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Factors shaping gender incongruence and dysphoria, and impact on health services

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Overview

The Office for National Statistics collected data on the number of people identifying as transgender in the 2021 England and Wales census. This is the first time nationally representative data for this population has been collected. The Office for Statistics Regulation is reviewing the reliability of the data.[1–3]

Referrals to specialist child and adolescent gender identity health services increased from 210 per year for 2011-12 to over 5,000 per year for 2021-22.[4] There is less publicly available data for adults, but research suggests more are seeking support, with larger increases amongst younger adults.[5]

Some stakeholders understand this to be a result of increased societal awareness and acceptance of people with transgender and non-binary identities. Other stakeholders state there may be other biological,[6,7] psychological[8,9] or cultural factors[10,11] that could explain this.

The Gender Identity Development Service (GIDS, the service for children and adolescents) stopped seeing new patients in March 2023.[12] Prior to this, GIDS was seeing young people for their first appointment who were initially referred in 2019.[13] Most adult Gender Identity Clinics (GICs) have waiting lists of between 40 and 60 months.[14] There are concerns that waiting times are contributing to the distress experienced by children and adults.[15,16]

1 Background

The number of people seeking support from the health service for having a gender identity different to their sex registered at birth is increasing in the UK.[5,17,18] This includes people with transgender and non-binary identities (Box 1).

Measuring this demand, understanding why it is occurring and the factors shaping any associated distress is seen as important by some stakeholders to provide appropriate specialist health services, inform policymaking, and monitor service provision in line with the Equality Act 2010.[19] Other stakeholders question the need to understand why the increased need is occurring, and are concerned this could imply that being transgender or non-binary is a problem to be solved.

Some stakeholders think the increased visibility of transgender and non-binary people in society has enabled more people to explore their gender identity.[20]

Others are concerned with the demographic change of an increasing proportion of birth registered females seeking gender identity care from health services,[21,22] and those with neurodevelopmental conditions such as autism.[23] Some stakeholders think that these observations suggest there are other, or additional, biological[6,7], psychological[8,9] or cultural factors[10,11] involved.

Healthcare services in England for adults and children seeking support relating to gender identity currently do not have capacity to meet this significantly increased demand in a timely way.[15,24,25] There are long waiting times to access specialist care. The Gender Identity Development Service (GIDS, the service for children and adolescents) stopped seeing new patients in March 2023.[12] Prior to this, GIDS was seeing young people for their first appointment who were initially referred in 2019.[13] Most adult Gender Identity Clinics (GICs) have waiting lists of between 40 and 60 months.[14] There are concerns that waiting times are contributing to the distress experienced by children and adults.[15,16]

Specialist NHS services for children and adolescents are the subject of an independent review (the Cass Review).[18] The review was commissioned by NHS England and NHS Improvement to explore how services could be improved, and to ensure that the NHS can commission safe and effective services.[15] It has stated that the service developed "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". The review has published an interim report;[15] a full report, setting out further recommendations to improve care and outcomes, is expected later in 2023.

Adults have traditionally been seen in secondary care (often a hospital setting) in Gender Identity Clinics (GICs).[26] However, a current pilot scheme in four sites across England enables adults to access a range of transgender and non-binary healthcare services* in a community healthcare setting.[27]

Box 1: Terminology used in this briefing

The language used in this area is contextual and evolving. When referring to studies used in this briefing, the terminology used by the research authors may be quoted.

- **Sex** generally refers to biological and physiological characteristics, determined by sex chromosomes, reproductive function, hormones and their interactions.[28†]
- **Gender** is not defined in UK law.[30,31] It is commonly understood as a social or cultural identity expressed in terms of femininity or masculinity.[32]
- **Gender identity** refers to an individual's experience of their gender and can include a range of identities such as man, woman, and non-binary (where someone does not exclusively identify as male or female).[33] A person's gender identity may not match their sex registered at birth.[32] Some people may consider that they do not have a gender identity.
- **Gender incongruence** occurs when a person's gender identity markedly and persistently does not match their sex registered at birth.[34,35]
- **Gender dysphoria** refers to psychological distress from an incongruence between sex registered at birth and gender identity. To meet criteria for a medical diagnosis, the dysphoria must be associated with several factors, including, significant distress or impairment in social or occupational functioning.[36,37]
- **Trans** is an umbrella term for a person whose gender identity is different from their sex registered at birth.[38] A trans woman is a person registered male at birth who identifies as a woman. A trans man is a person registered female at birth who identifies as a man.[39] A transgender person is someone whose firm view is that their gender does not match their biological sex.
- **Non-binary** is a term used to describe someone who identifies in some way outside of the man-woman gender binary. This is used here as an umbrella term and includes other terms people use to describe their gender such as genderfluid or agender.[40]

* This range of healthcare refers to not only traditional medical and surgical interventions, but other services such as speech and language therapy, hair removal, peer support and counselling if required.

