Review of the implications of the Cass Report for the provision of Gender Identity Services for children and young people in Ireland

March 2023

In 2021 NHS England commissioned a Review of Gender Identity Development Service for Children and Adolescents chaired by Dr Hilary Cass.

Following publication of the Interim Cass Report, the HSE's Chief Clinical Officer (CCO) requested the National Quality and Patient Safety Directorate to review the interim Cass report and how it applies to clinical pathways from Ireland.

The HSE will establish a group during 2023 to develop an updated model of care for the treatment of gender dysphoria. The group will be led by an expert clinician from a relevant specialty who will oversee this process and ensure widespread stakeholder engagement.

The HSE's goal is to develop a person-centred model of care and invest in an integrated service that meets the needs of transgender people in Ireland.

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National Quality Patient Safety Directorate

February 2023

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Gender Dysphoria: Definitions and Clinical Classifications

Many countries, including Ireland, have enacted legislation that enables transgender people to achieve full recognition of their preferred gender and allows them to acquire a new birth certificate that reflects that change.

On 15 July 2015, the Irish Government passed the Gender Recognition Act. This Act allows all individuals over the age of 18 to self-declare their own gender identity. Young people aged 16-17 can also apply to be legally recognised, though the process is more onerous.

It is not unusual for young people to explore both their sexuality and gender as they go through adolescence and early adulthood before developing a more settled identity. Many achieve this without experiencing significant distress or healthcare intervention. This is not the case for all, and some may experience many challenges and need a range of supports, including family, clinical and social supports.

Two healthcare frameworks are used to provide diagnostic criteria in the classification of gender dysphoria; the WHO International Classification of Diseases (ICD)[1], and the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM)[2].

The ICD is used worldwide as a classification system to promote international comparability in the collection, processing, classification, and presentation of mortality and morbidity statistics. In addition to epidemiological investigation it is also used for reimbursement systems, and automated decision support in health care. The latest version ICD 11, came into effect in January 2022. In this updated version the term 'gender identity disorders' has been removed from the chapter on mental health and a section for *"gender incongruence and transgender identities"* has been added to the sexual health chapter. ICD-11 defines gender incongruence as being "*characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex*".

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[1] https://www.who.int/standards/classifications/classification-of-diseases

[2] https://www.psychiatry.org/psychiatrists/practice/dsm

Transgender Services in Ireland

In Ireland, a Model of Care (MoC) for all transgender services was developed by the HSE between 2014 and 2016, leading to investment in the service. A specialist service for adults was already in place, and there is ongoing debate regarding the range and location of tertiary specialist transgender services in this country. There are also significant challenges recruiting the expert staff that are needed to provide a service.

The HSE is committed to developing a seamless and integrated service for people with gender identity issues, with the support of all relevant stakeholders.

Current services for those with gender dysphoria in Ireland are:

Adult services:

These are based in Loughlinstown Hospital, which forms part of the Ireland East Hospital Group (IEHG) and work closely with St. John of God services, through which a Consultant Adult Psychiatrist is employed. The Endocrine and Mental Health Services work very closely together.

Children's services:

1. A Paediatric Endocrinologist is appointed to Children's Health Ireland (CHI) and located in Crumlin Hospital. This service had not accepted referrals for a year at the time of this report, due to capacity challenges.

2. There is no existing specialist Child and Adolescent Mental Health Service (CAMHS) transgender service in Ireland, though attempts continue to be made to recruit an expert to fill this post. HSE CAMHS teams around the country screen, assess and treat children/young people who express gender dysphoria.

3. Because there is no local specialist service, children or young people who require specialist psychological assessment are referred to the single NHS specialist service in the Tavistock and Portman Trust through the HSE's Treatment Abroad Scheme (TAS). The TAS is a HSE scheme that allows public consultants to refer patients to public health services in other countries for a service that they consider necessary for their patients and where that service is not available within the Irish health service.

