

**Over the past decade  
hundreds of girls were referred  
to this NHS building in northwest  
London. Many were prescribed  
puberty-blocking drugs. But was  
the treatment seriously flawed  
and even dangerous?**

The Tavistock Centre in northwest London



## **WHAT WENT WRONG AT THE TAVISTOCK CLINIC?**

Since 2010, the number of teenage girls referred to the Tavistock Gender Identity Development Service has increased by 5,000 per cent. Now former patients and staff members are speaking out. Janice Turner investigates



For me it began with a graph. In 2017, I was shown a chart of children referred to GIDS, the Tavistock and Portman Trust's Gender Identity Development Service clinic in northwest London. Overall case numbers had risen – from just 72 in 2009-10 to 1,807 in 2016-17 – but there was something more puzzling. Female referrals, once a fraction of males, now made up 70 per cent: from 32 to 1,265. The number of teenage girls with gender dysphoria (ie profound discomfort with their biological sex) had risen by 5,000 per cent in 7 years.

My journalistic curiosity was sparked, more so when I could find no mention of this in the mainstream press. The only people collecting data and testimony were online parents' groups in Britain and the US. Moreover, their stories revealed a distinct pattern, repeated worldwide from Australia to Sweden.

The stories all began with a daughter who rejected "girly" clothes and toys for "boyish" pursuits like skateboarding, comics or video games. At primary school she was mainly happy, and parents quietly assumed (and accepted) she would grow up a lesbian. But then puberty loomed. Now at secondary school she was bullied for looking "butch" or having same-sex crushes. She was often mentally vulnerable, prone to anxiety, food disorders, ADHD, depression or self-harm. She was horrified by her emerging female body: breasts that brought unwanted sexual attention; periods she found disgusting. Retreating into online forums, she emerged convinced she was really a boy.

Still parents were mainly unfazed: they didn't care if their daughter had short hair or wore only jeans. They weren't much concerned "she" asked to be called "he" and chose a male name. When a daughter, typically at 12-14, was referred to GIDS they assumed the Tavistock, world famous for its psychodynamic therapy, would explore a child's myriad underlying issues. Instead, sometimes after only two sessions, their daughter was recommended for the puberty-blocking drug Lupron – a "pause button", they were told, while s/he explored gender identity and decided whether to progress to testosterone at 16.

Many parents, informed by trans activist groups their child may commit suicide if they went through the "wrong puberty", signed the consent form. Others did research: they discovered that Lupron, while used to chemically castrate sex offenders or treat prostate cancer, is unlicensed for gender

dysphoria. They read blogs by "detransitioners", mainly young women in America – where private gender clinics perform double mastectomies on girls as young as 13 (a process TikTok-savvy surgeons jocularly call "Teetus Deletus") – who later regretted this hasty, irreversible process. And they felt an urgent mission to tell the world what GIDS was doing.

It wasn't the parents' views that surprised me when I began my own research, but clinicians within the Tavistock who were both desperate to speak out and terrified of being identified. So we met in discreet cafés, with one clinical psychologist driving across London to my home

cautious and more open-ended therapy.

This civil war was about to burst out of the clinic and into the press; into the office of Dr David Bell, a Tavistock governor who then wrote a whistleblowing report in 2018; into the inbox of Sonia Appleby, whom GIDS ostracised for trying to raise child safeguarding concerns; into the high court, when Keira Bell, a detransitioner prescribed Lupron by GIDS, brought a judicial review; into the Care Quality Commission, which last year rated GIDS "inadequate". And it is already there in the interim report by Dr Hilary Cass, a former president of the Royal College of Paediatrics and Child Health, whose full investigation will be published this year.

How did GIDS become the most controversial clinic in Britain?

A few streets from the Tavistock are Sigmund Freud's consulting rooms, now a museum. In 1920, Hugh Crichton-Miller, who successfully treated shellshock patients in the First World War, founded a clinic to apply his techniques, influenced by Freud, to civilians, both adults and (revolutionary at the time) children. The Tavistock specialised in "talking cures": therapy that sought to alleviate mental distress by delving deep into a person's environment and relationships. It quickly grew in size and reputation to become a world-renowned institution, particularly in the field of child development.