† There is current debate about how sex is understood, and how it should be defined in law.[29]

2 How big is the population of transgender people in the UK?

2.1 Census data

Historically, there has been little data about the number of people in the UK who identify as transgender or non-binary. This data is seen by most stakeholders as important because it enables health services to be planned according to demand.[19] For the first time in 2021, the census* in England and Wales asked the question: "Is the gender you identify with the same as your sex registered at birth?"

Overall, 45.7 million people (94% of the population aged 16 or over) answered the question.[1,2] If the respondent said their sex registered at birth and gender identity were different, they then had the opportunity to write in a term that best described their gender identity. Of the people who answered the question, 262,000 (0.54% of people aged 16 and over) said their gender identity and their sex registered at birth were different. Of these 262,000:

- 118,000 (0.24%) answered "No" but did not provide a written in response
- 48,000 (0.10%) identified as a trans man
- 48,000 (0.10%) identified as a trans woman
- 30,000 (0.06%) identified as non-binary
- 18,000 (0.04%) wrote in a different gender identity.[2]

The reliability of this data has been questioned; those with less English proficiency were more likely to answer "No" to the question, "Is the gender you identify with the same as your sex registered at birth?".[42] A paper by one academic (that has not been peer reviewed) suggested this arose because the question was poorly formulated.[43] A statement from the ONS highlighted the extensive quality control process of the development of census questions and that the census was available translated into nearly 50 languages.[44] However, one criticism is that there is no distinction between the words sex and gender in some languages.[43]

* The purpose of the census is to collect information the Government needs to develop policies, plan and run services (such as healthcare), and in decision making about public spending.[41]

The Office for Statistics Regulation decided to undertake a short statistical review on the approach used in the 2021 census.[45] This will comprise of four articles, the first of which was published in June 2023. This confirmed that there were no data coding or processing errors.[46]

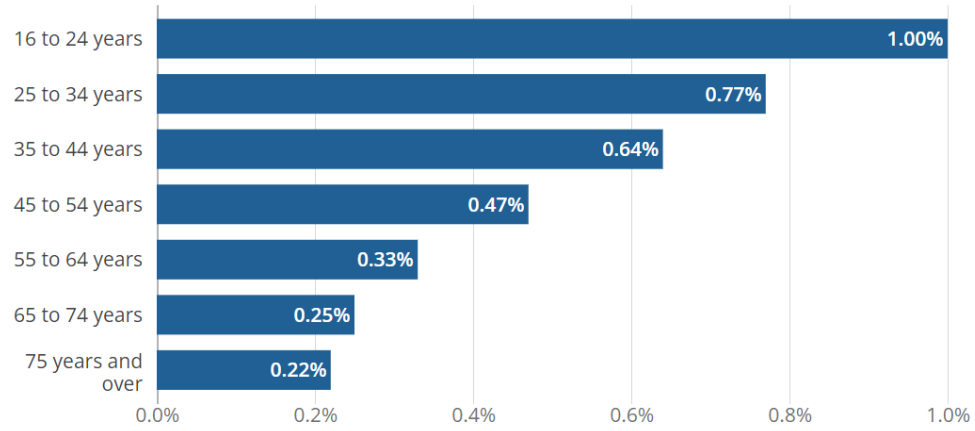
The Scottish 2022 census phrased the question differently: "Do you consider yourself to be trans, or have a trans history?"[47] Results are expected in 2024; data from this census will provide further context for the results from England and Wales. The 2021 Northern Ireland census did not include a gender identity question.[48]

For the purpose of the following discussion, those who answered "No" to the question, "Is the gender you identify with the same as your sex registered at birth?" will be taken as identifying as transgender or non-binary, despite the possible issues raised.

Age and gender identity

The England and Wales census data can be broken down by age group. Those aged 16-24 years had the highest proportion of people identifying as having a gender identity different to their sex registered at birth (1% of respondents).[49] The proportion of people who declared that their gender identity did not match their sex registered at birth decreased with age (Figure 1).

Figure 1: Percentage of usual residents, aged 16 years and over who declared that their gender identity did not match their sex registered at birth by age, England and Wales, 2021.