   The Interim Cass Report has seen the phased transfer from Tavistock to new centres in the UK. To that end a triage system in now in place whereby Tavistock no longer accepts direct referrals. Since November 2022 all referrals are reviewed by a Board and directed to one of the new centres described later in this report.

4. A total of 233 referrals to Tavistock have been made by consultants in Ireland since 2012 via TAS.

HSE Clinical Pathway to Tavistock

1. GP attendance when signs of transgender issues picked up by parents or expressed by child.
2. GP screens and may consider primary care psychology.
3. Following initial screening, GP refers the child to the CAMHS.
4. GPs may also refer directly to the paediatric endocrinology service at CHI who can also refer to Tavistock.
5. Any mental health issues experienced by patients seen by CAMHS are addressed by the service.
6. Once all co-morbid issues not related to their core gender issues are addressed, a referral may be sent by the CAMHS Consultant to the Tavistock service. At the same time application is made to the TAS for funding.
7. Tavistock service provides psychological assessment and support to those referred, including review by a psychiatrist if required. They liaise with the paediatric endocrinology team at CHI.
8. Endocrinology Consultant and team at CHI, in consultation with the Tavistock psychological support, considers treatment after their assessment. Work is underway to strengthen the psychology service at CHI by making an interim appointment.

Governance and Patient Safety

The governance of the referral pathway from Ireland to Tavistock has been strengthened over time. Since 2019, applications from CAMHS are sent by the TAS to the National Clinical Advisor and Group Lead (NCAGL) for Mental Health for approval. If they are not satisfied, they can contact the referring consultant for clarity.

Prior to the pandemic, psychologists from Tavistock travelled to CHI to conduct assessments, where there was liaison and consultation with the Paediatric Endocrinologist before, during and after any treatment. Ultimately the Consultant Endocrinologist was the medical professional who took the decision whether or not to prescribe hormone therapy.

In terms of quality and patient safety, following a full review of reporting mechanisms, there have been no Category 1 adverse incidents reported in relation to children or young people who have used this service, as per the HSE Incident Management Framework. If any incidents are reported they will be reviewed in accordance with HSE policy.

The HSE has been approached by family members of children/young people with gender dysphoria who have made complaints about the lack of access to services, but they have not made complaints about the quality or safety of the Tavistock service, either to the HSE or to Tavistock.

Current Service Provision for patients from Ireland

The HSE continues to refer children and young people to the NHS for specialist psychological supports, but since November 2022, the Tavistock centre has stopped taking direct referrals. All referrals to the NHS are now triaged by a Board and directed to new centres in the NHS.

There are two early adopter / first stage centres in the NHS: one is a partnership between Alder Hey and Manchester Children's Hospital and one is a partnership between Great Ormond Street Hospital, Evelina London Children's Hospital and the South London and Maudsley NHS Foundation.

There are over 5,000 patients on the Tavistock waiting list overall, and, when last validated 72 of these are previous referrals for children/young people from Ireland. These children/young people remain on the waiting list at Tavistock and are offered assessment there as appointments become available. Because the service is over capacity a very low number of those referred from Ireland are being seen at any given time.

The HSE is working to identify an alternative pathway for children/young people experiencing protracted waiting times. Discussions are underway with the paediatric endocrinology service at CHI and also with a psychology service to work on an interim solution until a full dedicated multidisciplinary service is established for Ireland.

In the past year, a very small number of (n<5) children/young people living in Ireland have availed of services at a centre in Belgium and Germany through the Cross Border Directive (CBD) and TAS schemes. This is in accordance with EU entitlements. Because of the very low numbers involved (n<5), further detail is not available. Under the CBD, people living in Ireland can be referred to a centre in the EU and seek reimbursement from the HSE if they are a public patient afterwards.

The paediatric endocrinology service had not accepted new referrals for a year at the time of this report and, despite funding and two recruitment campaigns, a CAMHS Consultant with a Special Interest in Gender Dysphoria has not been appointed.

