LGB Alliance
124 City Road
London, EC1V 2NX

LGB Alliance response to the final report from the Cass Review

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LGB Alliance welcomes the final report of the Cass Review, published today, and hopes that it will usher in the end of a global medical scandal that continues to undermine the health and welfare of so many young people. However, we warn that its many excellent recommendations can only be implemented if the ideological "capture" of clinical bodies is tackled and reversed. This concern is borne out by Dr Cass's remark that "attempts to improve the evidence base have been thwarted by a lack of cooperation from the adult gender services" (p. 20). Why did these services thwart the work of an independent review? How can this shocking defiance be addressed and remedied?

Dr Cass's report has clearly been prepared with painstaking care. We acknowledge her use of language we reject (e.g. cisgender, "assigned at birth"), in a clear effort not to alienate those who take a different view. It is part of her general approach, which displays great compassion for young people presenting with "gender dysphoria".

As Cass notes, most of the teenagers involved are lesbian, bisexual or gay: she quotes figures from the GIDS service in 2016 (Holt et al., 2016; the most recent data available) which reported sexual orientation in 57% (97) of a clinic sample of patients over 12 years of age for whom this information was available. 68% of girls were only attracted to other girls and 21% to both girls and boys. In the case of boys, 42% were attracted to other boys and 39% to both girls and boys. (p. 18). In other words, 89% of girls and 81% of boys were either homosexual or bisexual. These are extraordinary figures. But gay teens aren't sick. If they mistake their emerging sexual orientation for a "gender identity" issue, they need *assurance* that it is fine to be gay, lesbian or bisexual, not *affirmation* that they are the opposite sex and that drugs and surgery will relieve their distress.

Even though LGB teens are at the centre of this issue, the University of York's international survey found that only two out of the ten clinics surveyed broached the subject of sexuality/sexual orientation with its patients presenting with gender distress (p. 135). The York synthesis of international guidelines found that the guidelines issued by the World Professional Association of Transgender Health (WPATH), a pro-affirmation lobby group that has had immense – and we would say, malign – influence on practice in this field in the UK and elsewhere, does not include sexual orientation as a "domain" that should be assessed (p. 135, Table 7).

The often-cited clinical consensus on the benefits of the "gender-affirming" approach is misleading. It is based on a circular process in which WPATH quotes the guidelines of other organisations – which were either prepared with WPATH's help or based on WPATH's own guidelines.

It is not commonly known that most of those seeking “gender care” are LGB teenagers, and in particular lesbians. The public perception is doubtless influenced by the fact that LGBTQ+ support groups mainly endorse “gender affirming care” (Appendix 9, p. 7), in which a girl who says she is a boy must be affirmed in that belief. LGB Alliance emphatically rejects that view.

Cass rightly observes that in some strictly religious cultures, being transgender is seen as preferable to being same-sex attracted as it is then perceived as a physical rather than a psychological issue (p. 119).

Most children who are unhappy with their sexed bodies later desist. “A study followed 2,772 adolescents from age 11 to 26. Gender non-contentedness (as defined by the question “I wish to be of the opposite sex”) was high in early adolescence, reduced into early 20s, and was associated with a poorer self-concept and mental health throughout development. It was also more often associated with same-sex attraction when compared to those who did not have gender non-contentedness” (p. 122, from Rawee et al. 2024). They do need time to think, but as Cass points out, “There is no evidence that puberty blockers buy time to think” (p. 32).

A survey of detransitioners found that 23% gave homophobia or difficulty accepting themselves as lesbian, gay or bisexual as a reason for transition and subsequent detransition (p. 188). LGB Alliance is pleased that these figures will now finally reach a wider public, but full of sadness and frustration that it has taken so long.

It is extremely worrying that precisely the response recommended by Cass – a holistic approach, involving careful exploration of the underlying issues, is rejected by the secretive but influential Coalition Against Conversion Therapy, chaired by Igi Moon – and by all its many signatories. They regard an exploratory approach as a “conversion practice” and that is what they seek to outlaw with their drive to ban “transgender conversion practices”. LGB Alliance was very pleased to see the recent announcement by the professional organisation UK Council for Psychotherapy (UKCP) that it has withdrawn its signature from the Memorandum of Understanding on Conversion Therapy – and cancelled its membership of the Coalition Against Conversion Therapy – because it rejects the inclusion of minors in the MoU. Hopefully more will soon follow. Cass recommends that clinicians should “seek to understand the child/young person’s emerging sexuality and sexual orientation, consistent with assessments in other adolescent settings, where deemed appropriate to age and context.” (p. 143).

