

Cass Report and Implications for Transgender Youth and Services in ROI

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The first UK Gender Identity Development Service was established in 1989 in St Georges Hospital by Domenico Di Ceglie, a child and adolescent psychiatrist. Following a move in 1994 to the Tavistock and Portman NHS Foundation Trust, the service became known as the Tavistock Gender Identity Development Service or GIDS. Prior to its closure in March 2024, it was the longest running GIDS for youth, having been nationally commissioned by the NHS in 1990.

Initially the clinic worked with a small number of children (fewer than 10 referrals per year) who were biologically assigned male at birth and who experienced significant and persistent distress associated with their gender identity. The Tavistock was heavily influenced by their expertise in psychoanalytic psychodynamic therapeutic approaches and by the work of Donald Winnicott, resident and prominent British paediatrician, and psychoanalyst. The main stay of treatment at that time, as elsewhere was 'watching waiting'. This approach focused on creating a trusting and therapeutic environment providing a holding and containing space for the young person to explore and express their emotions and experiences. After age 16, only a small number of youth were referred on for hormone treatment suggesting that only

a minority (15%) showed persistence beyond adolescence¹². The GIDS changed from a Psychiatry-led service to a Psychology-led service following the retirement of Dr Ceglie.

Whilst gender affirming medical treatment had been available in the Netherlands for adults from 1972, it became available for a growing number of transgender teenagers in the late 1990s. This led to a global adoption of the 'Dutch Protocol' across the developed world, including North America, Europe, and Australia. This coincided with a widespread shift away from usual principals of medical practice, and the adoption of an 'Affirmative Model' for Gender Non-Conforming children, accepting unquestioningly a child's view regarding their gender and treatment. Detailed and comprehensive clinical assessments were seen as unnecessary, outdated and disempowering. Paediatric gender clinics were established.

Rates of prescription of puberty blockers (PB) increased exponentially and increasingly cognisant of the lack of empirical clinical trials, European Governments began collating the extant evidence (Table 1). Universally, these reviews found no evidence of benefit and considerable risks in using PB in teenagers. It also emerged that the early Dutch studies on which these services had been based on had been methodologically flawed, leading to unreliable conclusions.

Over the years, referrals to GIDS increased exponentially well surpassing capacity, even with a second service opening in Leeds in 2012. By 2016, 1,766 youth were referred, 269 under 12, the average age of referral was 14 with an age range from 3 to 18³. The service also expanded to meet the growing needs of concerned families and professionals working with gender questioning and transgender youth and GIDS provided training and guidance for families, clinicians, and schools. Waiting lists grew and multidisciplinary assessment and treatments were difficult to sustain. Delays in assessment and passage of time created an urgency for onward referral to endocrinology for medical interventions such as puberty blockers and hormone treatment. By 2014, youth had access to hormone treatments separate to the previously research guided protocol.

A change in profile of youth referred to GIDS was observed. Increasing numbers of adolescent natal females were referred, with shorter duration of gender distress. Higher rates of comorbid Autistic Spectrum Disorder (ASD), other psychiatry disorders and adverse childhood experiences were noted. The average number of assessments pre-endocrinology referral was 6.7 (range from 1-44) and the average age of youth prescribed puberty blockers by endocrinology was 15 (range from 8-18)⁴. An audit of discharged cases (between 2018-2022) reported that 55% of endocrinology referred youth went on both puberty blockers (PB) and cross sex hormones (CSH), more prevalent in adolescent natal females and fewer than 10% of the cohort de-transitioned⁴.

Clinical concern had been expressed over the years regarding overall clinical practice and transparency at the Tavistock GIDS. Many senior clinical staff at GIDS resigned, reporting unsafe clinical practice and a perceived culture of intimidation by management. These accusations were upheld in a series of internal reviews, the first in 2005, by Dr Taylor, medical director of the Trust, followed in 2014 by Dr Bell, medical director of the Tavistock.

