REPLY BY THE PRESIDENT OF
THE COMMITTEE FOR HEALTH & SOCIAL CARE
TO QUESTIONS POSED BY DEPUTY DUDLEY-OWEN PURSUANT TO RULE 14 OF THE RULES OF PROCEDURE

As a pretext to these supplementary questions which derive from the Committee's responses to Rule 14 questions dated 15th March 2023 (available here), it is important to clarify terminology for the avoidance of doubt.

Question 3 of the Adult section of those questions asked: "*Will the Committee fund medical, mental health, and surgical and other revision procedures for any person who has availed themselves of the gender services available through HSC who may subsequently wish to detransition?*"

HSC responded that "*De-transitioning is more of a social issue than one of surgery, but this would be supported if the individual was in need of HSC care."*

Whilst it is pleasing to know that HSC would support such care if it were needed, especially in the light of rapidly increasing numbers of detransitioners and the rise in legal actions against health providers by detransitioners across the western world, it appears there is a confusion of terminology.

Generally, it is understood that the act of stopping a social transition is considered 'desisting', whilst returning to acknowledge one's birth sex and ceasing to identify as transgender after undertaking transgender-affirming medical and/or surgical interventions is considered 'detransitioning'.

The terminology is not always clear but it is in this context that these terms are being used in these questions.

1. **In its response to Question 10 of the Children section of the previous Rule 14 questions, the Committee states: "*The Interim Cass Review supports the provision of the right, timely care for children with gender identity confusion, and recognises the significant mental health benefits where a young person is able to socially transition.*"**

   Stating that the review: "*…recognises the significant mental health benefits where a young person is able to socially transition",* appears to be a significant misreading by HSC of the report.

   In this quote from her report, Dr Cass states that whilst at the moment there are differing views, it is clear she believes the jury is still out on the harms vs benefits but, that the act of social transition is not a neutral act and more information about the outcomes is needed:

   > **"*Social transition may not be thought of as an intervention of 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. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes."

Statsforgender.org, citing academic papers, reports that:

"Pediatric transition doctors in the Netherlands who first pioneered the use of puberty blockers in dysphoric children observe that social transition correlates with an increase in young people's persistence when it comes to gender identity. This led them to caution against social transition before puberty.

***Another paper notes that gender dysphoria is more persistent into adolescence where social transition has occurred, and as such asserts that social transition is a 'psychosocial intervention [which] might be characterized as iatrogenic' – a medical problem caused by the treatment itself*."**

For HSC to claim that the interim Cass Review "*recognises the significant mental health benefits where a young person is able to socially transition*" is both completely wrong and worse potentially extremely harmful.

Please can you explain how you arrived at your interpretation of the interim Cass Review's view of social transition?

As Deputy Dudley-Owen highlights, there are differing views as to the risks and benefits of social transitioning and the Cass review acknowledged this, but this is only one document/report on this complex issue.

In some cases, there are undoubtably mental health benefits, but this should not be immediately assumed or be the default position in every case.

It is also worth reiterating that as outlined in the quote above, the Cass Review makes clear that social transition is not always done within health services, and ultimately it is often a decision made by the individual with the support of family and friends. This means that social transitioning will often occur without the input of HSC. Nevertheless, HSC clinicians are aware of the differing views and carefully consider the issue of social transitioning with a young person and their family when required, on an individual, case by case basis, explaining that there might be benefits, and there might be risks or costs. Clinicians do their best to help individuals and families become aware of these, consider them carefully, weigh them up, and make decisions based on that analysis.

2. **Question 2 of the Adult section of the previous Rule 14 questions asked: *"In your response to the 2022 FoI request, you state that detransition is thought to be 1% in adults. Please can you give your sources for this estimation."***

HSC responded: *"This statistic was quoted in the Keira Bell vs Tavistock case which can be found here [link]."*

Having reviewed the linked judgment there is no reference to a detransition rate of 1% in adults. Paragraph 57 of the judgment does however say:

> ***"Of the adolescents who started puberty suppression, only 1.9 per cent stopped the treatment and did not proceed to CSH."***

This neither refers to adults *nor* to detransition generally.

As some people continue to cross-sex hormones and surgery and then detransition, this figure does not give any indication at all of the overall rate of detransition. There is some evidence to show that the average time to detransition is six to eight years and many detransitioners do not advise the clinic or hospital involved in their transition.