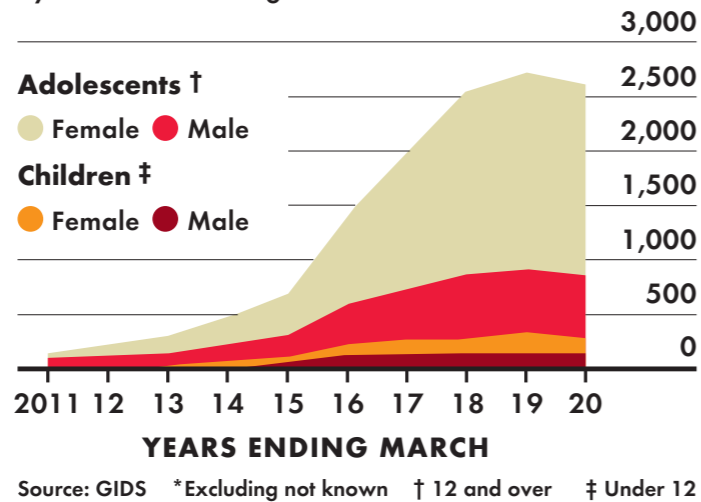
In 1994, a small child gender clinic at St George's hospital, founded by psychiatrist Domenico Di Ceglie, was brought under the Tavistock umbrella. Throughout the Nineties, 75 per cent of its tiny caseload was "feminine presenting" boys and Di Ceglie's ethos was "non-judgmental acceptance". He didn't seek to reverse or "cure" atypical gender behaviour in children, but instead conducted unhurried, open-minded therapy trying to pinpoint the source of bodily distress. Known as "watchful waiting", this approach acknowledged some children with gender dysphoria would later live as trans adults, while the vast majority of cases resolved themselves around puberty and, crucially, it was impossible to diagnose which way a child would go.

Then in 1996, two Dutch endocrinologists, Dr Louis Gooren and Dr Henriette Delamarre-van de Waal, published a paper called *The Feasibility of Endocrine Interventions in Juvenile Transsexuals*. It described a 13-year-old girl

## GENDER GAP

Britain, referrals to the Gender Identity Development Service at Tavistock clinic

By natal sex\* and age



while heavily pregnant. Pacing my kitchen, visibly upset, she described her frustration and horror that a new kind of patient – distressed, same-sex attracted girls with complex problems – was being funnelled by GIDS towards a universal panacea: medical transition.

I had blundered into this debate at a critical moment. GIDS was both at breaking point and bitterly divided. Numbers had shot up since it became an NHS-commissioned service in 2009, so clinicians struggled under caseloads of 120 young people, with a vast waiting list building behind. Yet GIDS had no agreed treatment model: parents didn't realise it was a lottery whether their child would meet a clinician who – as trans activist groups such as Mermaids demand – would immediately "affirm" a teenager's gender identity and proceed towards blockers, or one who "in stealth" (for fear of being branded transphobic by colleagues) conducted deep,

# MY ADOLESCENCE WAS CHEMICALLY DELAYED. I WAS THEIR GUINEA PIG

A former patient who went to the clinic at 12 talks to Lucy Bannerman

Alex was a girl who desperately wanted to be a boy. From the ages of 12 to 16, "he" embarked on four years of experimental treatment, in a desperate bid to transform from female to male. Now 18 and trying to catch up on a chemically delayed adolescence, he feels the Tavistock treated him like "a guinea pig".

The gender clinic that sent him into the medical unknown has no record of the outcome of his case, he says. It does not know the impact of those experimental drugs on his body, or the repercussions of this supposedly pioneering treatment on his life, he claims, because no one ever asked.

How, he asks, could the NHS's main gender identity clinic for young people claim its controversial approach was working if it wasn't recording the results?

Alex describes the service for young people struggling with their gender identity as a "drugs train". Destination: adult sex change.

He was one of the very few young people who jumped off, deciding after four unhappy years on puberty blockers not to make that final, irreversible leap to cross-sex hormones. The vast majority of children referred by the Tavistock for hormone blockers continued with their transition once they became eligible at 18, but how they are getting on remains unclear as the clinic did not collect the data – a fact that High Court judges in the Keira Bell case noted was "surprising given the young age of the patient group, the experimental nature of the treatment and the profound impact that it has".

At 18, Alex's understanding of what it means to be "transgender" is now completely different from what it was when he first begged the clinic for help as a vulnerable 12-year-old.

