

← → ↻ <https://tavistockandportman.nhs.uk/care-and-treatment/our-clinical-services/gender-identity-clinic-gic/> ☆ ⓘ ⋮

NHS
The Tavistock and Portman
NHS Foundation Trust

contact us Search

Home About us ▾ Care and treatment ▾ Education and training ▾ Research and innovation ▾ News, conferences and events ▾

Gender identity clinic (GIC)

The Gender Identity Clinic (GIC) is the largest and oldest gender clinic in the UK, dating back to 1966. We accept referrals from all over the UK for people with issues related to gender.

We are a multi-disciplinary administrative and clinical team, including psychologists, psychiatrists, endocrinologists and speech and language therapists. We work together in order to provide holistic gender care, focusing on the biological/medical, psychological and social aspects of gender.

The clinic is sometimes referred to as the Charing Cross (CX) Gender Identity Clinic due to its proximity to the acute hospital, but we are actually based in a standalone clinic just off Fulham Palace Road.

Visit the new GIC website

The service has launched a new website with information for service users and patients, along with referral information for medical professionals. You can visit the new site at gic.nhs.uk

Contact the GIC Patient Advice and Liaison Service

The Gender Identity Clinic has a separate, Patient Advice and Liaison Service, which can be contacted via PALSGIC@tavi-port.nhs.uk

A warm welcome to the Gender Identity Clinic

From today we will be the interim provider for the Gender Identity Clinic, a service for adults based near the Charing Cross Hospital in...

3 April 2017

Gender identity development service (GIDS)

For children and young people, and their families, who experience difficulties in the development of their gender identity.

Share this page

[f](#) [in](#) [t](#)

Privacy and your data (privacy notice) Accessibility Support and complaints Library Moodle MyTAP login page CQC rating: Good

Innovation in mind [f](#) [in](#) [t](#)

Reproduced for educational purposes only. Fair Use relied upon.

Vulnerable youngsters rushed into treatment. Staff too nervous to speak out: After resigning from controversial Tavistock gender clinic trust, a former governor says he fears we're hurrying children down a transgender path they may bitterly regret

By [MARCUS EVANS FOR THE DAILY MAIL](#)

PUBLISHED: 17:11 EST, 1 March 2019 | **UPDATED:** 05:51 EST, 2 March 2019

541
shares

 34
[View comments](#)



CAPTION: As an adult psychotherapist Marcus Evans deals with patients who may express their feelings in challenging ways

For four decades, I have devoted my career to trying to understand people who are greatly distressed and confused.

As an adult psychotherapist, I deal with patients who may express their feelings in challenging ways.

But my role is to pay careful attention and to try to tune in to what isn't being said; the hidden aspects of a patient's story.

Reproduced for educational purposes only. Fair Use relied upon.

The key to achieving this is patience, time and slow-moving, dogged determination — words that aren't fashionable in a fast-paced world intent on quick fixes and budget cuts.

But it's my view that to try to treat vulnerable patients in any other way can be hugely damaging.

This is, in part, the reason I resigned from my post as governor of The Tavistock & Portman NHS Foundation Trust last week.

A leaked internal report had branded the Gender Identity Development Service (GIDS) at The Tavistock Centre, England's only NHS youth gender clinic, 'not fit for purpose'.

The overwhelming feeling was that some children in its care were not being given enough time in their psychological assessment and treatment.

It goes without saying that the area of mental health — and particularly relating to gender dysphoria — is highly complex.

The service was accused of being too quick to give children and young people medical treatment (hormone-blocking drugs).

Treatment that has unknown far-reaching consequences and that, without sufficient exploration as to the child's feelings and motives, can have devastating life-long effects on their identity and development.

Although, following this first critical report, the Trust had subsequently commissioned its own review of the situation, I began to worry that this second report was being used to close down rather than open up the debate about the serious and sensitive clinical issues.



As an adult psychotherapist Marcus Evans deals with patients who may express their feelings in challenging ways



© Jeff Blackler/REX/Shutterstock

Mr Evans writes: 'A leaked internal report had branded the Gender Identity Development Service (GIDS) at The Tavistock Centre, England's only NHS youth gender clinic, "not fit for purpose"'

Adolescence and childhood is a time when people are developing socially and biologically; when young people are identifying with different groups, and with male and female aspects of themselves.

There is pressure from the child who is in a distressed state, there is pressure from the family and the peer group and from the pro-trans lobbies — and all of this puts pressure on the clinician, who may want to help the individual to resolve their distressed state by going along with a quick solution.

There is a great deal at stake here, as these decisions have long-term consequences.

I first witnessed some of these consequences 30 years ago, when running a parasuicide clinic in London. This was for adults who had attempted suicide without the intention of actually killing themselves: it was sometimes a cry for help.

People ended up there for a variety of reasons, but a number of patients had taken an overdose because they had undergone gender reassignment surgery and regretted it.

At the time, I was struck by the commonality of their feelings. There was often a profound disappointment that the surgery hadn't provided the solutions they'd hoped for.