Legal cases brought before the courts and the employment Tribunal by patients and staff led to heated public debate. The CQC inspection of GIDS in October 2020, published in 2021 rated GIDS 'Inadequate', the lowest rating it could give, with multiple failures of clinical standards⁵. This led to the commissioning by NHS of an independent review by Dr Hillary Cass in 2020, former president of the Royal College of Paediatrics and Child Health. An Interim Report was published in February 2022 followed by the final report in April 2024^{6,7}.

The Cass Review

The specific aim of the review was to critically evaluate the provision of gender identity services or GIDS, including evidence concerning treatment approaches, and provide recommendations about future services development⁶. The Cass Review engaged with a diverse range of stakeholders, including professionals working within specialised GIDS, organisations working with LGBTQ youth and patients and families with direct lived experiences. An independent academic institution, the University of York, was commissioned to systematically evaluate the evidence, including peer reviewed publications, international guidelines, and surveys⁶.

The evidence synthesis is presented in the Cass Review and raised concerns about the paucity of good quality evidence regarding psychosocial or medical interventions with an absence of longer term follow up studies. Little evidence existed for psychosocial interventions⁸. Potential effects and influence of social transition on the mental health of youth and trajectory of gender development remained unclear⁹. Apart from the intended physiological effect, there remained many questions regarding the efficacy and safety of puberty blockers (PB)¹⁰. The review found no significant changes in gender dysphoria or body satisfaction following puberty suppression and was unable to support claims of reduced suicide risk in this population. A risk of bone density compromise was reported with most individuals who received puberty blockers progressing to receive masculinising or feminising hormones¹¹. Treatment effects on psychosocial health, cognitive development, or fertility in transgender individuals remain unresolved⁶.

The Cass Review made 32 recommendations for improving NHS gender services covering areas including assessment, diagnosis, psychosocial and medical interventions, service improvements, education and training, clinical pathways, detransition and private provision.

It recommended a shift to a regional model of care, with oversight from a National Provider Collaborative and delivery through formalised Operational Delivery Networks⁶. This new approach aims to improve access, consistency, and quality of care for children and young people seeking gender identity services in England. The review stipulated that all young people referred to NHS GIDS should undergo a comprehensive and holistic assessment of their needs, including a mental health assessment and screening for neurodevelopmental conditions. This would ensure the development of an individualised care plan tailored to each patient's unique circumstances and requirements⁶.

Core to these was the need to develop a robust evidence base and the enrolment of youth attending GIDS into research studies, enabling both short- and longer-term treatment outcomes to be established, whether medical treatment was offered or not. The Cass Review (2024) emphasised the need for extreme caution when prescribing hormones to young people under the age of 18 and recommended that any such prescriptions should be made with a clear rationale and only after careful consideration of the potential risks and benefit⁶. The review suggested that there may be a narrow indication for the use of puberty blockers in birth-registered males, specifically in cases where medical intervention is necessary to halt irreversible changes brought on by puberty, such as facial hair and a lower voice. In response to these recommendations, NHS England published two policies in March 2024, clarifying that whilst masculinising and feminising hormones are available from the age of 16, the routine use of puberty blockers is no longer available as a treatment option in NHS gender service¹²

13

Although the Cass Report has been criticised by activists on ideological grounds, many European countries have changed their service delivery and published more restrictive clinical guidelines, some predating CASS (Table 1).

Finland	Recommendation of the Service Board 2020: Gender identity of minors dysphoria associated with variations medical treatment of dysphoric dysautonomia
UK	Nice Oct 2020: Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria Nice Oct 2020: Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria.
France	French National Academy of Medicine 2022 Medicine and gender transidentity in children and adolescents
Sweden	Jonas F. Ludvigsson 2023 (Acta): A systematic review of hormone treatment for children with gender dysphoria and recommendations for research

	Guidelines 2022: Care of children and adolescents with gender dysphoria
Denmark	Mette Vinther Hansen 2023: Health services for children and young people with gender discomfort
Germany	Florian D. Zepf 2024: Beyond NICE

Implications for the provision of Gender Identity Services for children and young people in Ireland.

