

Gender specialists
questionnaire

conducted December
2021 – January 2022

Summary of responses

The Cass Review

Introduction

Context

About the Cass Review

The Independent Review of Gender Identity Services for Children and Young People (the Cass Review) was [commissioned by NHS England](#) to make recommendations about how to develop and improve the services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence.

The scope of the review is broad and will look at different aspects of gender identity services from primary care through to specialist services with a focus on how care can be improved.

Background

In May this year, the Review Chair, Dr Hilary Cass [wrote to NHS England](#) setting out some of the immediate issues with current provision of services and suggesting how the Cass Review team might help with the challenging problem of establishing infrastructure outside of the specialist Gender Identity Development Service (GIDS).

In Autumn 2021, the Review worked with an independent research and engagement organisation to create an online multi-professional panel of primary and secondary care clinicians and social care staff to explore their views on how to build and sustain the capacity, capability and confidence of the wider workforce.

You can read the report of this activity on the Cass Review website: <https://cass.independent-review.uk/>

About the gender specialists survey

Having concluded the professional panel exercise, the Review wanted to triangulate what it had heard with the thoughts and views of professionals working predominantly or exclusively with gender questioning children and young people.

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 specialists through our listening sessions and from primary and secondary care professionals engaged in the professional panel activities. Some of the questions posed were therefore deliberately provocative to stimulate discussion of some of the key issues. The survey included a mixture of quantitative and qualitative questions.

The survey was conducted between 14 December 2021 and 16 January 2022. The survey link was sent by email to current staff working in the Gender Identity Development Service (GIDS). It was also circulated to a number of former GIDS clinicians who had previously been in touch with the Review. The purpose of the exercise was explained to the participants, and they were informed about how the material collected would be used (including the use of quotes).

A total of 33 responses were received from current and former gender specialists. While this is a relatively small sample, the quality and fullness of the responses received was very high and the exercise yielded valuable insight and feedback. We are immensely grateful to all those who took the time to respond to the survey with such thoughtful and full answers.

About this report

This report presents summary thematic findings from the online research survey seeking the views and thoughts of clinicians and associated professionals working predominantly with children and young people needing support around their gender identity. All quotes have been anonymised.

The information gathered represents the views and insights of the 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.

Where comments have been made that relate to the quantitative questions these have been used to illustrate the insight from those questions. On a couple of occasions within the report, longer quotes have been shortened to allow as many different perspectives to be represented as possible. Where this is the case three dots (...) have been used. Every effort has been made not to change the meaning of the comment made. If a word has been added for ease of reading, this is represented in square brackets [].

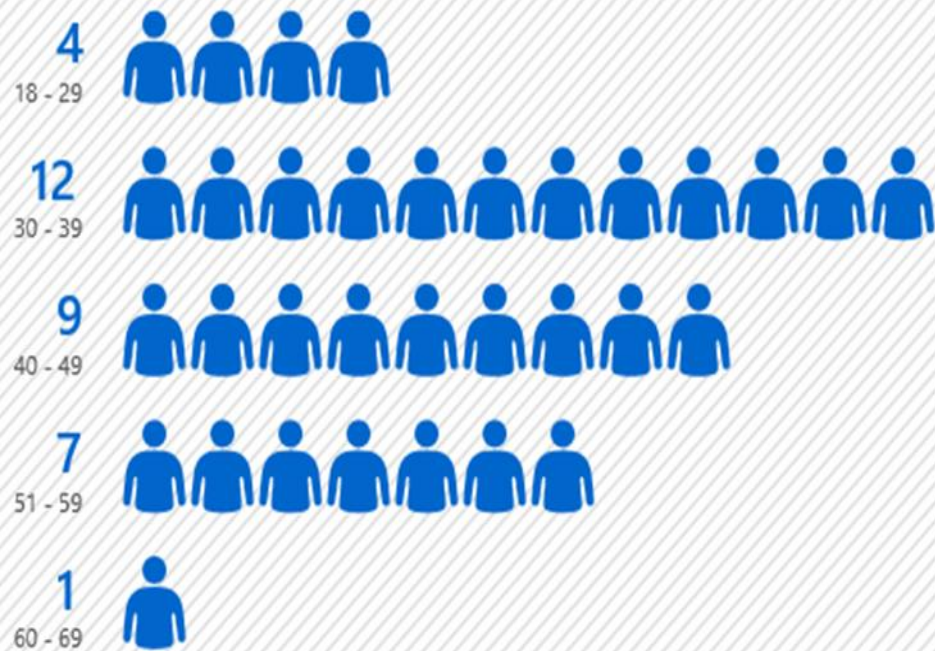
The report represents a sample of the specialist workforce and cannot be considered to represent the position of all specialists who are currently working or have previously worked in this field.

This is one part of the work that the Cass Review is undertaking to understand the experiences and views of those involved and/or engaging with health services for gender questioning children and young people.