Source: Office for National Statistics – Gender identity: age and sex in England and Wales: Census 2021.[49]

Other data about transgender and non-binary communities

The England and Wales census invited every household to participate and was nationally representative. Other sources of data have come from surveys with smaller sample sizes that may not be representative of the whole population, for example:

- **The GP patient survey for England** asked a similar style of question to the census and so may be subject to the same language limitations.

The survey first contained a gender identity question in 2021. In 2021, 0.65% of approximately 850,000 people reported having a gender identity different to their sex registered at birth. This rose to 0.76% of 720,000 people in the 2022 survey.[50]

- **The Government Equalities Office** previously tentatively estimated that there were 200,000-500,000 transgender people living in the UK in 2018.[51]

International comparisons

England and Wales were amongst the first countries globally to include a census question about gender identity. Recently, other countries have asked this question. The 2021 Canadian census asked: "What is this person's gender?" with a note explaining that gender "refers to current gender, which may be different from sex assigned at birth and may be different from what is indicated on legal documents".[52] It found that 0.33% of the population aged 15 and over living in a private household stated that they had a gender different to their "sex at birth".[53]

In 2014, the United Nations reported that different countries had estimates of between 0.1-1.1% for the proportion of their population that identified as transgender.[54]

3 Factors shaping distress

Some people with gender incongruence (Box 1) do not experience distress. Transgender and non-binary people can live happy, fulfilled lives and participate fully in society.[55]

However, others with gender dysphoria (Box 1) may experience distress in unique and varied ways. These can be described at different levels, including:

- **individual**, distress associated with one's body
- **interpersonal**, distress associated with social interaction
- **social**, distress associated with living as a transgender or non-binary person in society

The presence and relative importance of each of these factors is unique to each individual. This section outlines possible factors shaping this distress and the strength of the evidence for each factor.

Stakeholders with varied perspectives may interpret the same research in different ways. Research in this area is subject to a high level of scrutiny.[56]

The data available and referred to in the following sections (individual factors, interpersonal factors and societal factors) is limited.

The Cass Review described the data in this area as poor quality.[15] It noted that some parts of the research literature are open to a number of interpretations, with "a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint." In response to some of the evidence gaps in the research literature, the Cass Review has commissioned some studies to support its work.[57]

Many of the available surveys are designed and commissioned by LGBT organisations (2021 Trans lives survey;[58] 2012 Trans Mental Health and Emotional Wellbeing Study;[59] 2018 Stonewall LGBT in Britain Trans Report[16]). These surveys rely on people self-selecting to participate and to self-report their conditions. This could introduce a selection or recall bias.* The Government Equalities Office 2017 LGBT survey also relied on people self-

* Sampling (or selection) bias occurs when some members of the study population of interest (in this case those from transgender and non-binary populations) are systematically more likely to be selected in a study than others in the population. This could mean that findings from a study are not generalisable to the whole transgender and non-binary population.[60] Recall bias occurs when participants do not accurately recall previous information, or recall is influenced by subsequent experiences.[61]

selecting to participate and self-reporting outcomes and is subject to the same limitations.[62]

These surveys are cross-sectional, meaning they provide a snapshot of the outcomes surveyed. Cross-sectional surveys cannot tell us what caused the outcomes surveyed.

Other studies referred to in this report provide statistical data alongside the level of uncertainty associated with the data. This is cited where it is available.

3.1 Individual factors

- **Distress with body**. A comprehensive review of the academic literature from 1966-2015 showed how transgender and non-binary people may experience distress associated with genitalia and secondary sexual characteristics that do not align with their gender identity, or distress with their body more generally.[63]

- **Biological associations.** The validity of brain-wide imaging studies is a matter of widespread debate and disagreement within research communities.[64] A small neuroimaging study with a limited sample of 65 people has shown an association between specific areas of the brain and gender dysphoria.[65,66] This research may not be generalisable to all transgender and non-binary people.

- **The presence of mental health conditions**. Measuring the prevalence of mental health conditions in the transgender and non-binary population is thought to be challenging. Most studies looking at transgender and non-binary people's mental health are cross-sectional studies. These provide a single snapshot of participants mental health and do not follow people over time. This type of study design cannot tell us whether being transgender or non-binary causes poor mental health. These studies also often rely on self-reporting of mental health conditions which may introduce selection or recall bias.[60,61]

However, the international research to date indicates that amongst transgender and non-binary people there is a higher prevalence of anxiety, depression, self-harm and suicidality compared to the general population.[67,68] Data cited below refers to studies carried out in the UK context, since an individual's experience will partly be shaped by the availability of health services. Below are some examples of studies looking specifically at the UK population.