There is no clear and agreed pathway whereby young people move from the paediatric service in CHI to the adult transgender service in IEHG. Young adults who are on hormonal therapies are added to an existing long waiting list for the adult transgender service. Some remain with the paediatric team, which is cited as a high risk by CHI.

The Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust

The Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust is commissioned by NHS England to provide specialist assessment, support and, where appropriate, hormone intervention for children/young people with gender dysphoria.

Until 2023, it was the only NHS provider of specialist gender services for children/young people in England. The service has faced increasing internal and external challenges in recent years. In addition to an increase in the number and complexity of referrals, there are documented divergent opinions on the appropriate clinical approach, high staff turnover and reports of staff concerns about clinical care.

In 2021 NHS England commissioned a Review of Gender Identity Development Service for Children and Adolescents chaired by Dr Hilary Cass. Dr Cass published an interim report in February 2021. The full interim report is available at https://cass.independent-review.uk/publications/interim-report/. The main recommendations of the report are summarised in Appendix One.

Considerations for the provision of Transgender Services in Ireland

Following publication of the Interim Cass Report, the HSE's Chief Clinical Officer (CCO) requested the National Quality and Patient Safety Directorate to:

"review the interim Cass report 'Independent Report of gender identity services for children and young people' recently published in UK and how it applies to clinical pathways from Ireland.

[and] pay particular focus on HSE pathways of referral and any improvements that should be considered to strengthen and standardise ensuring safety and best practice."

Methodology

The request by the CCO formed the basis of this report and involved consideration of the findings and recommendations contained in the Interim Cass Report in the context of service provision in Ireland. A series of meetings and follow-up discussions took place with:

- Parent of a child who attended the paediatric service, including referral to Tavistock service via TAS
- National Clinical Director for Integrated Care and Chair of the Transgender service development Steering Committee
- NCAGL Mental Health
- Clinical Director and Medical Director Children's' Health Ireland (CHI)
- CHI Endocrinology
- Clinical Lead Adult Transgender Service and Chief Clinical Director IEHG
- Dr Hilary Cass and her team

TAS records were accessed to identify the number of referrals to Tavistock, the source of those referrals and the indication for referral (i.e. psychology or psychiatry).

Referral Data

A total of 233 children/young people have been referred to the Tavistock centre from the HSE since 2012. Over two thirds of referrals were from a CAMHS team, either HSE CAMHS (60%) or the St John of God CAMHS, Lucena (9%). The remainder of the referrals were made by a hospital consultant, the majority of whom were Paediatric Endocrinologists (Table 1).

Table 1: Source of Referral by Year

	2012	2013	2015	2016	2017	2018	2019	2020	2021	2022	Grand Total
CAMHS			<5	19	18	24	35	27	11	5	140
Hospital	<5	<5	14	13	17	8	7	<5	<5	<5	73
Lucena / St John of God				<5		<5	<5	7		<5	20
Grand Total	<5	<5	**15**	**36**	**35**	**34**	**46**	**37**	**14**	**12**	**233**

The vast majority of referrals were to Psychiatry in Tavistock (n=224, 96%) with nine referrals to Psychology in Tavistock (Table 2). Referral to Psychiatry would have included the wider Multidisciplinary Team (MDT).

Table 2: Indication for Referral by Referral Specialty

	Psychiatry	Psychology	
Psychiatry	164	4	168
Endocrinology	43	5	48
Paediatrics	13		13
Not specified on application	2		2
Gynaecology	1		1
Psychology	1		1
Grand Total	**224**	**9**	**233**

Service Provider Views

There was general consensus among service providers from healthcare services in Ireland who took part in this review that the current pathway for children/ young people in Ireland who express gender dysphoria is suboptimal and high-risk because access to services is variable. There is particular concern for young people who have commenced hormonal treatment and are awaiting transfer of care to the adult transgender service. These young people can experience long waiting times as they are added to existing adult waiting lists.