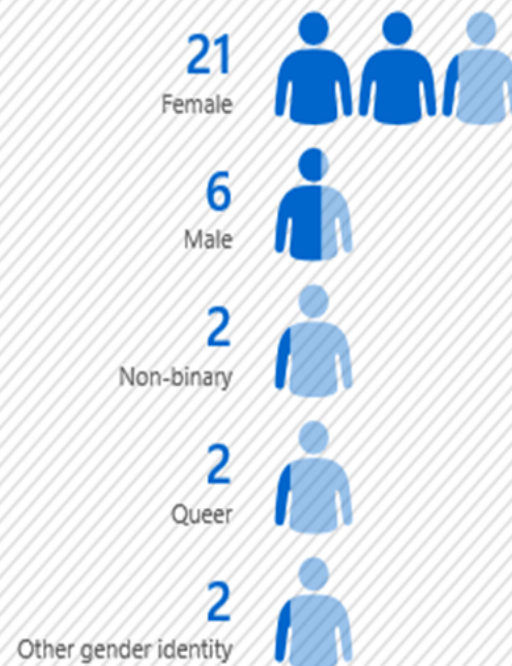
Respondent profile

Respondent profile

Age

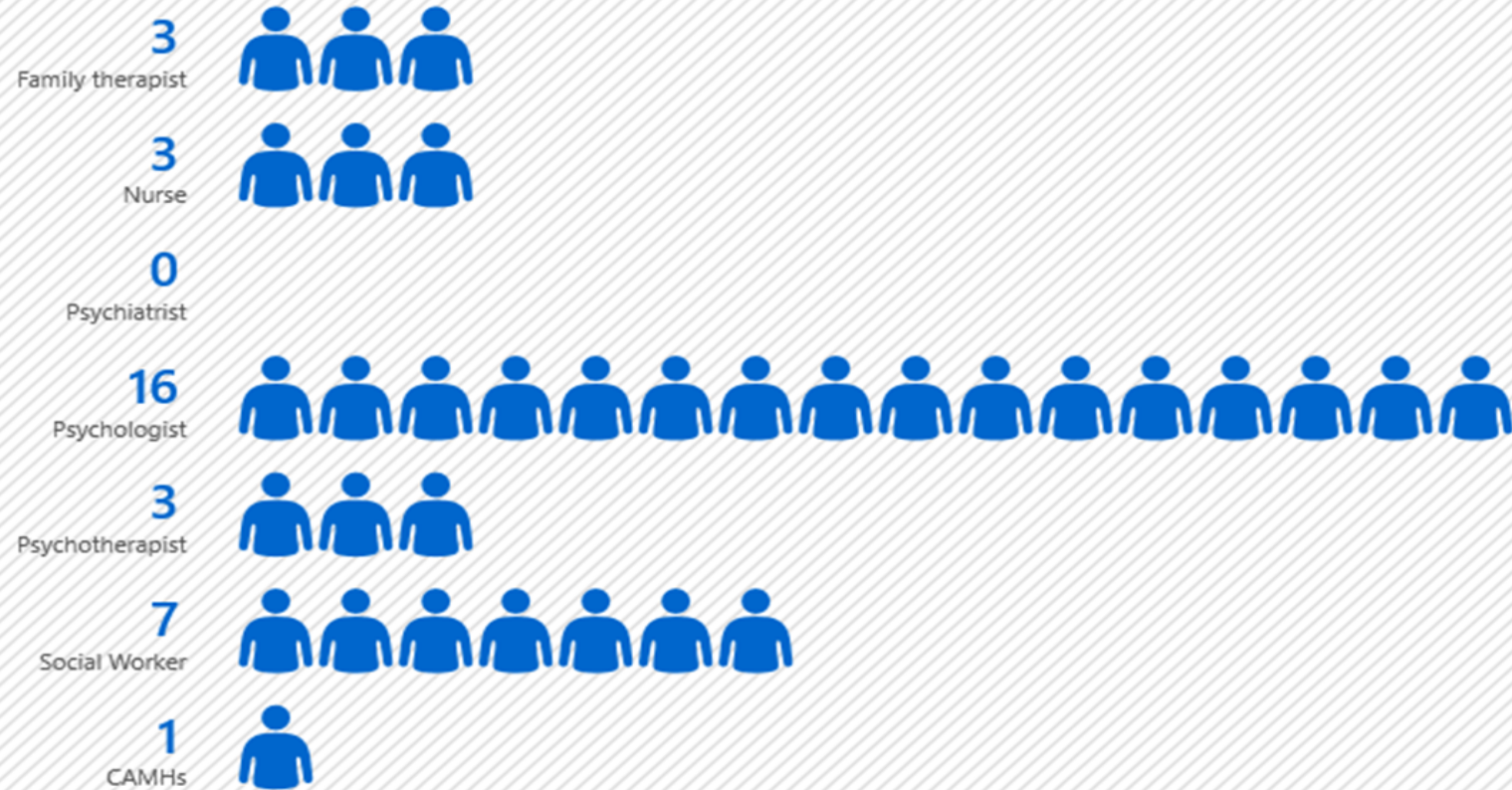


Identified gender

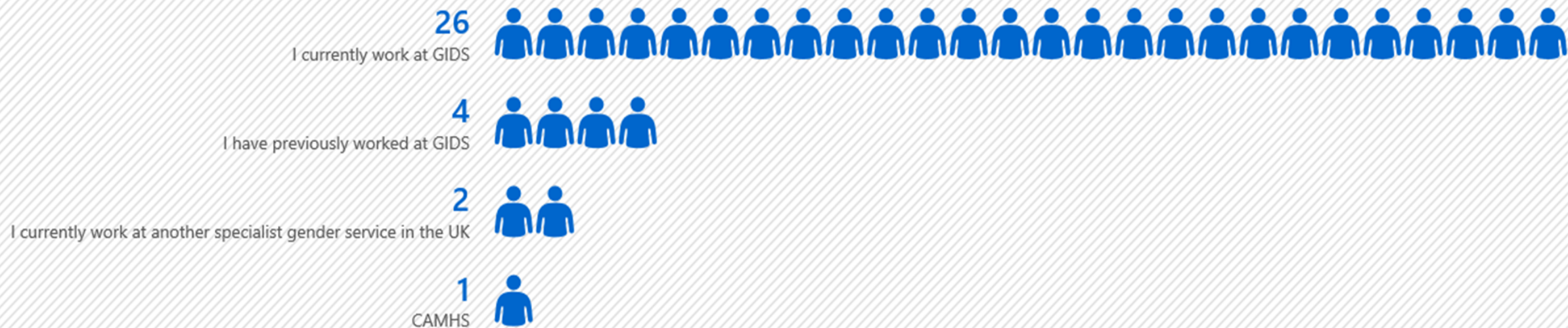


Respondent profile

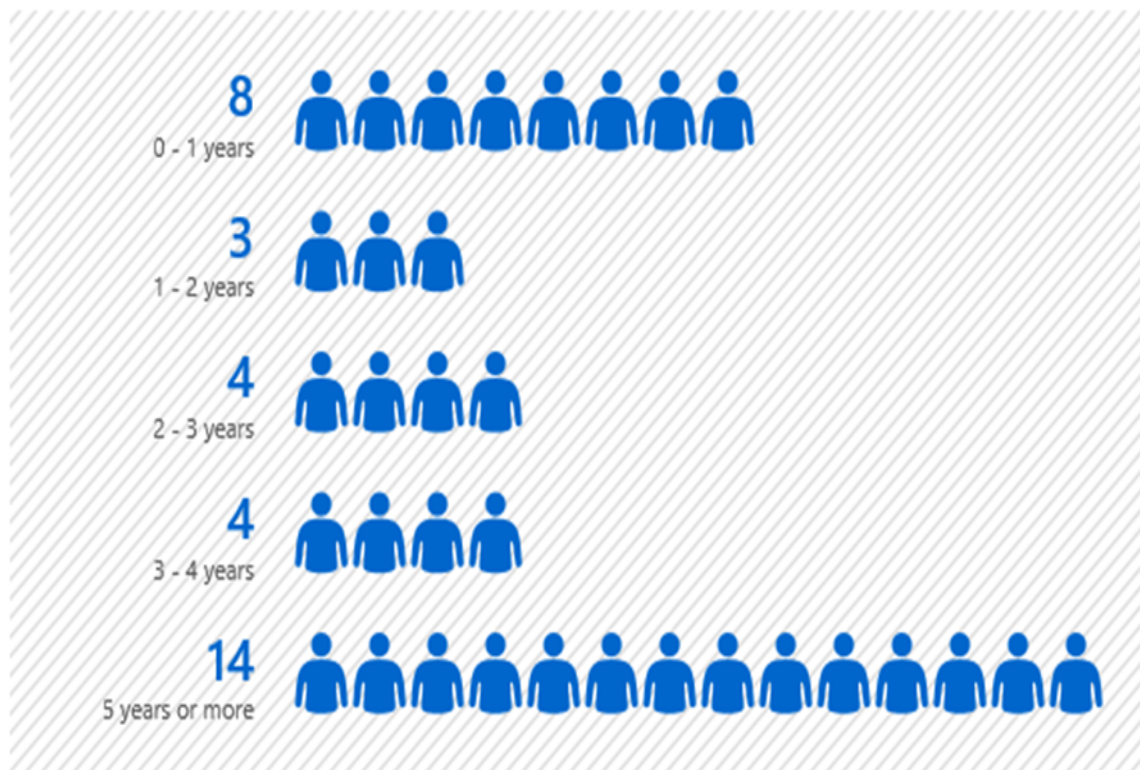
Profession



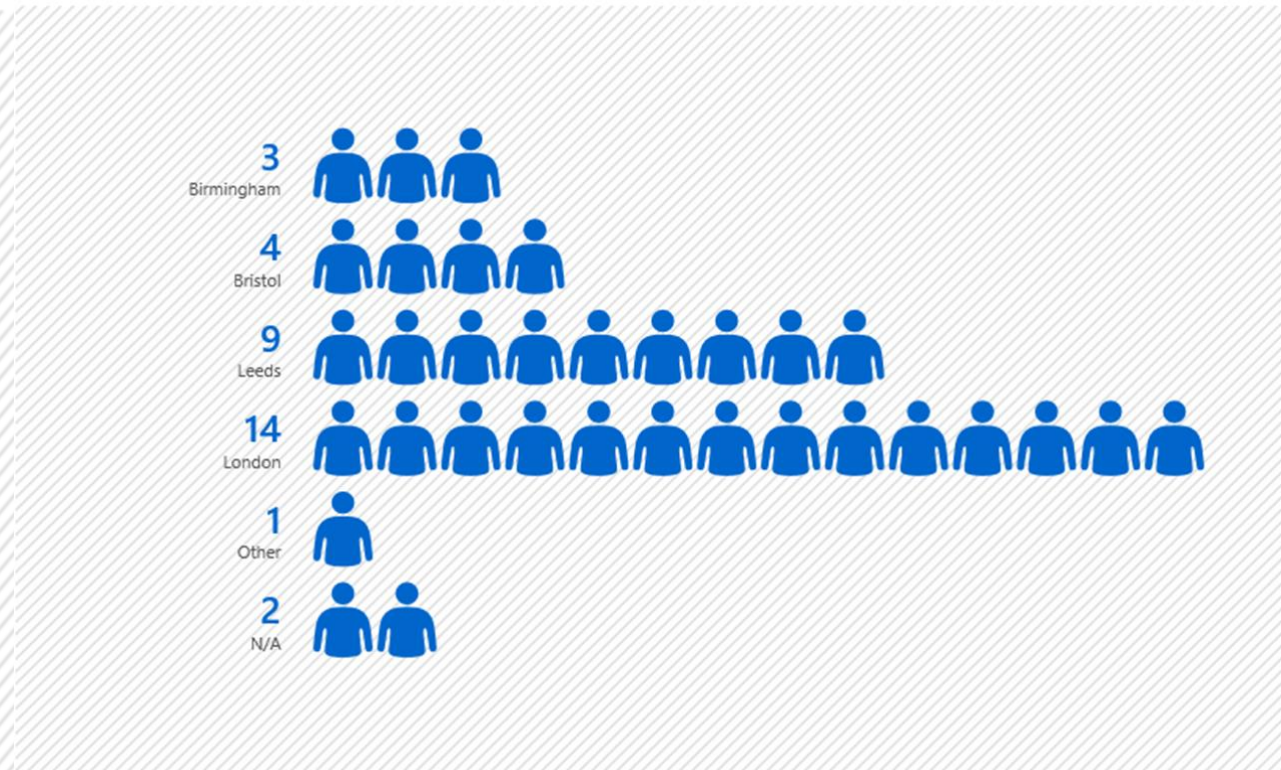
Employment



Years working at GIDS (if relevant)



Base if currently work / previously worked at GIDS



Overview of responses

Summary of findings

There are a number of consistent themes arising from the survey:

- The specialty is a rewarding but challenging field to work in, particularly given the waiting list pressures and level of external scrutiny of the service.
- The detrimental impact of the long wait to be seen by the specialist service can be seen both in terms of the mental health and wellbeing of the child/young person and their openness and ability to engage with assessment when they are seen at GIDS.
- There needs to be better links between specialist services and local services such as CAMHs to ensure the Child/young person receives a timely and holistic assessment and support.
- For the service offer to improve there needs to be more workforce capacity not just within specialist services but within the wider system, different pathway options and clear clinical guidelines.

However, there are also a number of areas where there is less consensus:

- There is not a clear agreed view about the primary purpose of puberty blockers, which may be different depending on the young person's age and stage of puberty.
- There is not a clear view amongst the specialists who responded to the survey as to the purpose of the assessment. Some respondents felt that assessment should be focused on whether medical interventions are an appropriate course of action for the individual. Other respondents 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 what the role of the specialist service should be within the wider care pathway.
- 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

Detailed Responses

About the service user cohort

Respondents were asked what they consider to be the differences or commonalities when providing a service for a child or young person who needs support around their gender identity compared to another child or young person experiencing non-gender-related distress.

Commonalities: Some respondents felt that there were many commonalities between this patient cohort and other children and young people experiencing non-gender related distress.

"In many ways [there are] more commonalities than differences - dealing with developmental issues, relationships and systemic issues."

Among the commonalities cited were:

- **The nature of young people themselves.**

"Young people questioning their gender identity and those who are not are similar in having a great many personal resources and resilience, as well as often having had very difficult early experiences in their lives (such as trauma)."

"Young people and families in distress are young people and families in distress. I feel that what often gets lost on the wider political debates is how to actually support the individual young people and their families who are in high states of distress who are locating that distress in gender."

- **The professional skills needed.**

"All of the usual skills for providing a service for young people and families are the same - e.g. engagement, compassion, curiosity, being responsive, and conducting appropriate assessments, formulations and intervention plans."

"There are lots of commonalities, in that you would be looking at all parts of a young person's life to understand their distress and how to support them best. You would be listening to the child or young person and really trying to understand their feelings and ideas about the world, and their understanding of themselves. You would be encouraging them to explore and question. You would be helping them to improve their confidence and self-esteem. Cultural competence and an open mind would hopefully be a commonality."

"Some of the commonalities are having an open and honest approach, empathy and caring. Multi disciplinary working, clinical skills."

- **The need to provide a safe space to discuss concerns.**

"Supporting young people and family to discuss difficult/complex/multi layered topics is a transferable from gender to non gender related distress. This involves creating spaces that feel safe, creating new ways of talking or thinking about things, helping families to navigate topics they are stuck with or find hard to talk about with out support."

"The importance of building a therapeutic relationship to enable engagement and communication. A safe space and time to discuss concerns/distress is a desire for young people whether they are experiencing gender related distress or not."

- **The need for a (non-directive) thoughtful approach and assessment.**

"I think all young people experiencing gender related distress could benefit from the same kind of therapeutic approaches as their cis counterparts managing distress, such as ACT, CFT, mindfulness and DBT techniques for managing distress, and trauma-focussed and systemic interventions."

"If it weren't for the availability of the medical pathway then I would argue that there is little difference in working with a child who is distressed about their gender as compared to any other child. For any distressed child you would need to do a full assessment, develop a formulation to help explain their particular distress, and then use interventions to try and alleviate that distress."

"All children experiencing psychological and physical distress should access thorough assessment and formulation to ensure that we can be clear about what intervention should be offered"

- **The need to work with the young person's family and the wider network.**

"Commonalities are that we work with the young person within their family and systems - school, CAMHS etc, we are interested in their experience of their gender identity as well as what other people around that have observed and heard."

"Involvement of families/parent/carers to support the young person."

About the service user cohort

Respondents were asked what they consider to be the differences or commonalities when providing a service for a child or young person who needs support around their gender identity compared to another child or young person experiencing non-gender-related distress. Continued.

Differences: Other respondents felt that there are more differences than commonalities between this patient cohort and other young people experiencing non-gender related distress.

“As well as there being commonalities, I would say the differences outweigh them.”

Among the differences cited were:

- **The need for clinicians to have specialist knowledge about gender identity.**

“A thorough understanding of gender diversity is needed by the clinicians, alongside knowledge of the difference between gender identity and expression, the available pathways and what these involve (especially that there is more than one pathway - there is a need to invite uncertainty and curiosity into the conversation - just because someone is trans does not mean that medical transition at this time is the right thing for them).”

“I think it is important to be as knowledgeable as possible about trans and queer identities, and conversations about gender which young people have...I think coming to the work with a general understanding of terminologies, ‘debates’, multiple perspectives on gender is important when having therapeutic conversations with young people, in order to clearly position yourself as not aiming to change their gender identity but hoping to help them to better manage gender based distress.”