- The 2012 Trans Mental Health and Emotional Wellbeing Study of 889 transgender and nonbinary adults found 84% out of 581 people who answered the question self-reported thinking about ending their lives at some point. Of these participants, 11% out of 427 had made a suicide attempt in the last year. Eighty eight percent out of 549 of respondents had experienced depression; 80% out of 498 had experienced stress; and 75% out of 512 had experienced anxiety.[59]

- A 2023 study in the British Medical Journal used data from the 6,333 transgender and non-binary respondents (age 16 years and above) to the 2021 GP patient survey. The authors found that transgender and non-binary people were approximately twice as likely to self-report a mental health condition, compared to other survey respondents.[69]

- An academic study based on data from GIDS gives an estimate of 4 to 34 per 100,000 for the annual suicide risk for transgender and non-binary children and adolescents, as opposed to 2.7 in the general population of similar age and sex balance.[70] This study is based on an extremely small sample size of 4 cases, with other uncertainties relating to the impact of other possible contributory factors. The estimated suicide rate does not necessarily translate as being representative of all transgender children and young people.

Some stakeholders argue that these mental health conditions may arise because of the stress of living as a transgender or non-binary person.[71]

The Cass Review highlighted that some of the young people presenting for care may have complex mental health problems and this should be explored in a more structured way.[15] In particular, Autism Spectrum Disorder is over-represented in this group of young people; this is discussed later.

3.2 Interpersonal factors

- **Discrimination.** Of the 698 respondents of the 2021 Trans lives survey (ran by TransActual, a transgender-led organisation), 40% reported having experienced transphobia* when seeking housing and 63% experienced transphobia while seeking employment.[50]

- **Bullying at school and in the workplace**. Transgender and non-binary young people are more likely to be bullied or to be a perpetrator of bullying at school than their peers who were not transgender.[73] There is also some evidence that individuals who experienced homophobic bullying at school are more likely to identify as transgender or non-binary in the future.[74] Bullying at school has been associated with an increased risk of self-harm and suicide attempts in transgender and non-binary youth compared to their peers who were not transgender.[75] In the 2018 Stonewall LGBT in Britain Trans Report, 33% of transgender respondents had received negative comments or conduct from work colleagues related to their gender identity in the past year.[16]

- **Concealment of identity.** People with gender dysphoria may conceal their transgender or non-binary identity to try and avoid stigma and discrimination.[76] A systematic review of 85 cross-sectional studies shows

* Transphobia includes harmful or unfair things a person does based on a fear or dislike of transgender and non-binary people. It also includes policies, behaviours or rules that result in the unfair or harmful treatment of transgender or non-binary people.[72]

that over time this can lead to chronic stress and poor mental health outcomes for transgender and gender-diverse individuals.[77]

- **Domestic abuse.** Studies have researched different forms of abusive behaviours. A recent review of evidence found that that 37% of transgender study participants experienced intimate partner violence[*] in their lifetime.[79] Similarly, the 2018 Stonewall LGBT in Britain Trans Report found that 28% of transgender and non-binary people in a relationship had experienced domestic violence in the past year.[16]

3.3 Social factors

- **Employment, housing and homelessness.** In the Government Equalities Office 2017 LGBT survey, trans men and trans women were the least likely groups to have been in paid employment in the past 12 months, at 57% and 65% respectively compared to other survey respondents.[62] Of the 698 respondents of the Trans Lives 2021 Survey (a survey run by a trans organisation), 27% reported that they had experienced homelessness.[58]

- **Legal recognition**. Gender reassignment[†] became a protected characteristic in the Equality Act 2010.[81] Since this has been recognised, many stakeholders believe this enabled people to live more freely and openly with their gender identity. The majority (57%) of participants in the Trans Lives 2021 survey reported wanting a Gender Recognition Certificate (GRC)[‡]; 7% reported having one.[58] The Government Equalities Office (GEO) reduced the GRC application fee in May 2021 to £5 (from £140) and launched a digital system in June 2022 to simplify the process of applying for a GRC.[83] However, many stakeholders view the process as overly burdensome and intrusive. The process for applying for a GRC involves providing two medical reports; proof of living in the acquired gender for at least two years; and a statutory declaration of intent to live in their affirmed gender for life.[84] There is currently no legal recognition of non-binary identities, people can change their gender only from male to female or vice versa.[85]

- **Healthcare**. Of the transgender respondents who had accessed healthcare in the 12 months before the Government's 2017 National

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[*] Intimate Partner Violence refers to any behaviour that causes sexual, psychological or physical harm within an intimate relationship.[78]

[†] "The characteristic of gender reassignment applies if the individual is proposing to undergo, is undergoing or has undergone a process, or part of a process, to change their physiological or other sex attributes."[80]

[‡] A Gender Recognition Certificate (GRC) allows an individual to have their affirmed gender (sometimes called acquired gender) to be legally recognised in the UK.[82] This enables a person to change the sex recorded on their birth certificate from male to female or vice versa.