He was seven when his mother first took him to the GP for advice. His parents had gone through a difficult divorce and, in a traumatic incident, which he still finds difficult to talk about, he was sexually assaulted by a boy in primary school. He rejected anything "girly" as negative,



covered his long hair with hats, envied his male peers and even now, in conversation, apparently unconsciously, equates femininity with "weakness". (None of this, he says, would ever be explored in detail at the Tavistock.)

When Alex was ten, the GP referred him to the local child and adolescent mental health services (CAMHS), where they explored his anxiety and struggle to make friends. But the mention of identifying as a boy triggered a referral to the Tavistock. "We were told a million times, 'They're the experts on this.'"

Alex and his mother went for the first consultation around 18 months later. "It wasn't like CAMHS at all. They didn't 'discuss'. They kind of just accepted [from CAMHS] that you were trans" – as if the act of referral were confirmation of transgender identity itself.

"They said, 'You're definitely trans.' See you in a month." At the end of the first session, before Alex had shared any personal history or discussed his feelings in depth, exploring for example, why he might not want to be a girl, he claims he was given forms for changing his name via deed poll. "It was like, 'Have you done this yet?'" He was 12. "It was insane."

"It was my fourth or fifth appointment [when] they said there are drugs that will make you feel better. As a child I thought, yeah, miracle cure. What I really wanted was a 'transgender guide to life!'"

As a gender non-conforming biological female who pictured, one day, settling down with a wife, Alex wanted to look like his male friends.

"I was tremendously anxious about looking like a girl. They said, 'We think you're the right age and you should try hormone blockers.' They sell the drugs very early, very hard.

"I was a child. All I wanted was something to make me feel less horrified by my body," Alex says, reflecting on the experience from his family home in the west of England. "I was listening to a doctor, so I went along with it," his mother adds.

They went regularly to the endocrinology clinic at University College London Hospitals (UCLH). Alex liked the injections because enduring the large, painful needles made him feel brave and therefore manly.

He hoped that halting the development of his female body would help him fit in with the male peers he so envied.

Instead, what they did was keep him in a child's body while his friends grew up. While the boys grew taller and hairier, Alex's growth slowed and weight ballooned, with the weight going to the hips and breasts, accentuating the female form he was trying to escape. The sudden weight gain also created angry, itchy stretch marks and a new anxiety about eating, which still remains. His little brother overtook him in height. "I felt even more depressed." The hormone blockers also kept Alex in the asexual state of a child while his friends were having their first sexual relationships.

He claims the clinicians failed to explain the possible side-effects or gain his informed consent as a minor.

"At first, I had insomnia. There would be days when I could not sleep at all. There were moments of euphoria, then the next day I'd just want to cry. Huge mood swings."

Alex claims the only psychiatric evaluation consisted of occasional form-filling, which wasn't followed up. "Tracking? There was none. If they actually gave a crap over what it was doing to my body, they would not have let me continue. If they had read those forms, they would have known I was not feeling any better. They just kept giving me higher doses."

Alex claims he was also put on beta blockers during this time, until one day

who reported to the Amsterdam gender clinic that she wanted to be a boy and was given gonadotropin-releasing (GnRHa) drugs, which arrested puberty. From this experiment came the “Dutch protocol”, a medical regime to arrest development of secondary sexual characteristics – Adam’s apples, facial hair, breasts etc – which make it harder for trans people to “pass” as the opposite sex in adulthood. This protocol had strict rules: a patient must have been dysphoric from early childhood and be psychologically stable (ie have no concurrent mental health issues such as depression or self-harm). While the puberty blockers were administered, the patient would have intense therapy sessions to explore gender identity before moving onto hormones.

The Dutch protocol was received enthusiastically by trans activist groups and US gender clinics. No more “watchful waiting”: here was a magic pill. In 2007, Susie Green, later CEO of Mermaids, a trans charity for children, took her natal boy to Boston to receive puberty blockers unavailable in Britain. (At 16, she took this child to Thailand for genital surgery, which is illegal in minors here, as it is now in Thailand). Then she campaigned for blockers to be prescribed by GIDS.

In the early Noughties, lobby groups such as Mermaids and GIRES (Gender Identity Research and Education Society) became increasingly influential at GIDS. They were invited to symposia, their leaders befriended clinicians, their weekend camps were recommended to GIDS parents. These groups echoed the demands of American gender medicine – where capitalism and activism collide – for new, earlier, more radical interventions on children without prior counselling. Children, US doctors argued, know their inner gender identity virtually from birth and parents can spot signs such as preferring toys or clothes stereotypically preferred by the opposite sex. Why wait?