- **Societal contexts including systemic and societal transphobia.**

“Social contexts can be very challenging for someone presenting with gender related distress. Young people presenting with gender related distress can seem to provoke strong reactions - both for and against - in others close by. I do not seem to have witnessed this to the same extent for other young people presenting with non-gender related distress.”

“Experiences of transphobia - such as bullying at school, or systemic transphobia in terms of lack of funding for services or systemic barriers to care.”

“Young people with gender-related distress often experience societal discrimination/bullying, needs to be taken into account within the work and addressed on a wider level.”

- **The need to be non-directive.**

“There needs to be a nuanced, education and thoughtful approach to support young people accessing gender services with no preconceived ideas as to what the young person may want. This differs to other areas of healthcare where there may be somewhat of an expectation that the medical professional will direct the appropriate clinical pathway.”

“You aim to reduce distress that some young trans and non-binary people experience by supporting them with their mental health and wellbeing; promoting self-acceptance, esteem, confidence etc. all of which can suffer due to minority stress and dysphoria. It's hard work and there isn't much evidence to let us know the most effective psychotherapeutic ways of alleviating distress in this group.”

- **Availability of local services / support for co-occurring conditions.**

“The GIDS model does not allow treatment for Mental Health problems to be provided at GIDS so we rely heavily on the local Network... It is becoming increasingly difficult to obtain support from CAMHS unless the young person is self-harming or suicidal, and even then the support offered is short-term and increasingly not fit for purpose...GIDS staff are left ‘holding’ these young people who do not have local support, which is inappropriate and unsafe/risky.”

“At present when there [are] associated Mental Health difficulties, I would not carry out the therapeutic work around this but rely on local services, however local CAMHS services are under resourced and the required work does not take place.”

- **The competence and confidence of clinicians outside GIDS to work with these young people.**

“I suppose one of the main differences is that mental health services think they know how to support young people experiencing things like low mood, anxiety, self-harm - and there are plenty of evidence-based therapies they can offer...I think with gender, people can feel very out of their depth. They worry about saying or doing the wrong thing, and there is a distinct lack of training on professional courses about helping people with gendered distress. This means that generally these young people will end up at specialist services, even if they have co-occurring needs that should have been met locally.”

“There is a lack of knowledge, understanding and expertise to support young people with gender related distress within mainstream services.”

“It is different in that other services have positioned gender as being so expert that only GIDS can manage it - with other difficulties often having gone untreated and worsening during the long waiting time.”

- **The medical model and medical interventions.**

“To work with gender related distress at the moment, you are constantly aware of the pressure of the medical model. A child/family can fixate on this being the only solution to the suffering and that makes them less likely to engage in the regular psychotherapeutic techniques described above.”

“Physical interventions for gender feel like a more long-term medical intervention than most other medical interventions offered to distressed young people.”

“The medical interventions we provide are not well-researched or evidence based, and they also have potentially life-long and life-altering impacts, which means the work we do is inherently more difficult, complex and thoughtful”

- **The focus on Gender alone and risk of diagnostic overshadowing.**

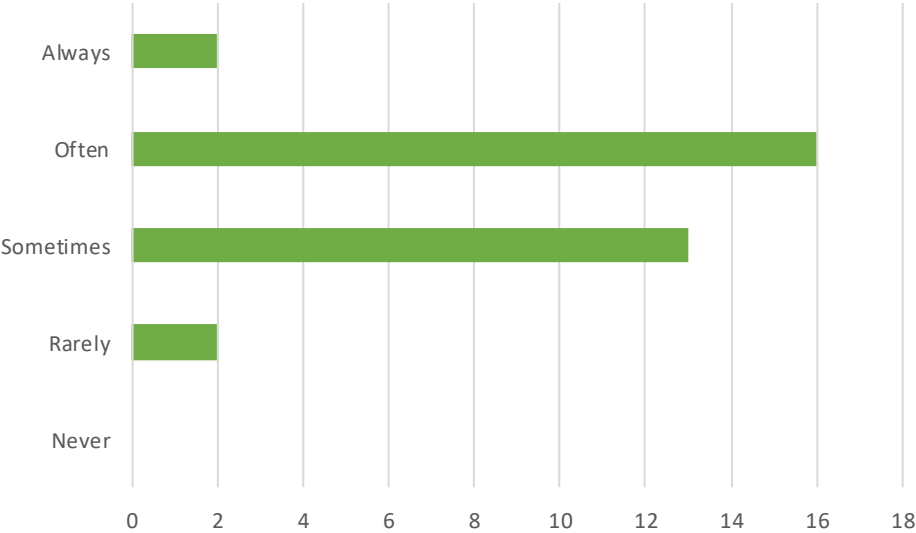
“Gender tends to be seen as the unique factor responsible of the young person's difficulties and distress, and it is much more difficult to hold in mind the possibility of addressing other needs, both for young people and their families, but also for other professional support services like CAMHS or GP.”

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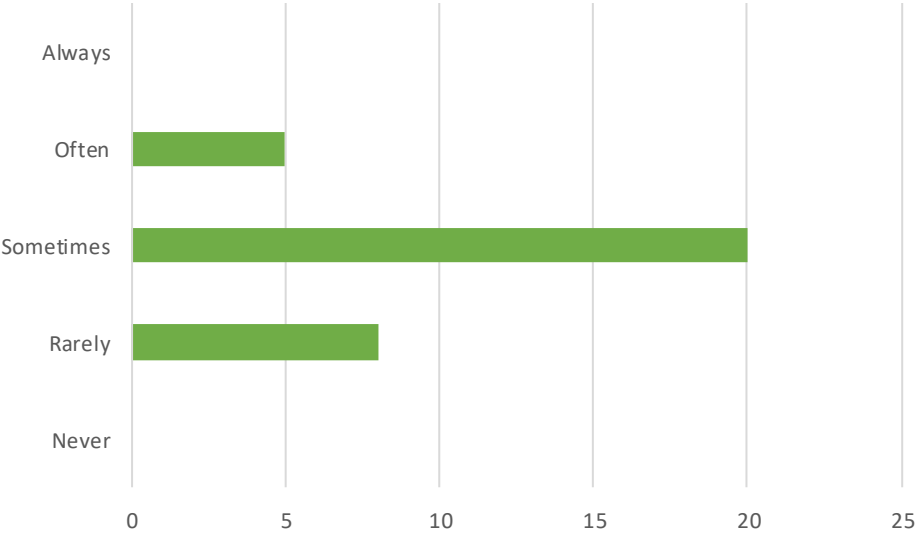
About the service user cohort

Respondents were asked the extent to which they agreed or disagreed with a series of statements:

In your professional experience, children and young people who need support around their gender identity have already obtained information about potential interventions and care pathways available to them



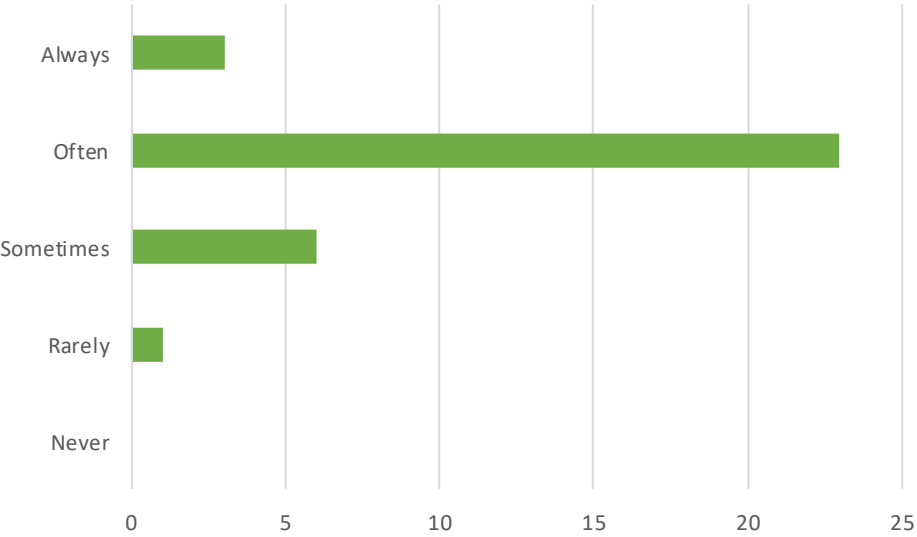
In your professional experience, children and young people who need support around their gender identity are well informed about their options



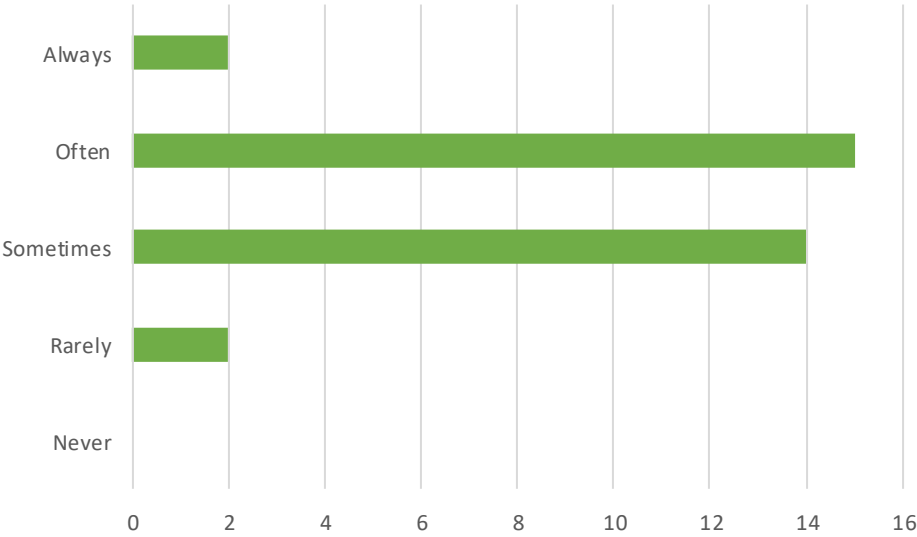
About the service user cohort

Respondents were asked the extent to which they agreed or disagreed with a series of statements:

In your professional experience, children and young people who need support around their gender identity arrive with a pre-determined preferred intervention/pathway in mind



In your professional experience, parents/carers of children and young people who need support around their gender identity arrive with a pre-determined preferred intervention/pathway in mind



About the service user cohort

Overview of findings:

- While a majority (87.5%) of respondents felt that children and young people often (48.5%) or sometimes (39%) arrived with some level of information about potential interventions and pathways there was less confidence that they were well-informed about their options on arrival with 24% of respondents stating that this was rarely the case and 61% suggesting this was sometimes the case.
- A majority (70%) of respondents felt that children and young people and to a lesser extent their parents/carers (45%) often arrived at clinic with a pre-determined preferred intervention in mind.

Comments made to other questions in the survey add more context to this and how it can affect the work GIDS does:

"In general, I regularly see children and parents who would have done extensive research on what is available to them in relation to gender related and therefore sometimes it can be a barrier to the exploration and assessment work if they have a fixed idea on what they want/feel they should receive. I would add that this is not the case for every family and even some who have perhaps set ideas when they arrive at GIDS do engage well with exploration."

"Young people and families often came with very definite views of the 'solution', which largely lies in physical interventions. Unlike in other services, GIDS were often seen as withholding something that private services were selling as the cure. This meant a higher proportion of people coming in with quite antagonistic attitudes towards the clinicians and armed with a very challenging approach."