LGBT Survey, 40% reported they had a negative experience because of their gender identity.[62] The most commonly cited negative experiences were having their specific needs ignored or not taken into account (21%), avoiding treatment for fear of a negative reaction (18%), and receiving inappropriate curiosity (18%).[62]

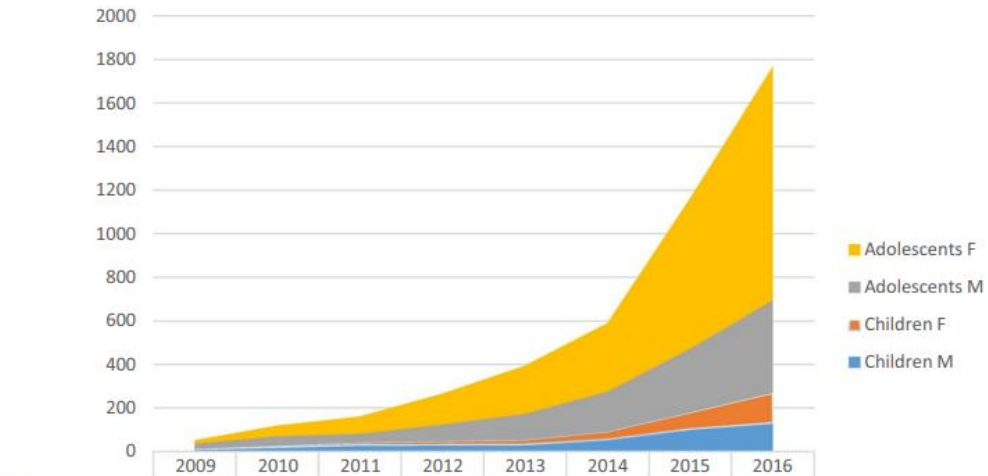
4 Health service impact

4.1 Demand for child and adolescent gender identity health services is increasing

In 2011-12, GIDS reported 210 referrals from across the UK, which rose to over 5,000 by 2021-22.[4] Historically, children could be referred to the Gender Identity Development Service (GIDS) by GPs, children and young people's mental health services, paediatric services, schools, social care, and a range of relevant voluntary organisations.[86] From March 2023, referrals may only be made from the health service.[87]

There has also been a change in the characteristics of those presenting for care (Figure 2). Children registered female at birth and presenting with gender distress now account for most referrals. In 2018-19, 74% of referrals were children registered female at birth compared to 42% in 2010-11.[88–90]

Figure 2: Number of GIDS referrals per year for child (<12 years) and adolescent (12-18 years) for sex registered at birth females and sex registered at birth males between 2009-2016.[90]



	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

The orange * indicates a statistically significant increase of referrals compared to the previous year.

Other countries have reported similar observations

- A study investigating referral trends for gender identity services in four Nordic countries (Denmark, Finland, Norway and Sweden) found a similar increase in referrals per year across countries. They found an equal number of referrals for children registered male and children registered female at birth; but more referrals for children registered female at birth, compared to children registered male at birth, in adolescence.[91]

- A two-site study in the Netherlands (Amsterdam) and Canada (Toronto) found more birth registered females referred from 2006 to 2013, whereas the opposite (more birth registered males referred) was recorded before 2006.[92]

- A study looking at specialist gender identity clinics in the UK, Belgium, the Netherlands and Switzerland found all four clinics had a higher proportion of referrals from birth registered females for adolescents aged 12-18 between 2009 and 2013.[93]

There are limitations in the data. For example, these are figures for number of referrals, they do not indicate whether this was an appropriate referral, whether the young person attended, or how many met the criteria for gender dysphoria after a clinical assessment.

