. There's more information on our site about how to keep us up to date, and what sort of information you should keep: Managing your grant

Sharing your story
It's important to tell people your funding came from The National Lottery so as many people as possible see how we use the money raised by National Lottery players to support people and communities to thrive.

And telling everyone where your funding comes from will help you spread the word about your project, and the great work you're doing in your community.

We'll publish the good news on our website and send the story to local media.

You can share the good news about your National Lottery funding with your community and local MP before we publish anything. Have a look here to find out more on how to share the good news.

If you use facebook or twitter, we'd love to hear more about your project through these channels:

- facebook.com/TNLCommunityFund
- twitter.com/TNLComFund

You can also download our logo and order free branded materials
at https://www.tnlcommunityfund.org.uk/funding/managing-your-grant/promoting-your-project

If you want to share images ofpeople taking part in your project
Make sure you get their consent first. You'd normally do this with a consent form. Once you have the photos make sure they're stored safely.

We'd like to keep in touch – to see how you're getting on
We'll keep sending you email updates. They should help you with things like:

- how to publicise your funding
- information on other funding
- ideas and tips on projects from other fund holders.

And last, but not least – well done
Congratulations on your project funding. And thank you for everything you do to support your community.

If you have any questions at all, please get in touch
You can email grantmanagement.bc@tnlcommunityfund.org.uk

Best wishes,
Julie Galano
Head of Funding

Phone: 0345 4 10 20 30 (Opening hours: Monday to Friday, 9am-5pm) For those with a hearing or speech impairment: Text relay 18001 plus 0345 4 10 20 30 BSL users can contact us using SignVideo

Apex house, 3 Embassy Drive, Edgbaston, Birmingham, B15 1TR
Website | Twitter | Facebook



IMPORTANT PLEASE READ: This e-mail and its contents are confidential, and intended solely for the use of the individual to whom it is addressed, and protected by law . The contents of this message will not be in any way binding upon The Big Lottery Fund, now operating as The National Lottery Community Fund. Opinions, conclusions, contractual obligations and other information in this message, in so far as they relate to the official business of the Big Lottery Fund, must be specifically confirmed in writing by The National Lottery Community Fund. If you are not the intended recipient, please notify the sender immediately, be advised that you have received this email in error and that any use, dissemination, forwarding, printing, or copying of this email is strictly prohibited. Additionally, the information contained in this email may be subject to public disclosure under the Freedom of Information Act 2000. We take our responsibility to protect your data seriously. You can find our privacy policy by visiting our website : https://www.tnlcommunityfund.org.uk/about/customer-service/data-protection.