In response to such pressure, in 2011 the new GIDS director, Dr Polly Carmichael, began a “trial” of puberty blockers. Then, before any research was concluded, she made the drugs broadly available in response, she said, to high demand. Case numbers had soared – with natal girls already overtaking boys – so a GIDS satellite clinic was opened in Leeds.

In 2014, GIDS lowered the prescription age for blockers from 16 to 11, and Carmichael appeared on the CBBC programme *I Am Leo* praising their benefits. “The good thing is,” she tells an apparently dysphoric female child, “if you stop the injections, it’s like pressing a start button and the body just carries on developing as it would if you hadn’t taken the injection.”

But already questions were being asked. Could you really arrest that complex moment in human brain and bodily development with no ill effects? Given that a barely pubescent ➤

he collapsed at school, after running 1,500m in athletics. His mother called the clinic, demanding a review of the treatment. Alex came off the beta blockers but continued with the hormone injections until, aged 16, tired, overweight, depressed and lonely, he decided to walk away from the Tavistock.

In his last consultation, at 16, “I said to [the therapist], ‘I’m not doing it any more.’ I’m being sold snake oil. It’s ridiculous.”

At that point, Alex and his mum claim the clinician invited Alex to step aside to make space for other young people on the waiting list – others, he allegedly implied, who were willing to continue to cross-sex hormones. “He said, ‘We have hundreds of other trans people who want to talk to us...’

“If you stop the drugs, they ditch you.”

The discussions about gender

## **‘I AM STILL TRANS, BUT NOT IN THE WAY THAT THE TAVISTOCK WANTED ME TO BE’**

reassignment had proved to be the last straw. Though he identifies as transgender, Alex felt very strongly he did not want surgery.

“It was just assumed.’ He felt pressure to proceed down the medical pathway to prove his commitment to his trans identity.

When he resisted that path, Alex claims, “It felt like they were saying, you’re not really trans then. You’re only trans if you’re willing to go this far.

“I know there’s nothing I can do that will change how I was born. If they dig my skeleton up in years to come, it will be recognised as female. But the Tavistock could not deal with that. They wanted trans people who were young, who they could mould into their idea of what trans is.

“They have their view of what being trans is. And if you do not fit that, you have no place in their service. I felt I was completely used to confirm their theories.”

“I’m still trans, but not in the way the Tavistock wanted me to be. I came to the conclusion that I would rather deal with it on my own as this [treatment] is not helping.”

With the support of his mum and three siblings, he came off the hormone blockers.

“They said, ‘You need to come off these because you might work out you’re just gay, but you’ll never know if you stay on them.’

“It was the best thing I ever did. Stopping the blockers has given me the ability to pick what I want from my life without feeling

like I have to fit in a certain box. I feel like I’m more able to present myself in a way that is more connected to how I feel.”

His mother now believes the Tavistock’s approach was deeply unethical. “They were pumping Alex with an experimental drug, then beta blockers, then talking about surgeries. So to come out of that system without any follow-up – that is negligent.

“When you’re doing experimental treatment, you take literally every scrap of data you can get and you analyse it.”

She also believes the blockers were pushed “too early”: “They are experimenting on children with no knowledge about how that’s going to affect their development. They had no idea what that was going to do to Alex’s body.”

Alex is now going to university to study screenwriting. He will be giving LGBT student politics a miss: he doesn’t believe his medical history should be politicised.

The period he had been so dreading arrived when he was 18, but he now regards it as merely “a monthly inconvenience”.

Relationships remain a puzzle. Two years on, since coming off the blockers Alex has still not experienced any sexual feelings.

“When you watch shows and there’s a fit girl, you say, ‘They’re fit,’ but you have no real understanding of what that means.

“That can backfire, because I don’t know what is the correct way of checking people out. I don’t know how this works.

“I imagine you’re supposed to get some feeling? But there is nothing. I feel like I can’t recognise what love feels like. Knowing you’re in love... I can’t even comprehend that concept. Because I don’t feel anything.”

It has been almost three years since his last consultation and there has been no follow-up.