Reasons for the increased proportion of referrals from birth registered females in children and adolescent services

There is lack of consensus as to why an increasing proportion of birth registered females are seeking specialist care from gender identity services. There is limited high quality research exploring the reason underlying this. Speculative suggestions discussed in some academic communities include:

- that the mental health and wellbeing of adolescents has worsened in the UK over the last decade.[94] Data shows there is an increased number of referrals for mental health services, and a higher incidence of depressive symptoms in adolescent girls compared to adolescent boys[95,96]

- birth registered females may experience more challenges associated with puberty than birth registered males[97,98]

- socially constructed views of femininity on social media may have a specific impact on birth registered females, especially those who do not identify with these stereotypes[99]

- birth registered males may face barriers to accessing care including increased societal stigma associated with a trans female identity[100]

4.2 The demand for adult gender identity services is also increasing, especially among younger adults

Data about adult services is less widely available. However, data from specific services in the UK suggests that the number of adults seeking care for gender incongruence and gender dysphoria has increased in the last decade, with an increased proportion being young adults.[5]

Some stakeholders are concerned that the adult services are not designed for the level of complexity that is being seen in younger people who will be moving from a paediatric to adult service. This complexity arises because some young people will have mental health conditions and neurodiversity.[101]

4.3 Factors shaping increased demand for health services

Increased visibility in popular culture and social media

Research has suggested that the increased visibility of transgender and non-binary people in the media has been associated with an increased awareness of transgender and non-binary identities, identity discovery and role-modelling.[13] The internet and social media may have enabled people to access information about diverse gender identities at younger ages.[15]

The role of social influence - research and stakeholder perspectives

Some stakeholders believe the increase in referrals to specialist child and adolescent gender identity services suggests that adolescents may be subject to social influence from their peers. Social factors can contribute to mental health conditions and some stakeholders believe that social factors are driving this change in referrals.[102,103]

Research found parents described seeing pre-existing friendship groups all beginning to express gender dysphoria around the same time, indicating there may be a social element to gender dysphoria in adolescence.[10] A second study (that interviewed people who had historically identified as transgender or non-binary recruited from populations from varied positions on transition) found that social influence, peers and social media had a role in some participant's experience of gender dysphoria and desire to transition.[104]

However, this is a contested research area.

Some stakeholders argue that in one of the studies, no transgender or non-binary youth were asked directly about their experience and question participant recruitment methods, as parents were mostly recruited from gender critical websites despite wider advertisement.[105]

The Cass Review discussed how gender dysphoria in children and adolescents is complex, with multiple biological, cultural, psychological and social factors interacting to form gender expression.[15]

Association with neurodevelopmental conditions such as Autism Spectrum Disorder (ASD)

Children referred to GIDS have more complex needs compared to the general population. One third of children referred to GIDS have ASD or neurodiversity.* [15] There is also evidence of over-representation of ASD in adults with gender dysphoria.[107] The reasons for this are not well understood.

Some research suggests this association may be because of reduced mentalising ability in people with ASD.[108,109] This refers to a person's ability to understand the mental state of oneself and others in order to predict and explain future behaviour. This could mean that people with ASD may struggle to understand how people who are not transgender can express their gender identity in diverse ways.

However, there is concern from some stakeholders that a focus on this association undermines the legitimacy of gender incongruence experienced by those with ASD.[110]

The Cass Review is looking at how best to provide care for children with gender congruence and ASD.[15]

Social determinants of health

Young people of White ethnicity are over-represented in the GIDS referral data.[111] Black and minority ethnic groups may face barriers to accessing care.[112] Reasons given in the academic literature for reduced access to care related to gender identity include cultural differences in health-seeking behaviours and perception of gender; feelings of shame; and that Black and minority ethnic groups are less likely to be registered with a general practitioner (GP) or to access specialist care.[113]

There is no data available on the role of socio-economic deprivation on seeking care for gender incongruence or gender dysphoria in either children or adult populations.

* Neurodiversity is a term used to describe how different people have variation in how their brain works and behavioural traits.[106] This is a term used in the Cass Review.[15]

4.4 Future healthcare provision

A new service is being designed because of significant concerns about the clinical pathway and the treatment children and young people receive (Box 2).[15] There is a debate about what good quality care looks like for this group of people.[114,115] The Cass Review noted that:

> "Evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally." [15]

The NHS has updated its service specification in order to provide the services required for both adults and children.[26,87] There are significant waiting lists for both child and adolescent and adult services.[15,24,25] Care on the waiting list is minimal.

Young people and their families on the waiting list will be contacted by NHS England outlining the transition to a new service model (see Cass Review below).[116] In addition, some online support materials for parents and families have been commissioned by NHS England.[116]

Adults on the waiting list can, in some places, access peer or community support groups but there is significant geographical variation.[117]

Detransition refers to someone who has undergone a social, legal, medical or surgical gender transition and subsequently halts or reverses this process.[118] There is concern amongst some academics and stakeholders that current services do not cater for individuals who detransition.[119]

Child and adolescent services

NHS England published their interim service specification in June 2023.[87] This was based on the interim report by the Cass review (Box 2). The service specification was based on the following recommendations from the Cass Review interim report:

- "Regional centres should be led by experienced providers of tertiary paediatric care* to ensure a focus on child health and development, with strong links to mental health services. These will generally be specialist children's hospitals."
- "They should have established academic and education functions to ensure that ongoing research and training is embedded within the service delivery model."
- "The services should have an appropriate multi-professional workforce to enable them to provide an integrated model of care that manages the holistic needs of this population."