"Often young people and parents have a fixed idea in their mind about the cause of the young person's distress, and the intervention needed to manage this (medical intervention)."

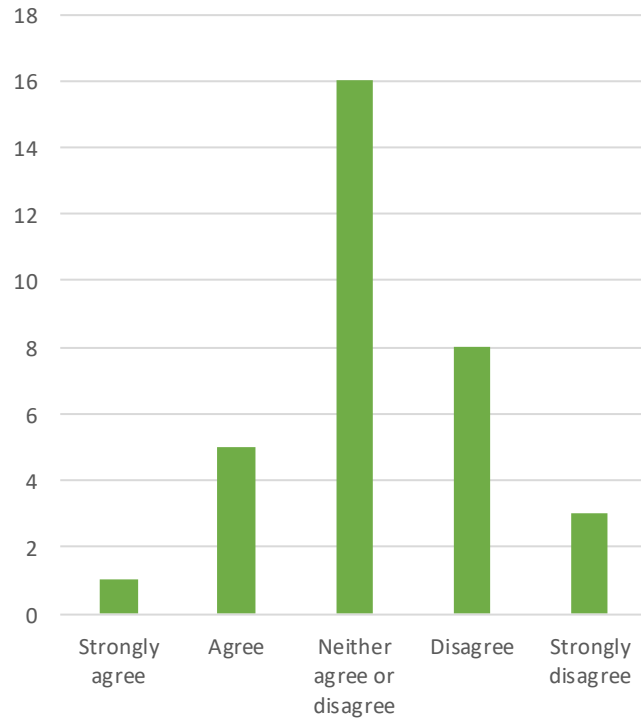
"I have found that initially young people present with very similar narratives to one another and events in [the] family tend to have unfolded in very similar ways however over time it becomes clear that the reasons why a particular adolescent has become immersed in online transgender spaces and has become drawn to the belief that they are trans do tend to be rather idiosyncratic."

"Families and clinicians often constitute polar opposites of [an] unhelpful dynamic. Parents and young people very often demand physical interventions, and do not see the need to engage in talking therapy; clinicians attempt to do their jobs, but often there is very little scope, the whole assessment being structured around deciding whether a young person will be referred to access endocrinology services by the end of it."

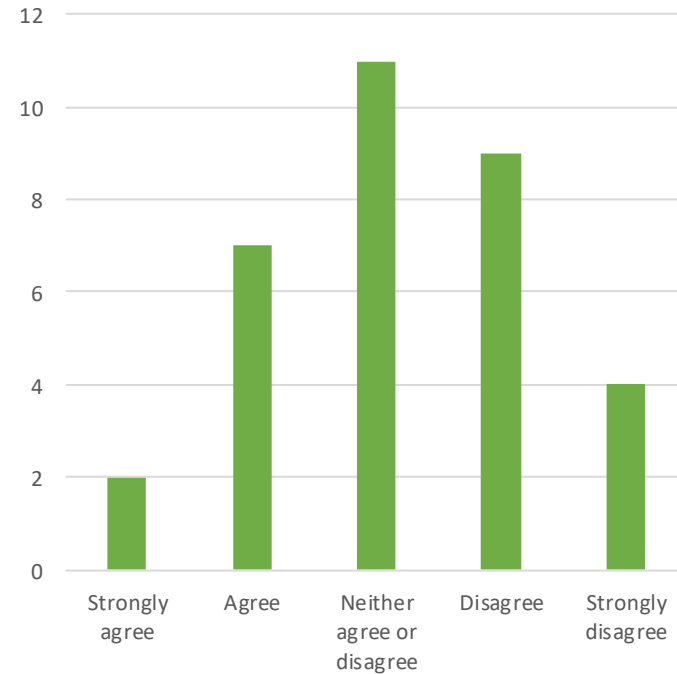
Assessment

Respondents were asked the extent to which they agreed or disagreed with a number of statements regarding the purpose of assessment of children and young people experiencing gender dysphoria.

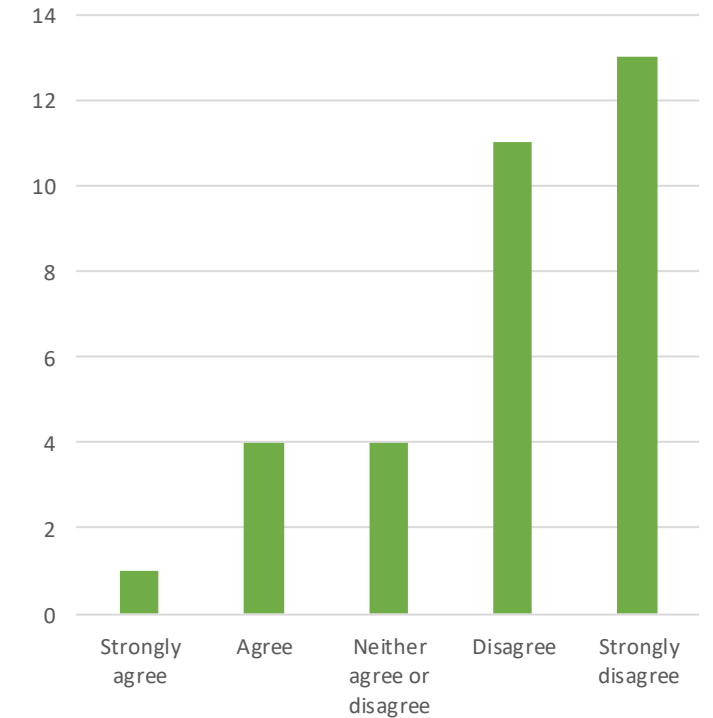
Children with gender dysphoria know their mind, and the purpose of assessment is to determine whether they wish to have medical intervention and their readiness for this.



Gender Dysphoria in children and young people is a symptom, and it is important to make a differential diagnosis as to whether transition is the right option or whether there is another way to address their gender-related distress.



Gender dysphoria is always an indicator of another underlying problem and assessment should focus on understanding the causes of their distress.



Assessment

Respondents were asked the extent to which they agreed or disagreed with a number of statements regarding the purpose of assessment of children and young people experiencing gender dysphoria

There was no clear consensus for any of the given statements regarding the purpose of assessment.

For all three of the given statements, more respondents disagreed than agreed.

It should be noted that several respondents commented that these statements were overly simplistic, which may be reflected in the numbers selecting “neither agree or disagree”.

The strongest consensus was disagreement with the statement *“Gender dysphoria is always an indicator of another underlying problem and assessment should focus on understanding the causes of their distress.”* (39.4% strongly disagreed and 33.3% disagreed with this statement).

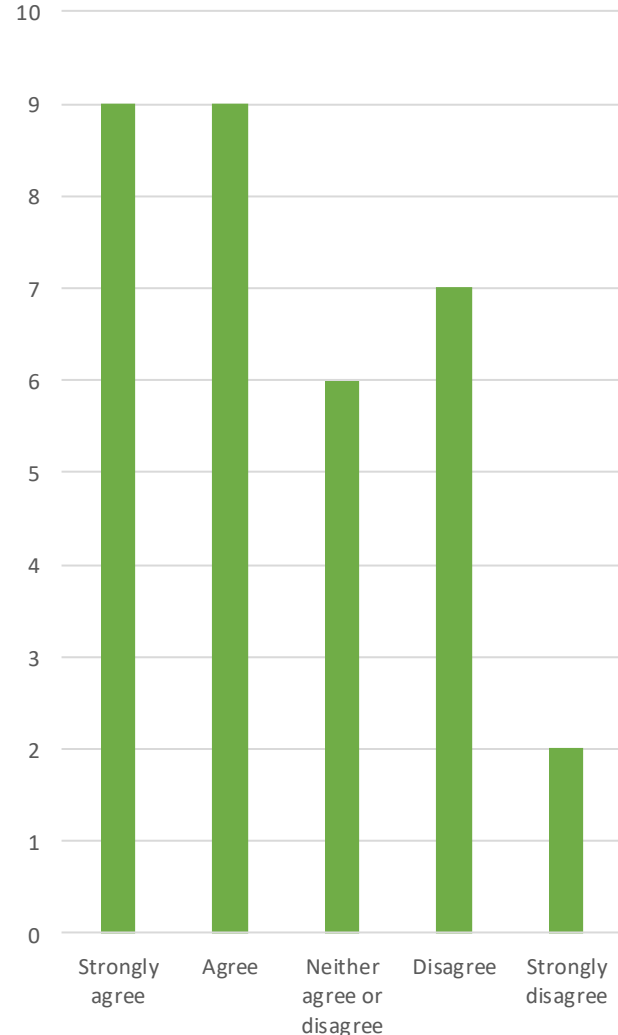
The statement receiving highest level of agreement was *“Gender Dysphoria in children and young people is a symptom, and it is important to make a differential diagnosis as to whether transition is the right option or whether there is another way to address their gender related distress.”* (6% strongly agreed and 21.2% agreed with this statement).

However, even in this case, more respondents disagreed (27.7%) or strongly disagreed (12%) with the statement than agreed.

Assessment

Respondents were asked the extent to which they agree or disagree that it can be helpful to undertake a mental state assessment on children and young people presenting at their clinic.

They were also asked what role they think a mental state assessment has in the care of children and young people needing support around their gender identity.



- A majority (55%) of respondents agreed or strongly agreed that a mental state assessment would be helpful in assessing the children they were seeing at their clinic. However, a notable minority (27%) did not agree with this.

- Respondents who agreed that a mental state assessment would be helpful reasoned that it would provide a fuller picture of the young person and was helpful in managing risk.

"It is helpful to understand risks and enable a multi-professional response within the YP [young person's] network. It is also helpful to understand the YP functioning so that assessment and intervention is tailored to the YP needs and level of understanding."

"I think it is imperative that young people receive a mental state as well as risk assessment in order to ensure all of their mental health needs are met and to reduce/manage risk. Living with gender dysphoria for a number of years (whilst on the waiting list) without the intervention of a specialist service can impact someone's mental health and increase their risk greatly."

- Some respondents suggested that it can be helpful but only part of a broader assessment process.

"I think mental state assessments are important, but only a (small) part of a broader assessment around gender development. It doesn't cover gender identity development over time and context, developing an understanding, family perspectives, hopes for future, developmental assessment, etc.."

- A smaller number of respondents felt that a mental state assessment had no role in the care of children and young people needing support around their gender identity and doing so risked pathologizing the young person unnecessarily.

"None. It is a snapshot of someone's presentation on that particular day at a particular time. It is a psychiatry tool that risks undermining the validity of patient experience and the ongoing, dynamic, and relational nature of the therapeutic relationship between client and clinician."

"None. This would be irrelevant for the young people I see. The tool lacks depth and complexity, and I would be unsure of the purpose of using it. The tool is part of psychiatry and has no place in GIDS."

- Some clinicians said that a mental state assessment should be undertaken only when clinically indicated but that it should be done by local CAMHS and was not the role of GIDS.