It is evident that the clinical pathway operating in Ireland helped to mitigate the specific risks identified in the interim Cass report, particularly around capacity, tracking and other procedural issues.

For example, the numbers of UK-based patients attending the service were far greater, and these patients were referred by a range of professionals and services, thus creating challenges in tracking these patients. This is in contrast to patients referred from Ireland, where very low numbers were referred. Data presented in this report shows that 233 referrals were made over 10 years, ranging from one to 46 per year.

In terms of tracking or oversight, the TAS requires referrals to be made by a Consultant, and data presented in this report shows that over two thirds of referrals were made by a CAMHS Consultant.

In Ireland the adult transgender service provider undertakes rigorous psychiatric assessment of people referred to them. When consulted for this review, the adult service provider cited multiple sources of referral to the TAS over the last 10 years. This is consistent with the TAS data presented in this report (Table 1 & Table 2).

In 2018 the adult transgender service provider conducted a consecutive administrative review of 18 people who had been referred to Tavistock as children or young people, and were then subsequently referred to the adult service from CHI.

In 8 of these 18 cases, there was documentary evidence of CAMHS assessment or involvement, while in 10 of these 18 cases, there was no documentary evidence of CAMHS assessment or involvement. While this of itself did not provide evidence that assessment had not taken place in the 10 cases, overall documentation was limited and incomplete and it is not clear whether or not a full assessment was done.

The adult service provider noted that the risks posed by their findings were mitigated by follow-up assessment and treatment in the adult transgender service. The adult transgender service confirmed that there have been no reported Category 1 adverse incidents associated with people who attended the Tavistock service, as per the HSE Incident Management Framework.

Service User View

In completing this work it was considered important to seek the view of a service user. The following section outlines the experience of one family as described by the parent of a child who attended the paediatric service, including referral to Tavistock. The parent spoke with the full consent of their child, describing both their experiences. Their story may not be representative of all families who have accessed services.

They told us that their child's needs were managed by the multidisciplinary team having followed the clinical pathway outlined in this document; Primary Care, CAMHS, Paediatric Endocrinology and Tavistock (via TAS).

They reported that mental strain and emotional distress experienced by their child and their family over the course of their transition was immense. Their child experienced social isolation, bullying at school and mental illness.

Their journey through the health service was characterised by experiences of anguish and uncertainty, impacting the entire family, which this parent attributed to:

- The absence of a published model of care and associated information material
- The lack of a support network of parents of children on a similar pathway - the support of the Transgender Equality Network Ireland (TENI) was acknowledged.
- Protracted waiting times for paediatric endocrinology, for Tavistock, for hormone blockers, for cross-sex hormones, for adult services.
- Financial strain of travel to UK and the need to seek private healthcare either to avoid waiting lists or to access specialist treatment.

Each step of the clinical pathway posed its own difficulties but they also reported experiencing high quality professional care and kindness, including the care they received from the Tavistock team whom they met in CHI and London. They found the approach of the Tavistock team to be cautious and procedural rather than gender affirming. They were frustrated by how long they had to wait before being prescribed puberty blockers.

Despite availing of paediatric care for ten years and having completed a social, legal and medical transition, the 18-year-old is now on a waiting list for an appointment with the adult service.

Meeting with Cass Team

A number of meetings were held with Dr Hilary Cass and her team to discuss their review, the clinical pathway operating in Ireland and plans to develop services in the UK and Ireland.

Dr Cass reiterated that safety concerns in her review relate to the reliance on a single, isolated, standalone service which in the case of Tavistock was over capacity. This was not a criticism of the professionals who worked there as these challenges were beyond their control. The work of the review team is as yet incomplete. However, they produced an interim report on areas on which they were sufficiently clear, so that action could be taken to address risks through the development of regional centres.