* Tertiary care is highly specialised care in the NHS.[120]

- "Staff should maintain a broad clinical perspective to embed the care of children and young people with gender uncertainty within a broader child and adolescent health context."[15]

NHS England is set to implement this advice initially in two sites; a southern hub and a northern hub.* The southern hub is expected to start seeing patients in autumn 2023 and the northern hub in spring 2024. The NHS plans to roll out further regional hubs in the future.[87]

Additional changes in the new service specification include puberty suppressing hormone therapies only being available as part of an approved research study.[116] LGBT organisations are concerned this approach coerces young people to participate in research that some medical organisations see as standard care.[114]

The Cass Review is conducting an international survey of clinical services in other countries with comparable health systems, to understand the range of medical guidance and services provided.[121]

Box 2: The Independent Review of Gender Identity Services for Children and Young People (the Cass Review)

The Independent Review of Gender Identity Services for Children and Young People, also known as the Cass Review, was commissioned by NHS England in 2020[56] to ensure that gender questioning children receive the best possible care.

The review was commissioned in response to a range of issues including the rise in referrals and challenges to GIDS' operational capacity. The review is examining several issues including care pathways, clinical audit, management and treatments, workforce issues, data collection and research priorities. It is also evaluating international evidence and approaches.

The final report is expected in late 2023.

* The southern hub will be a partnership between Great Ormond Street Hospital, Evelina London Children's Hospital (part of Guy's and St Thomas' NHS Foundation Trust) and South London and Maudsley NHS Foundation Trust. The northern hub will be a partnership between Alder Hey Children's NHS Foundation Trust and the Royal Manchester Children's Hospital (part of Manchester University NHS Foundation Trust).

Adult services

Historically, adult health gender identity services have been based in one of seven Gender Identity Clinics (GICs).[122]

Because of concerns around access and long waiting lists, four sites around the UK have trialled gender service pilot clinics.* These differ from GICs as they are based in either primary care and sexual health settings and typically offer service users a greater range of services, for example, the TransPlus clinic (Box 3).

Box 3. TransPlus (56 Dean Street, Soho, London)

TransPlus is the first integrated gender, sexual health and HIV clinic commissioned by NHS England. Initially it was one of the four pilot community sites. A recent independent evaluation of the pilot led the clinic to be commissioned on a standard seven-year contract with NHS England in early 2023.[123,124]

The clinic offers a range of transgender and non-binary healthcare in a community sexual health setting. Beyond traditional diagnosis, medical and surgical management, services available include specialist transgender and non-binary cervical cancer screening, contraceptive clinics, psychosexual therapy, dermatology clinic, support for those living with obesity, speech and language therapy and peer support groups.

The clinic emphasises moving people through its service, and aims for a second appointment (where potential treatments can be discussed) to be no more than four weeks after the initial assessment.

The service is increasing its capacity. Patients who are on the waiting list for hospital GICs are being given priority.

Services for people who detransition

There is lack of consensus about the number of people who detransition after receiving care for gender dysphoria. Estimates from international studies vary from less than 1% to 30% depending on the population and context studied and study design (such as how researchers defined

* The four pilots currently in operation are TransPlus in London (Chelsea and Westminster Hospital NHS Foundation Trust), which opened in June 2020, Indigo Gender Service in Greater Manchester from December 2020 (managed by GTD Healthcare), CMAGIC in Cheshire and Merseyside from February 2021 (Mersey Care NHS Foundation Trust) and the East of England Gender Service from June 2021 (Nottinghamshire Healthcare NHS Foundation Trust, in partnership with Cambridgeshire and Peterborough NHS Foundation Trust).

detransition).[125–129] People who detransition are a heterogenous group. However, initial research suggests that a high proportion initially transitioned before the age of 25.[104,130,131]

People who detransition are not specifically mentioned in the adult gender identity clinic service specification or the child and adolescent interim service specification.[87,122] However, these services are designed for people questioning their gender identity and so those questioning their transgender or non-binary identity would be eligible for support. There is concern from some researchers that people may avoid health services due to stigma and concerns that clinicians may be unable to meet their needs.[132]