Cass refers to a very worrying situation – in part the result of the efforts by Igi Moon’s group and other “affirmative approach” activist clinicians. That is the reluctance of clinicians to engage in the clinical care of gender-questioning children and young people. They are worried about making the wrong judgment and also express concerns about potential accusations of conversion practice when following an approach that would be considered *normal clinical practice* [italics ours] when working with other groups of children and young people.

The Report makes 32 important recommendations, which LGB Alliance is pleased to endorse. We single out just a few that address key concerns:

Key recommendations:

On young children:
"When families/carers are making decisions about social transition of pre-pubertal children, services should ensure that they can be seen as early as possible by a clinical professional with relevant experience."

Our comments
Some tomboys and "feminine" boys are hearing at school that they might be the opposite sex. If they succumb to this false propaganda, they should be referred to a mental health professional. Teachers are NOT qualified to make any decisions in this area: more needs to be done to halt "social transition" at school.

On children and young people in general:
"Clinicians should apply the assessment framework developed by the Review's Clinical Expert Group, to ensure children/ young people referred to NHS gender services receive a holistic assessment of their needs to inform an individualised care plan. This should include screening for neurodevelopmental conditions, including autism spectrum disorder, and a mental health assessment."

Our comments
The key word here is "holistic". All too often, distress about emerging sexual orientation and diverse other factors are ignored, and the focus is entirely on "gender".

On the age group 17 to 25:
"NHS England should establish follow-through services for 17-25-year-olds at each of the Regional Centres, either by extending the range of the regional children and young people's service or through linked services, to ensure continuity of care and support at a potentially vulnerable stage in their journey. This will also allow clinical, and research follow up data to be collected."

Our comments
This is a very welcome addition. At present, 17-year-olds are referred to adult services. There is a clear need for a bridging service, acknowledging that the prefrontal cortex, which governs decision-making, does not mature until around age 25.

On detransitioners:
"NHS England should ensure there is provision for people considering detransition, recognising that they may not wish to reengage with the services whose care they were previously under."

Our comments
LGB Alliance has called several times for a dedicated service to cater for the complex needs of detransitioners, many of whom are LGB. They are dealing with a range of mental and physical issues – often including shame. Most have no wish to return to

those who gave them such poor care, and they are left completely in the lurch.

On research:
"The evidence base underpinning medical and non-medical interventions in this clinical area must be improved. Following our earlier recommendation to establish a puberty blocker trial, which has been taken forward by NHS England, we further recommend a full programme of research be established."

Our comments
Although this is obvious, those who promote the "gender-affirming" approach consistently resist calls for research in this area. After all, children "know who they are".

On private operators:
"The Department of Health and Social Care should work with the General Pharmaceutical Council to define the dispensing responsibilities of pharmacists of private prescriptions and consider other statutory solutions that would prevent inappropriate overseas prescribing."

Our comments
This is crucial. Whether driven by a desire for profit, ideological zeal, or both, private operators are springing up to fill the gap left by the NHS's new more cautious path. Some have no safeguards whatsoever and are plying an unregulated drug market. The recent approval by the Care Quality Commission of the new Gender Plus Hormone Clinic is of particular concern.

The Report carefully skirts around an important problem in dealing with gender dysphoria: "Because gender incongruence is not considered to be a mental health condition clinicians are often reluctant to explore or address co-occurring mental health issues in children and young people presenting with gender distress" (p. 18). This refers to the reclassification of gender dysphoria/incongruence in the DSM-V and ICD, which no longer regard it as a mental disorder. Nonetheless, the Report recommends: "Identifying and treating mental health difficulties should be an integrated part of the care for children and young people presenting with gender dysphoria." (p. 142).

For LGB Alliance, the final report of the independent Cass Review highlights the medical scandal that is underway, the main victims of which are lesbian, gay and bisexual teens. It provides stark if overdue proof of the need to separate TQ+ activism from LGB groups. Why? Because all TQ+ groups campaign vigorously for the "gender affirming" approach to minors with gender dysphoria – from social "transition" to puberty blockers, cross-sex hormones and mastectomies. The findings of the Cass Review make it indisputably clear that such support is not just misguided but harmful – especially to LGB teens.

In her Foreword to the report, Dr Cass says: "There are few other areas of healthcare where professionals are so afraid to openly discuss their views, where people are vilified on social media, and where name-calling echoes the worst bullying behaviour. This must stop." Let us all redouble our efforts to discuss this serious healthcare issue in the measured language it deserves. Let us proceed on the assumption that we all want distressed children and young people to receive the best possible care. No one who hurls abuse at people with different views can contribute to this shared goal.