These UK regional centres will become direct service providers, assessing and treating children and young people who may need specialist care as part of a wider pathway. Each regional centre will need to develop links and work collaboratively with a range of local services within their geography to ensure that appropriate clinical, psychological and social support is made available to children/young people who are in early stages of experiencing gender distress.

It is notable that these centres are aligned to major paediatric hospitals, and it is the view of Dr Cass and her team that transgender care for children should be aligned to paediatric hospitals rather than adult transgender services.

The Cass report highlighted variance in the conceptual understanding and consensus about the meaning of gender dysphoria. "*At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual, or a more fluid and temporal response to a range of developmental, social, and psychological factors. Professionals' experience and position on this spectrum may determine their clinical approach".*

The lack of consensus and paucity of peer-reviewed research evidence to guide gender services and clinical practice was mentioned as a risk and reality shared by health services and healthcare professionals in all countries. Work is underway to undertake research in this field, and in the UK a core dataset is being established and a protocol developed.

Finally, clarification was provided by Dr. Cass that the procedure in the UK and Wales is to continue the service at Tavistock, pending the establishment of six new centres. The short term capacity challenge was acknowledged but the Tavistock centre is doing its best to mitigate these risks.

Conclusions and Recommendations

The purpose of this report was to:

- *" review the interim Cass report 'Independent Report of gender identity services for children and young people' recently published in UK and how it applies to clinical pathways from Ireland.*
- *…pay particular focus on HSE pathways of referral and any improvements that should be considered to strengthen and standardise ensuring safety and best practice."*

1. The Interim Cass Report impacts the future delivery of care for children/young people in Ireland who express gender dysphoria.

The report highlights how the epidemiology of gender dysphoria has changed in recent years with increasing numbers of children/young people presenting with gender related distress. It is evident from the report and discussions with Dr Cass and her team that this is not a homogeneous group and the different pathways through gender dysphoria need to be understood to meet people's complex care needs.

Children and young people are already disadvantaged by limited service provision and they are further disadvantaged by the paucity of evidence to support care decisions. Children, young people and their parents have a limited period of time in the child's life to understand what gender related distress means for them before they make decisions. This reinforces the need to address wider societal awareness and to provide information, a range of supports and interventions required by this diverse grouping.

2. The slow development of specialist services for children and young people expressing gender dysphoria in Ireland is adding to risk.

Recent investment commitments are acknowledged. However rather than improving, since the pandemic service provision for children and young people has fragmented and deteriorated. The course through the clinical pathway is lengthy, so the risk of anxiety and emotional distress for parents and children/young people alike may be heightened by uncertainty and isolation. People living in Ireland, albeit it in very low numbers, are now availing of multiple pathways and services outside Ireland (NHS, Belgium and Germany) through TAS and other schemes.

3. Ireland has mitigated some of the risks highlighted in the Cass report by proactively providing care at primary and secondary level.

Supports within primary and secondary care are as important as tertiary specialist care. While people may need to wait for specialist care, they need quality information, support for mental health needs and avoid the risk of being subject to misinformation or potential safeguarding concerns.

Ireland has a strong multi-disciplinary adult transgender service but the need for closer liaison between the adult and paediatric centre to ensure a seamless clinical pathway as adolescents enter adulthood is evident.

Notwithstanding the deficits highlighted by the parent and service providers consulted, and based on follow up discussions with Dr Cass and her team, the clinical pathway in operation in Ireland helped to mitigate the risks identified in the Interim Cass Report.(The Cass report findings and the HSE mitigations are summarised in Appendix Two).

1. A range of improvements are required *"to strengthen and standardise ensuring safety and best practice."* Current service provision is fragmented and un-coordinated, and the following recommendations are made by this review:

    a. Model of Care (MoC)

    It is clear that Ireland needs to update our MoC, due to the changing epidemiology of gender dysphoria, changes to the MoC in the NHS and the opportunity presented by the Interim Cass Report to participate in collaborative international research. The updated MoC should provide for the mental and physical healthcare needs of this diverse group from childhood through adolescence and adulthood.