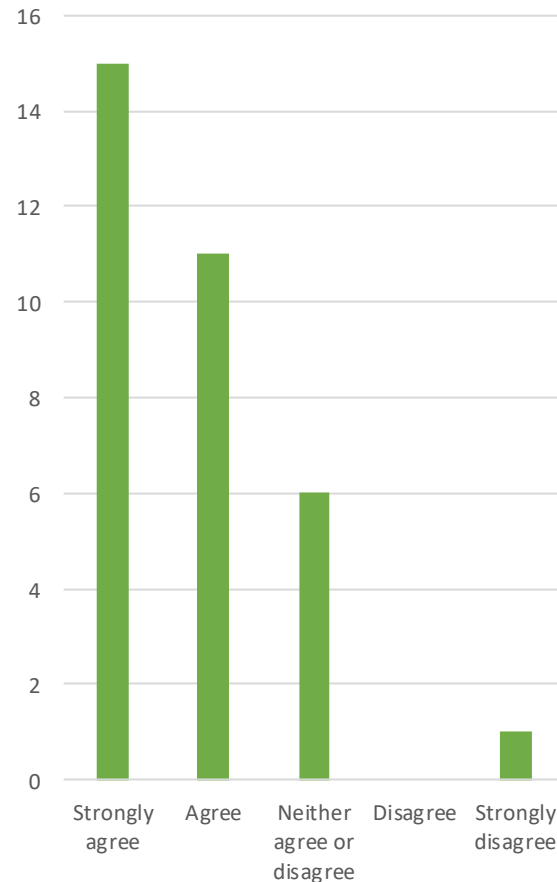
"The same as in any service, that if someone is presenting in acute distress/mentally acutely unwell then a mental state assessment would be appropriate but would be done by their local network and not in GIDS."

"As gender dysphoria isn't considered a mental health condition, it is unclear what role a mental state assessment would play. If there were concerns regarding mental health needs, my view is that it would be the responsibility of the local CAMHS team to undertake a mental health assessment."

Assessment

Respondents were asked the extent to which they agree or disagree that it can be helpful to use psychological formulation* with children and young people presenting at their clinic.

They were also asked what role they think psychological formulation has in the care of children and young people needing support around their gender identity.



- The majority (79%) of respondents agreed or strongly agreed that psychological formulation can be helpful in assessing children and young people needing support around their gender identity. 18% neither agreed or disagreed and 3% (1 respondent) strongly disagreed.
- Those respondents that agreed that psychological formulation is helpful reasoned that it can provide a structured process for understanding the child or young person's distress and provides a more holistic picture of the young person which can be helpful in developing an appropriate care plan.

"The process can build an understanding around the factors underlying any distress. This may identify those related to gender or those not and can enable exploration with the young person and build an understanding and picture. This can also enable signposting to other services if required, i.e. CAMHS, GP etc."

"Bringing together all relevant aspects of someone's life and context to make sense of their current experiences and indicate possible helpful ways forward. When co-created this can be one of the most powerful interventions when working with children, young people, and families. With gender-related distress, the aim is to explore and understand, rather than explain away, someone's experiences"

"It's key - how can you know how to help someone if you haven't got an individualised hypothesis as to why they are suffering? If you just use diagnostic assessments then you lose the individual details and so the differences between children's experiences - which are vast - and you are at risk of both confirmation bias and a one size fits all treatment approach, which we know inevitably won't work for everyone."

- Other respondents, while recognising psychological formulation can be helpful in some circumstances, were concerned that it could serve to further stigmatise the young person.

"I don't think it's fair to use gender dysphoria as a psychological formulation as a way to further stigmatise young people as it's not a mental health condition. Some young people and family may internalise having gender dysphoria as having something wrong with them."

"It depends what you're formulating. If you're formulating distress, then yes absolutely. If you're formulating someone's trans or non-binary identity, then no as that feels discriminatory. We don't formulate why a person is cisgender or straight... We need to be constantly self-reflective to detect and interrogate these underlying assumptions that might underpin our desire to formulate a person's gender identity."

"A psychological formulation may be useful in understanding the emotional and relational aspects of existing as a trans person in society. However, it is not appropriate to understanding the aetiology of why someone may turn out to be trans or gay for that matter."

- A couple of respondents felt that it was not possible to have formulation and diagnosis.

"...you can't really have a formulation and a diagnosis, so if a diagnosis is essential for progress through the system the diagnosis trumps the formulation. Some clinicians and the young people do not want a formulation they want diagnosis to go onto treatment, that's what they come for."

* Diagnostic 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.

Assessment

Respondents were asked if there was anything else they wanted to say about assessment of children and young people needing support around their gender identity.

- **The assessment process needs to be tailored to the individual.**

"The assessment of children and young people has to be tailored to the individual child and families circumstances, this includes when certain topics are asked and the pace of the assessment. It is also dependent on their communication needs and readiness to speak about gender. Speaking about gender and the pertinent issues (relationship to the body, gender identity development over time, puberty, sexuality) is emotive and has to be done with respect and sensitivity."

"I believe it is crucial to be able to respond to an individual young person and their circumstances, which means as a clinician I need to retain flexibility and manoeuvrability in response to the young person."

- **Many respondents said that there needs to be adequate time and space given to holistically explore with the child and their family based on their individual needs.**

"What is needed is a space whereby people's understandings of themselves are valued, whilst also providing an open space for exploration of what this means to the individual, and what support they need in order to live a happy and fulfilled life."

"It needs to be done carefully and take as much time as required. It must be conducted in an ethical, purposeful way, that respects the needs of the young person and their families. It should be accountable and open to challenge."

"As a development service, we should be just that. A service that enables a young person space and time to explore, rather than feeling the pressure (clinicians feeling the pressure) to diagnose a young person and place them on a medical pathway."

- **The extensive waiting list has hampered GIDS staff's ability to take this approach.**

"[The] wait has changed the work that we do with families considerably. When we can see young people soon after they seek a referral, we are able to do some exploratory work with them, some of them come to us wanting to explore gender or think about possibly socially transitioning. We are also then able to provide timely and appropriate interventions to [them]. However, now, young people have waited several years, have sought support elsewhere and now mainly come to us wanting to access physical interventions, however for many of them it is too late and we just do an onward referral to an adult GIC [Gender Identity Clinic]."

- **While some respondents feel the current GIDS assessment is robust and thorough they have suggestions on how it could be improved.**

"I think GIDS assessment process is robust, holistic and thorough, which I fully believe is the best way to be conducting these assessments at the current time. I would hope that going forwards, there would be more treatment options available for young people experiencing gender-based distress as well as physical interventions, such as third wave CBT, family therapy or psychotherapy at GIDS"

"I really value the assessment process in GIDS and see this as a cornerstone of the work. It is an intervention unto itself. It is generally a very helpful collaborative process which can support gender diverse young people and their families/carers in a range of ways. I do think the format could be somewhat different perhaps allowing for more flexibility in terms of times between sessions and longer sessions utilizing more creative methods in terms of assessment."

- **Better links between specialist services and CAMHS is needed to ensure the CYP receive a timely and holistic assessment and support.**

"Having worked at both GIDS and CAMHS, I strongly feel that there is a need to change the way in which young people are assessed to ensure they receive a timely and holistic assessment and support. I believe GIDS clinicians should be linked to all CAMHS services in order to support more localised holistic assessments."

"I cannot stress enough the importance of the local support for co-occurring mental health problems, and how it's almost non-existent in many parts of the country... I would very much like to be able to offer therapy to young people at GIDS as I think we might be able to make a difference. A group of us at GIDS are interested in using 3rd wave CBT therapies such as CFT and ACT to alleviate distress and build self-compassion in our trans and NB young people."

- **There is variation of practice in how assessments are carried out.**

"I think the service has tried to be open to different perspectives on the role of adverse life experiences but this results in variations in practice in how assessments are carried out. I think these variations in practice mean that different clinicians end up having different ideas about how common complexity is amongst the population we are seeing (to what extent the developmental history is explored depends on the belief of the clinician about the importance of the developmental history)."

- **The assessment should not be rooted in pathology.**

"The assessment should not be rooted in pathologising young people and/or their experiences. Assessment and outcomes should be holistic - extending to family members, members of network such as GPs and schools."

"We need to be creating gender services that listen to and respect the experiences of young trans people. And that help to normalise those experiences rather than pathologise them."

Care Pathways

Respondents were asked what they think the role of the specialist service should be.

- **To be specialist in their specific area of expertise**

“Offer specialist intervention, support and knowledge to those it works with. To add to and develop the research base for the specific area of specialism. To advocate for this area of expertise and for the people who uses services in this area. Be a beacon for knowledge, skills and training. To have a national presence to add to the discussion in this area.”

“To be the lead in assessing and care planning around gender identity.”

“The service should have specialist knowledge and training.”

- **To provide a fuller assessment, including addressing other cooccurring conditions.**

“Detailed assessment of all areas of health before 17-year-olds go to adult services.”

“To provide a fuller specialist assessment and advise [the] young person/family on options for the future - including addressing co-existing mental health issues and watchful waiting.”

- **To upskill local services, provide expert consultation and manage more complex cases**

“Ideally local services should be available to young people where they can discuss and explore their gender, be supported to try out social transition etc. If this was the case a specialist service would only be needed if they wanted assessment for physical interventions or there were multiple factors at play that local services felt unable to support with.”

“GIDS should move to a consultation only model with all work around gender carried out locally. I think young people are not well served by having gender-based distress separated out from broader thinking about their mental wellbeing. Often, I have felt young people could benefit from more intensive therapeutic support that it is not possible for our service to manage due to current waiting times and the distance that families would have to travel for more regular appointments.”

“Primarily consulting with and skilling up local services, to enable them to feel much more confident and capable to manage gender distress within their daily work. Alongside this there would need to be more funding for local services though... I feel that GIDS could then only see the more complex cases rather than any case where gender or sexuality is just mentioned.”

“To liaise with a wider network and to educate local services who can support that person in a more robust way”

- **To review and support a young person and family to explore gender and have a safe space to do so.**

“A service that enables children/young people and/or their parents/carers [to have] a safe space to explore around gender. For them to feel supported and listened to, and [have] time to build the therapeutic relationship. For the clinician(s) to adapt their approach to enable accessibility to the service and provide [the] child/young person and/or their parents/carers with appropriate information around this area to enable them to make informed choices.”

“To support young people who are experiencing gender related distress, both through therapeutic discussions and [to] support them in thinking about medical interventions and if this is the right path for them.”

- **To explore whether physical interventions are appropriate for the individual**

“To hold a curious, open, safe, reflective, informed and knowledgeable space to think broadly around gender identity [and] gender development with young people and their families. If a young person would like to access a medical pathway, to support a young person with this process via an assessment and as part of this [give] further consideration to the medical pathway to fully support the young person to make an informed decision without having an opinion either way whilst bearing in mind we are working with a community that experience systemic oppression and there is a need to ensure that the work we do is collaborative and gentle and without judgment.”

“Providing gender related advice and support to young people and explore whether physical intervention (hormone blockers and cross sex hormones) is an option for the young person, and [if] it's not support and exploration of other pathways should be given. Support around managing gender dysphoria, and young people feeling validated and supported. Managing uncertainty around the future and providing support on how to manage this. Offering a space for reflection for the young person and family. Also liaising with school, CAMHS, GP and other organisations to ensure the young person's holistic needs are met.”