Although not explicitly outlined, historically, the care pathway for young people with gender identity issues in Ireland involved a multi-step process. General practitioner (GP) referrals were directed either to Child and Adolescent Mental Health Service (CAMHS) or more latterly, the endocrinology service at Children's Health Ireland (CHI) Crumlin. As the number of referrals to CHI Crumlin increased, and under pressure from families of gender diverse children, and lobbyists, consideration of medical management led to an engagement with the Tavistock GIDS in the UK. This soon led to a system whereby a child with gender diversity/gender dysphoria could be referred to the Tavistock GIDS, under the Treatment Abroad Scheme (TAS). The criteria about who could refer and who could be referred to Tavistock GIDS via TAS were unclear. No direct referrals for medical intervention were accepted by clinicians in CHI Crumlin. The Tavistock service provided either direct or indirect ongoing oversight of cases, including, in some cases, eventual recommendations for medical intervention to be provided by CHI Crumlin clinicians. The governance structures around this were never clear. CHI Crumlin maintained that as the Tavistock GIDS input was being funded/delivered by the TAS (HSE), that local governance was not required. Crumlin clinicians were placed in an invidious situation, as with time, MDT members from Tavistock jointly attended clinics on site.

There are no specialised Child and Adolescent Mental Health Service (CAMHS) for transgender youth in Ireland, driven in part by significant challenges in recruiting staff with the necessary expertise. Between 2012 and 2023, records show that 233 referrals were made from Ireland to UK GIDS¹⁴. At the time of the Interim Report, 5000 patients were on the Tavistock waiting list, of which 72 were from Ireland¹⁴. Whilst the GIDS Tavistock ceased operations in March 2024, two new CYP services are being established: the Northwest (Alder Hey Children's and Royal Manchester Children's Hospital) and London (Great Ormond Street Hospital, Evelina London, and South London & Maudsley NHS Foundation Trust).

Many challenges remain for clinical services in ROI. The substantial body of evidence showing little, or no evidence of benefit and possibility of harm is of grave concern. Access to GIDS UK has now been removed and there is a lack of clarity regarding alternative care pathways. As

we wait to be informed by future evidence and service developments, how should we respond to parents when they ask for advice about referral or treatment? Are we knowledgeable or confident to advise regarding social transition? How should clinicians respond when faced with a youth who has been placed on PB or CSH and previously had been supported by the Tavistock GIDS? Or a pre-pubertal youth waiting months or years on a waiting list, only to arrive at the top of the list and faced with what seems like a blanket ban for PB (at least in NHS clinics)? What can we say when asked by a carer or youth why must they travel to UK for gender-specific healthcare services? Or when a youth questions the requirement that they enrol in a research study to access care? Why should access to clinical care now be diverted through psychiatry services such as CAMHS? How should clinicians respond when faced with youth prescribed PB or CSH by online or other private practitioners, often outside of the jurisdiction? How can we safeguard youth and ensure that whatever stance we take follows our Hippocratic oath, and our promise to ‘primum non nocere’?

For transgender youth seeking treatment, no medical intervention can be considered in isolation, and that a robust clinical pathway with fully resourced MDT led by child and adolescent psychiatrists, and paediatricians with special interest adolescent medicine, must be core to any future management of gender diverse individuals under the age of 16. Given the potentially fraught nature of some referrals, a medical ethicist would be a valuable member of the team both to protect the child but also the healthcare professionals from what can be very difficult discussions. Institutional support for this will also be key, including clear governance structures, and communication to all stakeholders.

In the Hippocratic school, Epidemics, Book 1, “Practice two things in your dealings with disease: either help or do not harm the patient”. It appears we may need to pause, recollect and go back to Donald Winnicott’s watchful waiting. This time we will also be waiting for research towards safe evidence-based practice. Clinicians also eagerly await the development of a National Model of Care. A National Clinical Lead has been appointed and taken up post in July 2024.

Declarations of Conflicts of Interest:

None declared.

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