    Under the policy framework of Slaintecare, the HSE should commission a multi-disciplinary team to develop an integrated MoC for transgender services. The team should be led by a clinician from a relevant specialty, whose role will be to ensure there is widespread stakeholder engagement and that the MoC will incorporate a multi-tiered approach, where care will be delivered at the lowest level of complexity required.

    b. Service User Involvement

    The development of the MoC must be informed by extensive service user and stakeholder involvement. The identification of stakeholders should be based on having lived experience as a service user or service provider.

    c. International Collaboration

    The publication of the Interim Cass Report presents an important opportunity for Ireland to collaborate with England and over 15 other countries with similar health systems that are assessing their MoC.

    NHS England is due to launch consultation on its interim service specification for children with gender dysphoria shortly. Service developments in Ireland will benefit from the output of that consultation.

    There is also an opportunity to join research teams, share data, participate in longitudinal studies, and learn from research as it emerges in the coming months and years.

    Finally, Ireland may benefit from closer service collaboration and joint training opportunities for all disciplines

Appendix One: HSE Mitigation of Risk

The findings of the Cass Report are summarised in the first column of Table 3. The mitigations afforded by the HSE clinical pathway are described in the second column of the table.

Table 3: Summary Findings Cass Report /HSE Mitigation

Conceptual understanding and consensus about the meaning of gender dysphoria1	
CASS REPORT	HSE MITIGATION
The review highlights debate regarding conceptual understanding and lack of consensus about the meaning of gender dysphoria *"At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual, or a more fluid and temporal response to a range of developmental, social, and psychological factors. Professionals' experience and position on this spectrum may determine their clinical approach".*	Notwithstanding a robust process, wide consultation and a broad- based representative membership of the steering committee, the HSE MoC for Transgender Services remains unpublished. Divergent clinical opinion on service configuration and the clinical pathway has impeded service delivery and development in Ireland
The lack of consensus coupled with a failure have an open discussion of the issue is impeding the development of clear guidelines.	
Service capacity and delivery	
CASS REPORT	HSE MITIGATION
The epidemiology of gender dysphoria is changing with a significant increase in the number of referrals to specialist services in recent years.	Similar trends noted in Ireland.
Until recently the Tavistock service accepted referrals from a range of sources, sometimes inappropriately. Local service provision in the UK did not develop in parallel.	There is an onus on Consultants referring via TAS to ensure that the service to which they are referring is appropriate for their patient Cases are screened by primary care, Paediatric Endocrinologists, CAMHs and in

	some cases NCAGL as part of the TAS referral.
The mix of young people presenting to the service is more complex than seen previously, with many being neurodiversity and/or having a wide range of psychosocial and mental health needs.	In advance of referral to Tavistock children/young people would have seen their GP and Paediatric Endocrinologist and/or CAMHS consultant. In circumstances where hormonal therapy is being considered the child or young person would also be in the care of a Consultant Paediatric Endocrinologist. The HSE refers to Tavistock for psychological/psychiatric assessment only under TAS. Ongoing complex care needs are managed within the HSE or HSE funded services.
Demand has now outstripped capacity at the Tavistock clinic. This has resulted in long waiting lists and concern about how the NHS should most appropriately assess, diagnose and care for this population of children and young people.	The HSE has developed a MoC and a multi-stakeholder steering committee worked on developing transgender identity services in Ireland. Recommendations from this committee included funding for a CAMHS psychiatrist (failed to recruit on two rounds of advertising).
The service is experiencing recruitment and retention problems exacerbating the over- capacity problem.	
Capacity constraints cannot be addressed through financial investment alone; there are some complex workforce (recruitment; retention; and training) and cultural issues to address.	
Initial review findings suggest many professionals working at primary and secondary level feel that they have the transferable skills and the commitment to offer more robust support to this group of children and young people, but are nervous about doing so, partly because of the lack of formal clinical guidance, and partly due to the broader societal context	Primary and secondary care teams are involved in the care of Irish children and young people.
Primary and secondary care staff reported pressure to adopt an affirmative approach that is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters.	No evidence that a gender affirming approach has influenced hormonal therapy in Ireland.
Long waiting times creates clinical risk to young people. By the time they are seen,	CAMHS available to Irish patients but the effect of long waiting times is noted.