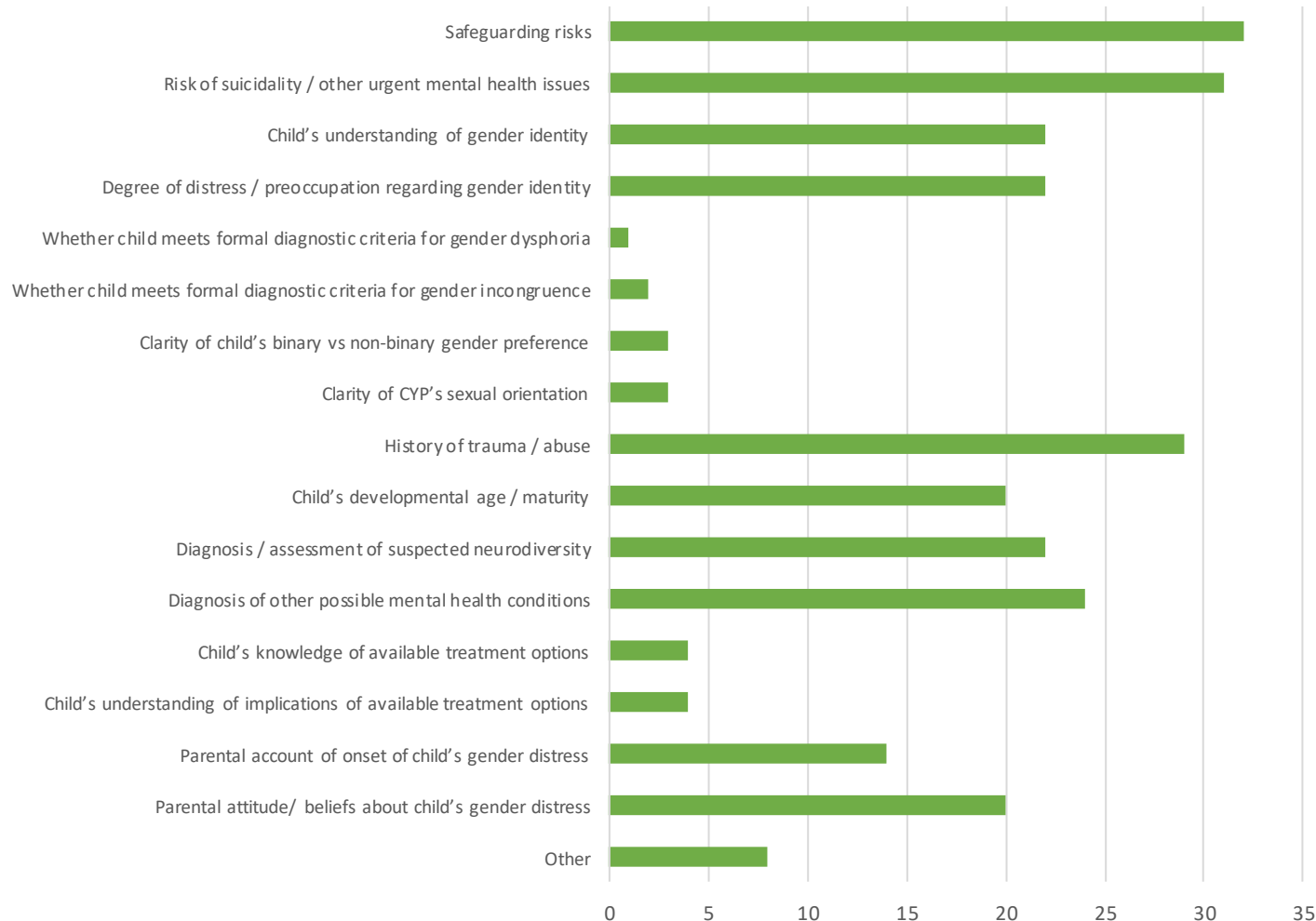
- **It should contribute to research and thinking**

“To research and publish treatment findings, as well as reflective and sociological pieces.”

“To develop a coherent and evidence-based understanding of the massive increase in adolescents identifying as transgender and develop a therapeutic psychological model for helping children and young people to feel comfortable with themselves and with their bodies that can then eventually be disseminated across local services.”

Care Pathways

Respondents were asked about their minimum expectation of the support other agencies should have offered to young people and their families before they are referred to GIDS



- **The top responses were:**

- Safeguarding risks.
- Risk of suicide and other urgent mental health issues.
- History of trauma or abuse.
- Diagnosis of other possible mental health conditions.
- Diagnosis or assessment of suspected neurodiversity.
- The child's understanding of gender identity.
- Degree of distress / preoccupation regarding gender identity.

- **Respondents added a couple of “other” types of support or information they would expect other agencies to have offered prior to referral to GIDS:**

- Physical health and whether they are on any medical treatments.
- Who is involved in the [young person's] network.
- Broader mental health support to manage a range of associated difficulties.

- **In addition, general comments made were:**

“None of these are support, they are assessments.”

“I have ticked the above in terms of what I would like to see provided to us, but we struggle to get GPs to do risk assessments of young people let alone more detailed assessments”

“Professionals completing referrals and children/parents need an awareness, understanding and knowledge that each person's gender journey is individual (even a heteronormative one) and there is no right way to transition, if indeed one does choose to transition. Not all people experiencing gender and/or sexual diverse identities need or want to access a specialist service or treatments.”

“This all really depends on what model of understanding – [as to] why a child identifies as transgender - is underpinning the professional's approach.”

“The above depends on the role the service should take. I have answered based on the way GIDS works at the moment.”

Care Pathways

Respondents were asked what factors might indicate that a child or young person would not be appropriate for GIDS referral.

- **If the child is not experiencing significant levels of distress a GIDS referral would not be appropriate.**

"No significant distress or impairment in relation to gender."

"If they are not experiencing gender related distress. If there is no impact on their daily functioning because of gender."

"In terms of how services stand at present I would say the only factor would be that gender is not a concern for the young person, sometimes referers don't understand the difference between gender and sexuality."

- **However, any distress relating to gender made a referral to GIDS necessary.**

"If there is distress in relation to gender then all referrals for GIDS are appropriate"

"I think that anyone who is experiencing distress related to their gender should be eligible for a GIDS referral. I don't think a referral should be delayed by input for any other needs as the waiting list is 3+ years, however if other needs are identified at the point of the referral they should be addressed and updates sent to GIDS while the young person is on the waiting list."

- **If the child or young person's gender identity is newly formed or still evolving.**

"If the young person had recently started exploring their gender and there was low levels of distress (i.e. if there was trained/competent staff in CAMHS they could be supported by CAMHS in consultation with GIDS if needed)."

"Very recent onset of gender questioning/gender-based distress/self-reporting thoughts about gender."

"A young person who has only been presenting with gender incongruence for a very short period of time and little exploration has been done locally."

- **If there are safeguarding concerns that would affect ability to engage.**

"Safeguarding issues that mean it may be unsafe to engage [the] child in work relating to gender before these issues have been resolved"

"Experiencing a level of distress that poses an immediate risk to their safety or prevents them from being able to meaningfully weigh-up decisions (e.g. eating disorder, psychosis, significant self-harm or suicidality)."

"Where the young person does not have sufficient stability (housing, risk, mental health, addiction, etc.) to engage in intensive psychosocial exploration."

- **Lack of a full formulation/general support from local services.**

"If there are other underlying issues that have not been addressed, a referral to GIDS in its current form would not be appropriate. Either GIDS clinicians need adequate training to work with co-morbid or underlying mental health issues, or these issues need addressing elsewhere first."

"Significant additional mental health difficulties that have not been managed locally"

"Unclear formulation from mental health service in relation to complexity, risk, unmet mental health needs, or safeguarding; evidence that the need can be met by local support services"

"A high level of risk that is not being managed. A young person being in the midst of complex trauma work and perhaps not being able to engage with two processes at one time."

- **If the referral is more about supporting the parents than the young person.**

"[If the] young person [is] not expressing any distress about gender (we receive referrals which are more about a parent's worry than a young person's)."

"[Where] parents [are] not aware of the referral."

"Their age - sometimes we get referrals for 3, 4, 5 year olds. Young children that have no true comprehension of gender identity at all. Here it is more the parent that needs support on holding options open for their child, but I'm not sure this should come from a national specialist service."

"Concerned parents more focused on gender issues than [the] young person."

- **If the child / young person is already accessing treatment privately.**

"That they [the child or young person] are already seeking medical intervention from a private provider for gender related distress."

"[If the] young person [is] already accessing treatment privately and [has] been assessed in the private sector - the young person will have to go through another assessment at GIDS which may cause distress."

"If they accessed private [treatment] which meant there was no way for them to come back into NHS protocol (e.g. cross-sex hormones under 16)."

Referral for medical intervention

Respondents were asked what factors they take into consideration when deciding suitability for puberty blocking treatment.

- A full exploration of gender identity, level of distress around puberty and understanding of general development is needed.**

"Full exploration of gender identity including discussion about puberty/relationship to body and fertility - consideration around distress and the benefit of the blocker to reduce this."

"Gender Development History: strong narrative/ weak narrative/Binary/Non Binary/Consistent"

"Exploration of sexuality and how this is or not linked to gender identity development."

"Young person's gender development history, current gender identification. Consistency of gender identification, understanding of gender identity as separate from gender roles etc."

- The young person and parent/carer's understanding of the medical treatment.**

"That it is what a young person wants and has expressed independently that this is what they would like to access, having been informed in detail of what Puberty Blockers do and don't do, expectations and side effects etc."

"Parental consent, as well as parents having a robust understanding of [the] risks/benefits of hormone blockers."

"Psychological and physical wellbeing. Ability to make an informed decision. i.e. to understand information relevant to the decision, retain this over time, weigh up and communicate their decision."

"Young person's and family understanding of [the] treatment pathway, and ability to manage with uncertainty around the future, and also their expectations."

"[Whether the child or young person has] realistic expectations around treatment [and] realistic ideas about the outcome of accessing a medical treatment."

- Understanding of external factors/influences.**

"[Getting a] sense of life in school, friends and broad wellbeing."

"[The need to] understand the relationship to online communities and any risk issues."

"[The need to] understand family context and history, key attachments [and] parent/carers stance towards issues."

"[The need to] understand spiritual, religious and cultural beliefs."

"[The need to understand any] coercion – ensuring [the] young person isn't coercing [the] parent and visa versa - individual sessions [held] with both parties."

- The extent to which alternative approaches have been explored.**

"How much they have explored alternatives and are aware of risks and benefits and whether they have thought about what they want in the future, areas such as fertility or their body."

"Exploration of alternative approaches (non-medical). Exploring how they [the child/young person] would see their life if they did not go down the medical route."

"Distress around the body (needs to be significant distress, and other attempts to alleviate distress have not been successful before we can consider blocker)."

"Clear indication that gender is a pressing issue and has been present as such for some time. That the child/young person and their family have been provided with access to and considered alternative options to puberty blockers. That shared decision making is based on informed choice, and a demonstrated ability to weigh up options."

- Mental health and general stability.**

"Relative stability in mental health and all other domains of life - or ability of accessing treatment being a factor in achieving stability."

"If there are mental health problems, how well the person is supported by local services. [The] level of functioning across the different areas in the young person's life."

"Get a thorough grasp of the nature of any additional difficulties and the impact of these on life and functioning."

"If there are mental health problems, how well the person is supported by local services."

"Stability around decision-making - is there sufficient stability and has the young person communicated a desire for this intervention for a prolonged period of time."