There are calls from some academics to increase research and the support available for those who detransition.[133]

There are currently no clinical guidelines available to aid care of people who detransition. Research has shown that people particularly need psychological support and support managing reduction or stopping of hormone therapy.[119,134]

5 Policy impact

The way the medical community defines gender incongruence is changing (Box 4). This has potential future implications for the way gender is recognised in legislation. Changing terminology also affects how people access related health services, as the first step to accessing gender identity health services in the UK currently is to receive a diagnosis of gender dysphoria.[26]

Box 4. Medical terminology that refers to gender incongruence is evolving

The World Health Organization (WHO) manages an international system for recording health conditions called the International Classification of Disease and Related Health Problems (ICD).[135] The ICD coding system of diseases, disorders, and health conditions enables digital health data to be compared globally.

In 2022, the 11th edition of the ICD changed gender incongruence from a mental health to a sexual health classification.[35] The WHO's position is that this facilitates individuals accessing medical and surgical interventions that they may need, and addresses stigma.[135] Some stakeholders argue that gender incongruence should be removed from the ICD*; they feel this action would demedicalise and destigmatise diverse gender identities.

Gender dysphoria is a diagnosis defined in the Diagnostic and Statistical Manual of Mental Disorders Version 5 (DSM-5).[37] Gender dysphoria occurs when there is an incongruence between a person's sex registered at birth and experienced gender, which is accompanied with clinically significant distress or impairment in social, occupational, or other important areas of functioning.[137] The DSM-V is an American classification system for mental health conditions and is widely used in UK psychiatry practice.

* Gender incongruence in children in particular is seen by some stakeholders as an unnecessary medical diagnosis as children with gender dysphoria rarely need to access medical or surgical treatment before the onset of puberty.[136]

In the UK applying for a GRC (Box 5) requires two medical reports from a doctor or clinical psychologists (one to confirm a diagnosis of gender dysphoria the other to describe any treatment received), to have lived in the acquired gender for 2 years and sign a statement to commit to live in the acquired gender for life.[138] However, LGBT organisations view this as an outdated approach and that a move towards self-declaration, and removing the need for medical assessments, would better reflect the changing understanding of gender identity.[139,140]

Some women's rights organisations are concerned that increasing access to GRCs could undermine women's rights.[141,142] The Equality Act 2010 (Box 5) already enables providers to restrict the use of services or spaces (for example hospital wards or domestic violence refuges) on the basis of sex, where limiting that service is a proportionate means of achieving a legitimate aim.[143] However, some stakeholders believe that liberalising the availability of GRCs, would give people registered male at birth increased access to spaces aimed at people registered female at birth and undermine the protected characteristic of sex.[144] There was a parliamentary debate about these matters in June 2023.[29,145]

Box 5 Key Legislation

- **Equality Act 2010.** Gender reassignment is a protected characteristic under the Act. The Act states that "a person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex".[80]
- **Gender Recognition Act 2004 (GRA).** The GRA enables transgender adults (18 years or older) to apply to the Gender Recognition Panel to receive a Gender Recognition Certificate (GRC).[146] This requires a medical diagnosis of gender dysphoria and proof of living in the acquired gender for at least 2 years.[138]

5.1 Recent policy developments

The House of Commons Women and Equalities select committee in its 2021 Reforming the Gender Recognition Act (2004) inquiry recommended that the Government should "remove the diagnosis of gender dysphoria from the Gender Recognition Act by 2023" whilst ensuring that "appropriate safeguards" remain in place "ensuring that the rights of natal women and the

use of single-sex spaces and separate-sex exceptions in the Equality Act 2010 are protected". The committee recommended that "robust guidance" on how a system of self-declaration would work in practice should be developed.[147,148]

The Scottish Parliament attempted to adapt the Gender Recognition Act 2004 by passing the Gender Recognition Reform (Scotland) Bill. This Bill would have reduced the minimum age a person can apply for a GRC from eighteen to sixteen; removed the need for a medical diagnosis of gender dysphoria; and removed the need to evidence living in the acquired gender for two years (to 3 months, or 6 months for applicants under 18, with an additional 3 month period of reflection).[149]

The UK Government used section 35 of the Scotland Act 1998 for the first time in history to prevent the Bill from proceeding to Royal Assent.[150] The UK Government said it was concerned with the impact having a different parallel system would have on the application on the Equalities Act 2010.[151] They stated this could impact single sex clubs, the Public Sector Equality Duty, equal pay and increase fraudulent applications for GRCs.[152]

There are currently no plans for the UK Government to change the criteria in the GRA for legal gender recognition in England.[153]

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