their distress may have worsened, and their mental health may have deteriorated.	
The review group cited concerns of diagnostic overshadowing as other complex care needs, that could have been managed locally, were overlooked when children or young people identified as having gender –related distress.	Primary and secondary care teams are involved in the care of Irish children/ young people
Concern was expressed that the age of transfer to adult services was too young.	

Service standards

In 2021 and following a series of court cases (Bell v Tavistock) a Multi-Professional Review Group (MPRG), set up by NHS England to ensure that procedures for assessment and for informed consent have been properly followed, has stated that the following areas require consideration:

CASS REPORT	HSE MITIGATION
From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision.	Irish patients referred for psychological/psychiatric assessment only. Professionals in Ireland manage the remainder of the care pathway.
From documentation provided to the MPRG, there does not appear to be a standardised approach to assessment or progression through the process, which leads to potential gaps in necessary evidence and a lack of clarity.	
There is limited evidence of mental health or neurodevelopmental assessments being routinely documented, or of a discipline of formal diagnostic or psychological formulation.	This assessment is completed by doctors in Ireland
Of 44 submissions received by the MPRG, 31% were not initially assured due to lack of safeguarding information. And in a number of cases there were specific safeguarding concerns. There do not appear to be consistent processes in place to work with other agencies to identify children/young people and families who may be vulnerable, at risk and require safeguarding	Safeguarding foremost in paediatric services in Ireland

International comparisons	
CASS REPORT	HSE MITIGATIONS
GIDS initially reported its approach to early endocrine intervention as being based on the Dutch Approach but significant differences in approach are now evident. Within the Dutch Approach, children / young people with neurodiversity and/or complex mental health problems are routinely given therapeutic support in advance of, or when considered appropriate, instead of early hormone intervention. Criteria to have accessed therapeutic support prior to starting hormone blocking treatment do not appear to be integral to the current NHS process	Psychologists meet /liaise with Paediatric Endocrinologist in CHI.
NHS endocrinologists do not systematically attend the multi-disciplinary meetings where the complex cases that may be referred to them are discussed, and until very recently did not routinely have direct contact with the clinical staff member who had assessed the child or young person.	Psychologists meet/liaise with Paediatric Endocrinologist in CHI.
In the NHS, once young people are started on hormone treatment, the frequency of appointments drops off rather than intensifies, and review usually takes place quarterly.	Ongoing monitoring by Paediatric Endocrinologist.
Evidence base	
CASS REPORT	HSE MITIGATIONS
Evidence on the appropriate management of children / young people with gender incongruence and dysphoria is inconclusive both nationally and internationally	Very low volume of cases in Ireland managed by single team. Divergent opinions are evident in Ireland also and we await the outcome of research being undertaken by Cass et al.
A lack of a conceptual agreement about the meaning of gender dysphoria hampers research, as well as NHS clinical service provision.	
There has not been routine and consistent data collection within GIDS, which means it is not possible to accurately track the outcomes and pathways that children / young people take through the service.	