- A small number of respondents expressed the view that blocking puberty should not be practiced due to unknown long-term effects and young people's ability to give fully informed consent.**

"Blocking puberty isn't safe because we don't know what the long-term impact is on brain development and it also means that male adolescents will require more invasive genital surgery if they continue with gender transition as adults and if they don't continue, they will be stuck with immature genitals."

"It is my experience that the vast majority of children and young people under 18 do not have the emotional maturity to discuss issues around fertility preservation, the possibility of wanting to have children in the future... etc. Hence, as I do not think under 18 young people should be in a position to actually decide about these treatments."

Referral for medical intervention

Respondents were asked what factors they take into consideration when deciding suitability for feminising/masculinising (cross-sex) hormones.

- **Young person's ability to consent.**

"Their chronological age (need to be 16+), do they have capacity/can give consent."

"Consideration if the young person requires any adaptation to understand and retaining information and if there is any conflict with parents/ carers [regarding] access to medical pathway."

"Current age/stage of development - level of maturity."

- **Young person/parent/carer's understanding of the treatment and side effects.**

"Young person/parents or carer's ability to understand, weigh and retain information about the treatment."

"Awareness of irreversible effects and exploring this with the young person and their parent/carer."

"Opportunity to consider fertility and fertility preservation options."

"When considering gender affirming hormones consideration [should be] given to [whether] it is what a young person independently wants and has been informed in detail of what GAH [gender affirming hormones] do, side effects, expectations etc."

"The potential benefit of starting [hormones] in the slow graded way at UCLH – University College London Hospital - (slowly increasing to an adult dose) versus starting on a full adult dose in adult services."

- **Exploration of different pathway options and understanding of potential outcomes.**

"[That the young person has the] opportunity to consider multiple gender pathways, potential for gender development and change."

"The degree of therapeutic engagement that has been possible. How much do I feel I have been able to think with this young person in a meaningful way?"

"[That the young person has the] opportunity to consider a range of influences on experiences of gender and distress if they wish (e.g. trauma, family relationships, gendered experiences growing up, heteronormativity and patriarchy, sexuality)"

"The young person's thoughts on how they would manage if they came to a different idea about their gender in the future - whether the young person understands possibility of regret."

- **The young person has a holistic view of what it means to transition and the impact of taking hormones.**

"How well a young person is doing in their life in a broader way. Is there evidence that a young person has been able to meaningfully engage in life whilst presenting in another gender."

"A young person's experience of relationships - friendships as well as romantic/sexual relationships, their sexuality and how they currently identify."

"Plans for the future in relation to gender."

"Able to think to the future about impact on life, relationships, medical care, openness vs secrecy."

"How the young person has responded to hormone blocking treatment."

"That they hope to move toward something rather than/alongside escape from something, e.g. not just trying to escape societal expectations regarding women."

- **Mental health and general stability.**

"Their mental health and if they need/are getting any support."

"[That the child/young person has had] stable and consistent mental health for at least six months."

"Consideration around mood/mental health and if there is any further support needed alongside support from GIDS."

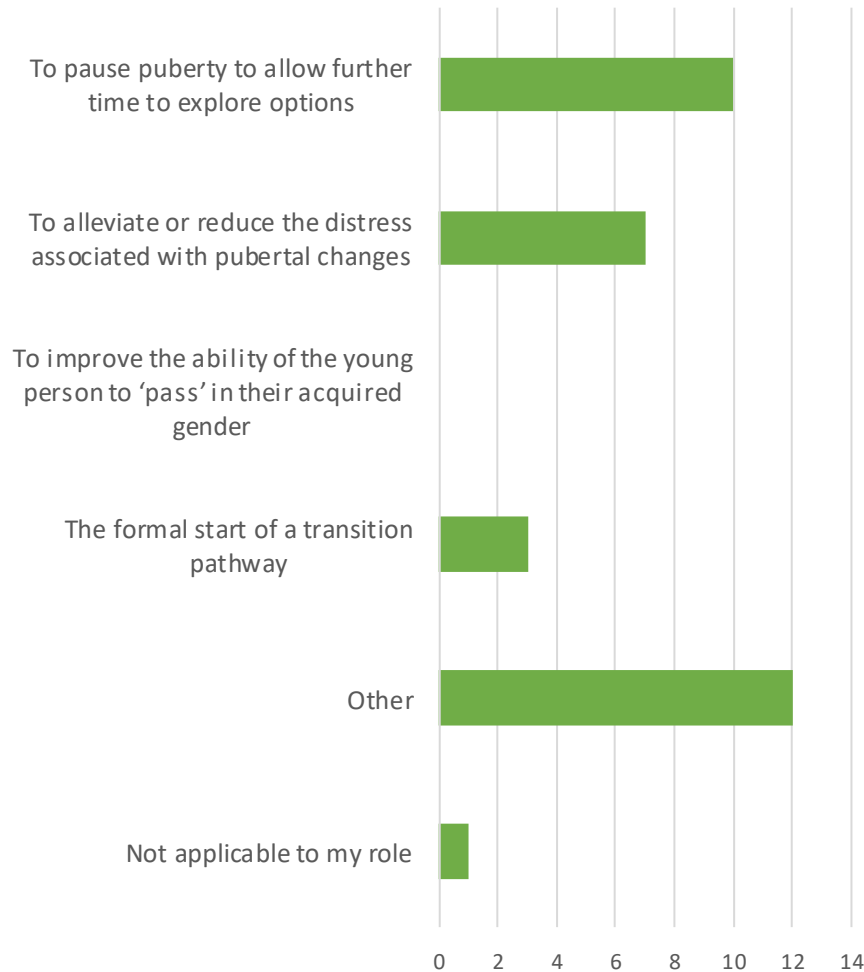
- **A small number of respondents expressed that cross-sex hormones are not safe for adolescents.**

"It's not possible to predict in adolescents who will continue to identify as transgender into adulthood and the risks of harm are profound."

"Adult issues are being 'thought about' with children who simply do not have the emotional development to be able to really think about it all."

Referral for medical intervention

Respondents were asked how they would describe the main purpose of puberty blockers when discussing treatment options with a child/young person.



- **The top responses for the given statements were:**

- To pause puberty to allow further time to explore options (30.3%)
- To alleviate or reduce distress associated with pubertal changes (21.2%)
- The formal start of a transition pathway (9%)

- **Several respondents indicated that there are multiple purposes.**

"I think the puberty blockers main use is more than just one answer. I think it is to firstly pause puberty to allow a young person space to explore whilst hopefully reducing distress associated with the pubertal changes."

"To both pause puberty in younger children and create space for further exploration, and/ or alleviate distress associated with pubertal changes."

- **Several respondents said that it depends on the individual's age and stage of development.**

"This is hard because the answer depends on age and stage of puberty, it would allow further time to explore in perhaps older young people who have mostly been through puberty."

"There isn't one main purpose, it really depends on where a young person is at and what they want. For younger children [it] is to reduce any anxiety about further pubertal changes which can in itself give more time to think - these points go together, they are not separate. For older teenagers many of them want the blocker because it enables them to access hormones, this is a fault with our service pathway as the blocker has very little use to them when they are post puberty."

- **Others said that it is important to understand the young person's expectation of what the blocker will achieve.**

"I think it's much more helpful to explore what the young person and family hope for hormone blockers to achieve so that this can be explored."

"This will be individual to the young person. Providing the young person with an understanding around why other young people may access these pathways could help build understanding. But also acknowledging not all young people access medical pathways, and exploring what they would like and what this would mean to them."

- **Some respondents mentioned the uncertainty around the purpose and impacts of puberty blockers.**

"I speak about the purpose as being the first [statement] but talk about how there is a possibility that going on the blocker may close down thinking for some young people. Note that people who do not take the blocker are less likely to take further physical interventions in the future. I explain how we don't know whether this is because we are only letting the "right" people go on the blocker or whether this is because there is something about the blocker that prevents young people from considering different pathways."

"I'm not actually sure what the purpose of the blocker is for us as a service right now. I would state the potential benefits to young people as being about pausing puberty, preventing further development of sex characteristics (which may prevent further intervention later on), and an experience of being on medical intervention and a medical pathway can also be useful"

Referral for medical intervention

Respondents were asked to describe the most challenging aspect of supporting children and young people in relation to informed consent to puberty blockers.

- **Concerns about the ability of young people to consent to treatments when they may not fully understand the consequences.**

"Assessing competence to make a decision now about something which may have life long future consequences, which are hard for young person to understand or imagine."

" Ensuring that enough information has been provided given that we are drawing from a limited amount of research, especially of long-term effects. And balancing that with how much of a positive difference they can make to some young people."

"Aware of the side effects - like hot flushes, and that the young person may need to be able to leave a class at times to manage hot flushes."

"[There is a] worry that young people can not meaningfully think about what it means to risk their potential for future satisfying sexual relationships and fertility"

- **Difficulties if the child is non-communicative due to distress or other factors.**

"[It] can be challenging if young people have learning difficulties/ASD/high levels of anxiety so say very little in their sessions."

"It can be difficult if young people have additional significant needs that make conversations and assessment of understanding difficult, especially if parents or guardians are unable to support with this."

"[There are] lots of difficulties/challenges when children/young people present as very distressed but are unable to engage in assessment process because of this."

- **A focus on accessing hormone treatment can limit exploration of other options.**

"The expectation from young people and families that this is the one and only answer to the difficulties being experienced. This forces clinicians into a gatekeeping role which obscures the options for exploration and psycho-social support."

"Another challenge is that young people/their parents are usually very focused on accessing the hormone blocker. While we can get informed consent, there is still often little alternative."

"The bind young people find themselves in where they have to both show that they could consider different options and could think about other ways of managing puberty at the same time as demonstrating that they are adequately distressed by puberty."

- **The friction between needing to do a full and complete assessment and a desire to resolve the child/young person's distress quickly.**

"Increased parental anxiety hoping for the assessment to speed up when more space/time is required to explore."

"Often due to distress, young people and [their] parent/carer request the process to be 'quick', however, thorough assessment is required to enable the informed consent to be obtained. Complexity of this can increase when a young person and/or parent/carer is unable to verbally consent/engage in the assessment either due to other complexities or distress - and alternative methods are used/extended time is required = to ensure the young person and/or parent/carer voice is heard and deemed informed."

"The tension between the child's puberty development and processes/waiting lists/assessments which means it is a tightrope of timings."

- **The additional scrutiny decisions around decision to refer for puberty blockers.**

"The process following on from the judicial review has significantly lengthened the process for young people accessing a medical pathway and caused in many cases extreme amounts of distress and for many young people traumatic experiences of going through pubertal changes that has negatively impacted their experience of themselves, their body and overall wellbeing."

"The bureaucracy, scrutiny and challenges of carefully considered and formulated clinical decision making [that] the service and professionals working in it experience, which disadvantages service users of GIDS and people waiting to become service users of GIDS."