“I never got a phone call asking, ‘How has it been to come off the drugs?’ From their perspective, it would be useful for them to know what happened,” said Alex.

Alex questions how much has been learnt. “I think of the person who took my place. Are they going through the same thing I did?”

If the clinic hasn’t recorded the outcome of his case, he asks, how can it inform the care of the next young patient?

“I view the Tavistock and the blockers as some of the worst decisions I’ve made in my life. So it’s horrifying to think that someone else, maybe someone even younger than I was, is being sold this same snake oil.

“How will they know what happened to me?” ■

*Alex is not his real name*



child prescribed blockers who goes on to take cross-sex hormones – as almost every patient does – will be infertile and unable to orgasm, since their gametes will not have matured, could a 13-year-old really understand what her future adult self stood to lose?

In 2017 I interviewed Bernadette Wren, then GIDS associate director, and asked if she had concerns. She admitted the long-term effects of Lupron were unknown. “Do you think I don’t worry about blockers?” she asked. “We all worry. Of course we worry.” She told me that although parents “want a remedy... to get your kid out of this predicament”, GIDS maintained a “degree of uncertainty about what the future might be and [is] keeping options open”.

Dr Kirsty Entwistle joined Leeds GIDS in 2017. Having trained to be a clinical psychologist after working since 2003 in children’s homes, and at a private school for boys with behavioural problems, she was excited to join the prestigious Tavistock. But from the very start at GIDS she felt expected to “unlearn” everything she already knew. Chatting with a colleague, she remarked that while studying for her doctorate and throughout years working with the “most wild, disinhibited kids”, gender identity never arose and seemed to her to “come out of the blue”. The colleague reported her as “transphobic”.

Staff worked in pairs: one talking to the child, the other to parents, and cases were later discussed at a team meeting. Entwistle was astonished when her clinical partner cited a female patient’s early love of *Thomas the Tank Engine* as evidence she should be referred to endocrinology. “This girl was horribly bullied and called a ‘dyke,’” she says. “It blew my mind that a toy was used as evidence for medical transition. My partner said, ‘Oh, but she hates her periods.’ I said, ‘But so do many girls.’” This patient was not referred and later, at sixth form where she ceased being bullied, told GIDS her dysphoria was resolved. “Yet she could easily have been put on a medical pathway,” says Entwistle.

Another early case was a female patient: “A very confident, relaxed and striking young person of 15 or 16 who passed as a boy and seemed to be doing pretty well.” Entwistle’s partner asked if she felt social transition was enough or whether she needed to medically transition. “This kid said, ‘I’m OK now but maybe when I’m 18...’ My partner argued she should go on puberty blockers right now. I was horrified.”

Other natal girls – 50 of the 60 cases she saw were female – had huge social problems: “Money or housing issues, or a chaotic family set-up, which needed addressing first. I’d begin talking about their lives, but my partner would ask about gender.”

As a junior (band 7) clinician, Entwistle was supposed to have a more senior partner. But staff were so overloaded, leading to a spate of new recruits, that her partner was also band 7. There was no approved treatment model. “It was the blind leading the blind,” she says. “You had to forget all your clinical knowledge and start from scratch.”

Entwistle quickly grew alarmed at how a child could be funnelled towards medication on an indication as vague as a female wearing boxer shorts. “I said in the Nineties this was what girls wore with baggy jeans. How was underwear being brought into a clinical space to decide whether you should go on hormones?” Meanwhile, pressure from families for medication grew. “Those who’d connected with Mermaids were terrified, because they’d been told that their child was going to kill themselves if they didn’t get blockers.” (The GIDS website states “suicide is extremely rare”.)

At this time, Entwistle noted that many adolescent girls had indications for autism

really complex case, a young person who was highly distressed about life in general, not just gender. The clinician put them on the blocker in session No 1. Then I was paired with Dr Anna Churcher Clarke, who had a very thoughtful, safe and cautious approach. So it was an eye-opener to have both in the first week and realise that, ‘Gosh, what’s happening here? People are practising in very different ways.’” The first, very troubled patient went on to have a psychotic episode. “I was shocked that a clinical psychologist with 20-plus years of experience had done that to a person at high risk without having explored any other aspects of their mental health.”

This colleague, he learnt, was on the board of Gendered Intelligence, a trans lobby group founded on “queer theory”, which believes clinicians must not “gate-keep” a child’s medical transition. So it was a systemic issue for some senior clinicians that they could not, or did not want to, go against what outside organisations pushed for.”