Could you please advise therefore what HSC believes the detransition rate amongst adults is?

There is no robust evidence in this area. The statistic quoted was in the reporting around the above case, where multiple experts were asked to comment. It was not from the judgement itself.

3. **Question 6 of the Adult section of the previous Rule 14 questions asked: *"How many referrals do you expect to make each year to the London Transgender Clinic?"* HSC replied: *"It is anticipated that referrals will increase year on year as people become more comfortable with expressing their gender."***

   Bearing in mind that the LTC will take referrals from those aged from 17, who will most likely have expressed a transgender identity for some years as children i.e. under 17 years, can the inference be drawn from this response that HSC believe the only, or the main driver of the rapid increase in transgender identities in recent years is greater social acceptability of people expressing their gender?

   If not, what do HSC believe are the principal drivers for the rapid increase in the rate of transgender identity seen across the western world?

   Evidence demonstrates that the two largest cohorts, by far, claiming a transgender identity are teenage girls and middle-aged men. Could the Committee provide an insight as to why they think this is the case and whether they believe these observations point away from the idea that trans identification is in any way innate?

HSC does not believe that there is any one reason for an increase in referrals and did not intend to convey that through the answers previously provided. The statement made by HSC implies that one reason for an increase in referrals will be growing awareness of the

referral route, and that people may become more comfortable with expressing their gender identity with less stigma attached to doing so. However, this does not rule out there also being other reasons for a potential increase in rates.

For example, as the Cass Review highlights, one reason for increased referrals is a change in the referral system. Historically Tavistock accepted referrals only from psychiatrists, but then expanded this to allow referrals from GPs and until very recently and local professional, including non-health professionals (this was not the case in Guernsey where referrals were only made by CAMHS). Whilst this approach did remove barriers to accessing such treatment, the Cass Review also notes that this did also lead to increased waiting lists and additional strain on the service

It is not reasonable for HSC clinicians to give a firm view on the causes of the increase in the rates of people identifying as transgender. There is no one locally who has carried out research in this area, and all local clinicians can do is to point at published research. At present there remains much debate in this area.

With regards to the specific cohorts referenced, although this appears to be the case across all UK services, there has been no explanation for this, even from the specialist services themselves, so this is outside of HSCs knowledge. HSC is keen to support this vulnerable cohort, but does not have expertise in this complex area, hence forming a partnership with a specialist service in London.

4. **In Question 6 of the Adult section of the previous Rule 14 questions, HSC stated: *"At a clinical level HSC endorses the spirit of WPATH."***

   Can the Committee confirm if this includes the recently introduced Chapter 9 on eunuch identities, and whether the HSC would facilitate a referral of a male who wished to have his testicles removed to affirm his eunuch gender identity?

All of the referrals for individuals expressing gender dysphoria are received from General Practitioners. In Guernsey, we are lucky in that individuals are often known to their GPs very well and for many years, which is certainly not the case in other jurisdictions. GPs are therefore able to provide a wealth of information about the individual which can help secondary care services in their assessment.

Every referral of this kind is taken to our weekly Intake Meeting. This is a multidisciplinary meeting, with senior clinicians from all areas of our service represented. This meeting carefully considers each case based on the information supplied. If the referral meets the secondary care threshold, a decision is made as to who has the most appropriate experience to carry out an assessment.

Each assessment is a comprehensive and lengthy process, which includes not just the presenting complaint, but all aspects of an individual's history, their mental state, risks and other psychological and social complexities.

If the presenting individual is felt to require more specialist assessment and potentially an intervention not provided on island, then they may be referred to specialist providers. In the case of gender dysphoria, HSC have an established Service Level Agreement with the London Transgender Clinic (LTC).

LTC carries out specialist, multidisciplinary assessments and provides comprehensive reports on every case, to create bespoke treatment plans for each individual.

Although we have never received a referral as described, we would follow the above process.

It is not helpful or appropriate to comment further on a hypothetical, 2-dimensional case, other than to say that Guernsey should strive to be an inclusive community, which respects and accepts all individuals, regardless of how they identify, valuing all parts of our diverse community, whilst recognising potential vulnerabilities. This is the spirit in which HSC operates.

As this is a complex area, HSC would be happy to arrange a meeting should there be a desire to further understand the approach in this area.

Date of receipt of questions: 6th June 2023
Date of response: 21st June 2023