- **The impact of external influences/factors.**

"The fact of their life stage - that they are at an adolescent stage of development and therefore forming their identity, of which gender is a major part. Societal pressures to conform to the gender binary, particularly when many are at secondary school. Bullying in the form of name calling. "

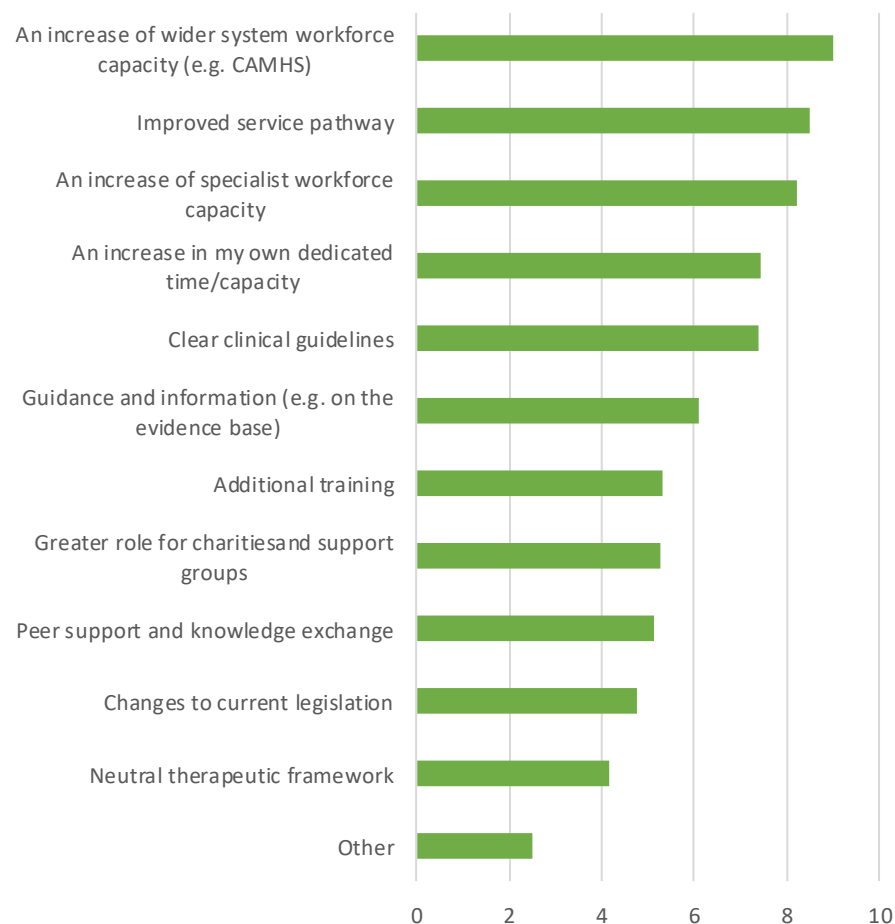
"There is so much peer pressure. The teens are all comparing themselves and their transitions to that of their peers. It makes it hard for them to think clearly about their individual needs and long-term health I think."

"The most challenging aspect at the moment are the layers of systemic transphobic barriers to care that the young people experience."

"When everyone around you (media, other staff in GIDS, people in the Tavistock etc.) are so anxious and fixated on possible regret. We do not see the level of focus on regret in other areas of medicine, even when the regret rates are known to be much higher. The current media frenzy sometimes makes it hard to think clearly."

About your role

Respondents were asked what would make their role supporting children and young people around their gender identity easier. They were given a number of options and asked to rank the options from most helpful to least helpful. The list of options was constructed from feedback from the primary and secondary professionals' panel (see introduction).



- The top responses were:**

- An increase in wider system capacity.
- Improved service pathway.
- An increase in specialist workforce capacity.
- An increase in clinician's own time/capacity.
- Clear clinical guidelines.

- Respondents indicated a number of other aspects that would make their role easier:**

- A reduction in time spent doing administrative tasks.
- An upskilling of the wider workforce.
- Research into epidemiological changes.
- Consensus on how GIDS works as a service.
- A transformed societal understanding of what gender means.
- Safeguarding in relation to gender.
- Exploratory therapeutic support to be seen as primary intervention.
- To have GIDS clinical work properly valued, respected and supported.
- Removal of the endocrine pathway.

- Additional comments made included:**

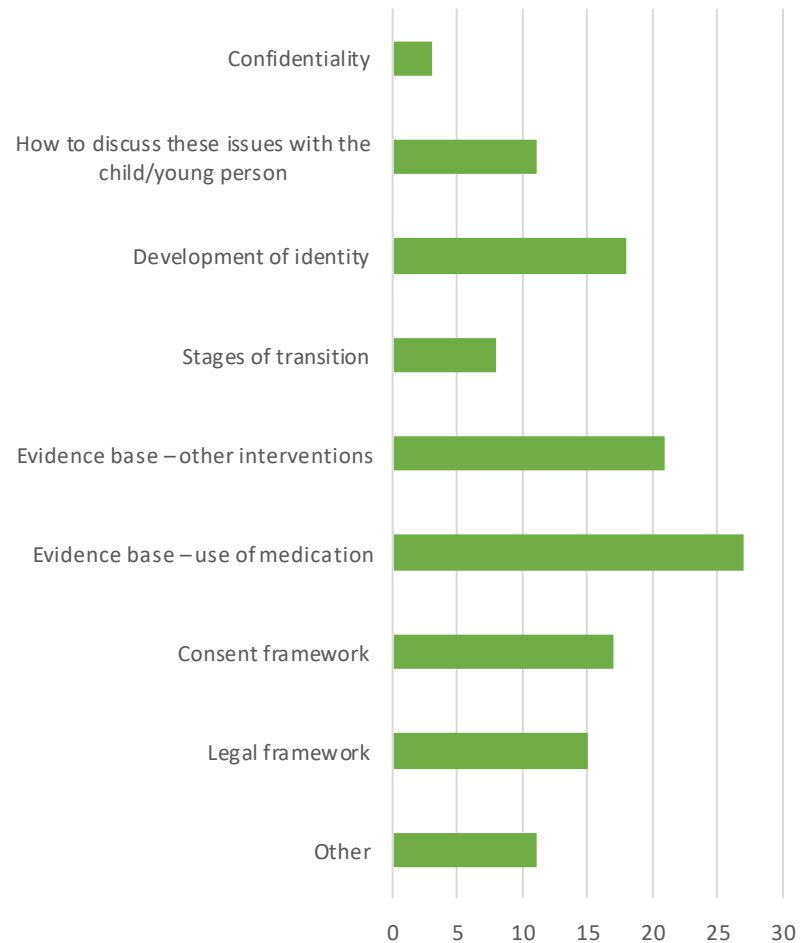
"To have GIDS clinical work properly valued, respected and supported."

"I don't think we need more staff, I think we need consensus as a service on how we work, what we offer and why, and clearer guidelines. As well as reduced case/workloads so we have time for the thought and reflection this work requires"

"We need to increase capacity. Fiddling about with the waiting list or making referral criteria is not the way to approach this. We are massively under resourced. Either invest properly in specialist services. Or open up the protocols to ensure treatment pathways, including endocrinology, can be accessed via primary and secondary care."

About your role

Respondents were asked, in their professional interaction supporting children and young people around their gender identity, on which of the following areas would it be helpful to have more information to guide their thinking on appropriate care/management – respondents could tick multiple answers. The list of options was constructed from feedback from the primary and secondary professionals' panel (see introduction).



- **The top responses were:**

- Evidence base around the use of medication.
- Evidence base around other interventions.
- Information/training on development of identity.
- The consent framework.

- **Respondents indicated a number of other aspects where more information would be useful:**

- How people develop an understanding about their relationship to their body.
- Training in the induction about gender affirming hormones/puberty blockers and their mode of action.
- Safeguarding in relation to gender.
- Ethics.
- Sexuality, detransitioners/long term outcomes.
- Long term studies with follow-ups of psychological/psychotherapeutic work with young people who presented with gender dysphoria.
- Working effectively with neurodiverse and Autistic people who are also gender diverse.

- **Additional comments included:**

“I believe all of the above are in place already. Improvement and ease of access, including clinicians' capacity to review and continued professional development inclusive of the above would be beneficial for all disciplines.”

“It is not really a question of more information. It is more a question of creating a climate in which different therapeutic approaches can be discussed and developed without fear of vilification, legal action or complaints being brought. I believe the Cass review has a role to play here.”

“I think we do have a lot of the above already. I am not clear about what 'other interventions' refers to, do you mean how safe binding is, or how useful psychosocial support is?”

General comments

Respondents were invited to add any further comments about services for children and young people needing support around their gender identity.

• Thoughts on the current service.

"It's been a tough few years in our service and young trans people are the ones who have suffered in terms of treatment being halted and huge waiting lists."

"The [GIDS] team offer a very unique service and that it is impossible to compare it to another service within this country, therefore it is very hard to review its success or its failures. That staff shortages should be looked at as a priority and recruitment and retention drives [should] be at the centre of change and also ensuring training is available. The image of GIDS to the wider arena may need to change for this to happen."

"I really enjoy working at GIDS- I like working with the client group and their families, I like working with my colleagues."

"We are drowning in paperwork at GIDS and overwhelmed with high caseloads of increasingly complex young people... It is no wonder people have left GIDS in droves. If many more people leave there won't be enough expertise to manage the current patient numbers and certainly no capacity to train newly hired staff - so the waiting list will remain in the dire state it's currently in."

"I feel disheartened and disappointed by the long waiting lists and the fact that these young people are not receiving the support they so desperately need in a timely manner."

"There continues to be a climate of fear and intimidation when discussing the issues connected to children and adolescents who identify as transgender. Our profession needs support or some kind of intervention that enables Clinical Psychologists to think and speak freely about our professional experiences, theories and concerns."

• Thoughts on a future service model.

"With the current numbers, the model of a single national service that treats this matter as a 'specialist service' is no longer sustainable. After more than 5 years working at GIDS, I have come to the conclusion that the matters needs to be addressed locally through CAMHS and other TIER 2-3 services, in the context of the other difficulties that these young people inevitably experience. We have to face this is no longer a specialist issue, but a wide-spread experience amongst young people, and local services should be equipped to address this as such."

"I think that services should be completely overhauled and the focus should be on reduction of waiting times."

"In my previous role at CAMHS I was attempting to set up a specific pathway at a local level as I felt it was very much needed. I still do."

"We need to maintain our clinical excellence and develop it further on all fronts. We also need to be able to offer more psycho-social interventions alongside the known medical interventions."

• Thoughts on pathway options.

"Differentiation of pathways within GIDS for [different] age groups, different associated difficulties (LD/ASC/MH) and a differentiation for those AMAB [assigned male at birth] and AFAB [assigned female at birth] would be beneficial - especially in the case of AMAB where stigma, safety and risk in wider society are most problematic."

"I believe there should be a range of therapeutic and medical options for young people, including psychological therapy for gender diverse young people, and non-blocker pathways for those who have completed puberty."

"To be able to offer a non-blocker pathway to the older adolescents. Lots of older trans boys want the blocker so they can have [testosterone], it has very little physical benefit to them but can result in side effects. It is more ethical to offer them a non-blocker pathway."

"I think the main thing that is needed over and above everything is a clear pathway for young people to be offered meaningful psychological therapy in order to explore what is going on. Currently we offer people physical interventions or very sporadic sessions... I feel that we are failing these young people by not at least offering this as an option."

"I believe there should be more specific provision for 17-20 year olds who are often lost in the gap between children and adult services."

The Review is grateful to all the participants for sharing their time and expertise and for their thoughtful consideration in responding to the survey.

The Review will build on the work 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.