## THE PRIORITY WAS TO ASSESS AND PROCESS REFERRALS IN JUST A HANDFUL OF SESSIONS

(female autism has until recently been under-diagnosed as girls devise social strategies for concealing it), “Yet there was no special investigation into this new phenomenon.” When she asked the clinic manager if patients were followed into adulthood to see if medical intervention worked, “She said, ‘No, we can’t follow them because their NHS number changes if they transition.’” After a year of tense meetings, being repeatedly called a transphobe for asking questions and feeling she was letting down children with complex problems, Entwistle left GIDS.

Psychotherapist Anastassis Spiliadis joined the London clinic in 2015 aged 28, as another band 7 in the huge intake of new staff to deal with mounting case numbers. While training at the Maudsley hospital in south London he’d already encountered gender dysphoria, “And it registered with me that cases can have different outcomes.” When he joined the Tavistock, its reputation led him to believe that therapy would be at the centre of his work.

But he immediately felt the priority set by Polly Carmichael – “who kept telling people that she was not a great believer in psychotherapy of any kind” – was to assess and process referrals in just a handful of sessions rather than deeper inquiry.

Spiliadis also treated patients with a clinical partner. “First I was with a clinician on a

Spiliadis became close to Churcher Clarke and they published a paper, *Taking the Lid Off the Box*, which studied 128 young people (two thirds female) who arrived at GIDS adamant they wanted hormone blockers but after extended psychotherapy changed their minds about medication. (Although many still saw themselves as trans.) During therapy, common problems emerged: a sense of isolation from peers; ruptured parental relationships; female autism; homophobic bullying.

He recalls a female patient whose family was riven by chronic illness “and therefore had a really strong relationship to medication”. When he spoke with the patient alone they said, “My mum wants me to go on the hormone blocker more than I do.” Spiliadis raised this family pressure as a safeguarding concern at a team meeting, but the patient was prescribed blockers anyway.

Spiliadis saw many girls with chronic eating disorders at GIDS. “Most anorexics are natal females who reject their femininity and are repulsed by their secondary sex characteristics. They were being put on puberty blockers, which is awful as they’re already not developing because of their eating disorder. So you are double-blocking them.”

Gay clinicians at GIDS began to discuss how they had experienced an adolescent phase of gender dysphoria as “effeminate” boys or “butch” girls. Spiliadis says that trans clinicians were revered for having superior insight and authority, but the testimony of gay staff was dismissed as irrelevant, even transphobic. “So we formed a thinking group and said to management, ‘We are medicalising some people who would later identify as lesbian, gay and bisexual, not trans.’” How did Carmichael react? “I was repeatedly told by Polly to stop asking questions. Anyone who challenged the status quo and tried to think about complexity was perceived as the problem and scapegoated.”

In 2018, Spiliadis was one of ten GIDS clinicians who in frustration and growing horror about what was happening to children knocked on the office door of Dr David Bell. A distinguished psychiatrist and psychoanalyst, he was also staff governor at the Tavistock, where he’d worked in adult services for 25 years.

From these anguished clinicians he learnt that GIDS under Polly Carmichael was ignoring everything the Tavistock espoused. “Line one, page one of a psychotherapeutic approach – be it Freudian, Kleinian, Jungian, it doesn’t matter – is what you get is not what there is. There’s something else beneath the manifest.” But children were being pressured by families or schooled by activist groups in what to say to receive medication. “How do you get beneath the surface then?” Bell asks. “With 3,000 referrals, the answer is you can’t. Polly Carmichael told me, ‘There are straightforward cases.’ But how do you have a straightforward case of a child who wants a double mastectomy?”

Bell was horrified to learn that gay clinicians were silenced. “Freud’s most famous book is called *Three Essays on the Theory of Sexuality* and, while there are things we’d disagree with now, sexuality remains a core part of the psychoanalytical understanding of who we are. And here is a clinic that doesn’t talk about sexuality, only gender. It’s so peculiar.”

He notes that the current GIDS chief executive, Paul Jenkins, is the first not to be a clinician. “Almost every time he spoke at a meeting he talked about patient involvement.” While Bell agrees that we must all be involved in our medical decisions, “At a certain point it corrodes – it becomes a vehicle for attacks on expertise. So if the child or the family say they want this, we affirm them, without any interest in knowing why they want it.”