Internationally as well as nationally, longer-term follow-up data on children/young people who have been seen by gender identity services is limited, including for those who have received physical interventions; who were transferred to adult services and/or accessed private services; or who desisted, experienced regret or de-transitioned.	
There has been research on the short-term mental health outcomes and physical side effects of puberty blockers for this cohort, but very limited research on the sexual, cognitive or broader developmental outcomes.	
Much of the existing literature about natural history and treatment outcomes for gender dysphoria in childhood is based on a case-mix of predominantly birth-registered males presenting in early childhood. There is much less data on the more recent case-mix of predominantly birth-registered females presenting in early teens, particularly in relation to treatment and outcomes.	
Aspects of the literature are open to interpretation in multiple ways, and there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint.	
Within the UK, the single specialist service has developed organically. The clinical approach has not been subjected to some of the usual control measures that are typically applied when new or innovative treatments are introduced.	
Many of the challenges and knowledge echoed internationally, and there are significant gaps in the research and evidence base.	
The mismatch between service user expectations and clinical standards	
By the time children/young people reach GIDS, they have usually had to experience increasingly long, challenging waits to be	While long wait times are an issue for Irish Children/young people accessing the Tavistock service, there is no evidence that

seen. Consequently, some feel they want rapid access to physical interventions and find having a detailed assessment distressing.	hormonal treatment or other physical intervention has been fast tracked.
Clinical staff are governed by professional, legal and ethical guidance which demands that certain standards are met before a treatment can be provided. Clinicians carry responsibility for their assessment and recommendations, and any harm that might be caused to a patient under their care. This can create a tension between the aspirations of the young person and the responsibilities of the clinician.	

Appendix Two: Summary of Cass Recommendations

MoC

1. The Review advises that the regional centres should be developed, as soon as feasibly possible, to become direct service providers, assessing and treating children/young people who may need specialist care, as part of a wider pathway.
2. Each regional centre will need to develop links and work collaboratively with a range of local services within their geography to ensure that appropriate clinical, psychological and social support is made available to children/young people who are in early stages of experiencing gender distress.
3. Clear criteria will be needed for referral to services along the pathway from primary to tertiary care so that gender-questioning children/young people who seek help from the NHS have equitable access to services.
4. Regional training programmes should be run for clinical practitioners at all levels, alongside the online training modules developed by Health Education England (HEE). In the longer-term, clearer mapping of the required workforce, and a series of competency frameworks will need to be developed in collaboration with relevant professional organisations.

Data Audit and Research

5. The regional services should have regular co-ordinated national provider meetings and operate to shared standards and operating procedures with a view to establishing a formal learning health system.
6. Existing and future services should have standardised data collection in order to audit standards and inform understanding of the epidemiology, assessment and treatment of this group of children and young people.
7. Prospective consent of children/young people should be sought for their data to be used for continuous service development, to track outcomes, and for research purposes. Within this model, children/young people put on hormone treatment should be formally followed up into adult services, ideally as part of an agreed research protocol, to improve outcome data.

Clinical approach

8. There needs to be agreement and guidance about the appropriate clinical assessment processes that should take place at primary, secondary and tertiary level.
9. Assessments should be respectful of the experience of the child or young person and be developmentally informed. Clinicians should remain open and explore the patient’s experience and the range of support and treatment options that may best address their needs, including any specific needs of neurodiversity children and young people.

Hormone treatment

10. Any child or young person being considered for hormone treatment should have a formal diagnosis and formulation, which addresses the full range of factors affecting their physical, mental, developmental and psychosocial wellbeing. This formulation should then inform what options for support and intervention might be helpful for that child or young person.
11. Currently paediatric endocrinologists have sole responsibility for treatment, but where a life-changing intervention is given there should also be additional

medical responsibility for the differential diagnosis leading up to the treatment decision.

12. Paediatric endocrinologists should become active partners in the decision making process leading up to referral for hormone treatment by participating in the multidisciplinary team meeting where children being considered for hormone treatment are discussed.
13. Within clinical notes, the stated purpose of puberty blockers as explained to the child or young person and parent should be made clear. There should be clear documentation of what information has been provided to each child or young person on likely outcomes and side effects of all hormone treatment, as well as uncertainties about longer-term outcomes.
14. In the immediate term the Multi-Professional Review Group (MPRG) established by NHS England should continue to review cases being referred by GIDS to endocrine services.