He puts medically transitioning children alongside the early 20th-century craze for curing mental illness with lobotomies. “Like lobotomy, there is no evidence. Like lobotomy, it starts with a patient in an impossible state and, initially, seems to work, then it becomes the universal cure.” Bell argues that with

mental (as opposed to physical) medicine, “The existence of a treatment creates the illness. Good centres for pneumonia wouldn’t create more pneumonia cases. Whereas with ‘false memory syndrome’, in the Nineties, suddenly you had lots of cases. It was the same when Freud wrote about hysteria.

“So I think we have a group who, at one time, would have been anorexic. A lot of them became self-harmers, had borderline personalities, and then became transgender. So they’re people dealing with similar kinds of problems, but they get refracted through the lens of what’s going on in the culture.” Would he recommend GIDS to a young person uncertain about their gender? “Definitely not.”

Bell does not believe a national child gender service should exist. “It doesn’t make sense. We don’t have a national service for people who are depressed. It’s illogical, because any problems with gender need to be seen in the context of all the other properties children have.”

In 2016, NHS England commissioners

But so much has changed already since 2017. This epidemic of trans-identifying girls now has a name – rapid onset gender dysphoria – chronicled in Abigail Shrier’s book *Irreversible Damage* and academic papers. Keira Bell ultimately had her judicial review overturned, but the case blew GIDS open to public scrutiny, showing an institutional incuriosity and failure to record how children on experimental medication turn out as adults.

In countries such as Sweden, Finland and France, gender clinics now prescribe blockers with extreme caution. Most significantly, in the US, where testosterone can be obtained from Planned Parenthood with no questions asked, psychologist Dr Erica Anderson, 71, a trans woman, who has seen hundreds of teenagers through medical transition, believes gender medicine has “gone too far” and is clearly a social contagion. “A fair number of kids are getting into it because it’s trendy,” she has said.

In Britain, Dr Michael Webberley, a private GP who alarmed GIDS clinicians by

## ‘ANYONE WHO CHALLENGED THE STATUS QUO AT THE CLINIC WAS SCAPEGOATED’

ruled that GPs, schools and social workers could refer patients to GIDS directly without any formal diagnosis of gender dysphoria. Too often a troubled child is seen by overstretched, underfunded CAMHS (child and adolescent mental health services) with multiple problems, but if gender is mentioned they will be offloaded to GIDS, their other problems remaining unaddressed while they sit on a two-year waiting list.

“Then,” says Bell, “the GIDS clinicians don’t have the experience of getting to know children for a year or two. Getting them to go down to those dark places takes time. They only see children, if clinically at all, for very brief meetings. So they don’t really have a sense of how a child ticks inside.”

After Bell’s 2018 report on clinicians’ concerns was suppressed by GIDS, he resigned. But what he wrote is echoed in Hilary Cass’s interim government report. Cass notes that at GIDS the original Dutch protocol was violated: puberty blockers were prescribed to neurodiverse or mentally ill young people who then received less therapy, not more. She talks of a “clinician lottery” and lack of formal clinical guidance. On the highly charged issue of hormone treatments she writes in her opening letter to young people, “There is still a lot we don’t know about the long-term effects.”

prescribing hormones to children as young as nine, with scant counselling, has been struck off by the GMC as “reckless”. His wife and co-practitioner, Dr Helen Webberley, is suspended pending a tribunal. Until now, LGBT groups have decried the concept of “rapid onset gender dysphoria” in girls, because to suggest these are cases of social contagion undermines the core tenet of gender identity: it is innate. Yet recently a senior figure at Stonewall, which has been gung-ho for child medical transition, said to me, “I think the wrong people are being referred to GIDS.” Even they sense the wind is changing – and lawsuits pending.

It looks ever more certain it will be the Tavistock whistleblowers, rather than those advocating sterilising drugs and double mastectomies for troubled children, who will end up on the right side of history. ■

*A Trust spokesman said, “Following a thorough assessment, and for those under 16 an independent review by a multi-professional group, a minority of GIDS patients are referred to expert paediatric endocrinology teams for consideration for treatment with hormone suppressants. The Trust refers to these teams in line with good practice, and the Supreme Court has confirmed it is for clinicians and patients to make decisions about the best care pathway for each individual patient.”*