As a result, there was much anger towards medical and psychiatric staff who, in their minds, had failed to examine in sufficient depth their reasons for wanting to change sex.

This is ultimately the issue being raised with The Tavistock: the concern being that children in its care aren't been given enough time with clinical professionals to explore their difficulties and reasons for what's driving them to believe they inhabit the wrong body. And the fear is they might end up like the patients I saw all those years ago.

I have a long association with The Tavistock, and I imagine former colleagues will accuse me of damaging the service and its reputation.

But I feel the Trust's tendency, in relation to this contentious issue, to close down debate is so unhelpful that it justified me leaving my role and speaking out.

Such an approach is worrying at any level in the NHS, but particularly in an area where we still know so little. After all, the figures of how many young people are seeking treatment are startling.

Over the past five years, the number of children referred to The Tavistock Centre has risen from 468 to 2,519 a year, a rise of more than 400 per cent.



Mr Evans writes: 'The overwhelming feeling was that some children in its care were not being given enough time in their psychological assessment and treatment'

Dr Polly Carmichael, director of the GIDS at The Tavistock, this week admitted that the centre was under pressure, although she insisted that the service has 'really long assessments over periods of time, with the specific aim of allowing young people to think about what is right for them'.

How that squares with the concerns raised by the internal report is beyond me.

In that report, its author Dr David Bell, then a staff governor, suggested the service was failing to fully consider psychological and social factors in a young person's background — such as whether they had been abused, suffered a bereavement or had autism — which might influence their decision to transition.

Staff had anonymously contacted him to say that some patients were going on to medical treatments after just a few hours of contact with clinical staff. Although this was later denied by the Trust.

The aim of this medication is to halt the growth of secondary sex characteristics such as breasts or facial hair — features that would cause the patient great distress.

I share the concerns about the fact the long-term side-effects of these powerful hormone-blocking drugs are, as yet, unknown.

Indeed, around the time the report was being compiled, I was contacted by a group of parents whose children had been assessed in the GID service. They, too, expressed concerns that their children were being rushed through to medical treatment without adequate evaluation and engagement.

The report also alleged that the clinic bowed to pressure from 'highly politicised' pro-trans lobby groups.

In fact, several of us in The Tavistock have long held concerns about the GID service.

I trained at The Tavistock in 1986 and was the first nurse appointed the following year. I worked as an adult psychotherapist for 20 years and I was also head of nursing and went on to become associate clinical director.

As a manager, I was on the clinic's committee more than ten years ago when concerns were first raised by members of staff within the GID unit that the assessments of patients weren't in-depth enough.

So it is a service that has long been mired in controversy. But there is a seeming reluctance to engage with this.

And when you have a service that fails to address the concerns of staff adequately — or makes them feel fearful of reporting what's actually occurring on the shop floor — you are in a disturbing situation.

Take this week's Panorama investigation into The Tavistock. What troubled me most about the programme was the number of staff who only felt they could speak about these issues anonymously, off the record.

This in itself suggests that being accused of being transphobic or having bigoted views is not just happening outside The Tavistock, it's happening inside it, too.

Why would so many concerned staff, who felt strongly enough to talk to the programme, refuse to be identified? It seems to me they felt their views wouldn't be welcomed.

One anonymous member of the service told Panorama: 'In the majority of cases, I was simply unsure how well things would work out for them in the future.'

Another anonymous contributor made the point that, counter to child development theory and knowledge, there is an emphasis less on helping a person psychologically, wherever possible, to cope with their bodies — and much more on changing their bodies as a way of improving their mental health.

Yet it is essential for a clinician to work with the young person and family over a long period to understand the developmental history, family dynamics and various peer group dynamics; after all, these make up the experiences that shape us.

Childhood and adolescence can stir up all sorts of doubts and conflicts. When these become overwhelming, they may push the child to focus on a fixed solution — one of which might be, 'I'm the wrong sex'.

This situation requires considerable experience and clinical maturity, as one needs to be able to empathise deeply with the individual's confusion, distress and mental

pain.

Yet, at the same time, one needs to maintain adequate distance so that one resists the pressure to join them in their view that active medical (rather than psychological) intervention is the only solution.

A thorough assessment needs to include a full discussion (which may require many meetings) about the potential losses and costs, both emotional and physical, of medication and later surgery.

This process will likely incur resistance. The child or young adult and their family may feel this kind of engagement from the clinician is interfering or obstructive, cruel even.

But these patients need an independent clinical service that has the long-term interests of the patient at its heart.

To some extent, this involves a capacity to remain empathetic to the child's distress, but to also stand up to pressure coming from various sources: from the young person, their family, peer groups, online/social networking pressures and, of course, from pro-trans groups.

And, crucially, at the heart of any clinical service must be the knowledge that the medication it prescribes its patients is safe. I cannot think of one other area of medicine where it would be permissible to use so extensively medication whose long-term effects are unknown. But there are emerging concerns.

In the Panorama programme, Carl Heneghan, professor of evidence-based medicine at the University of Oxford, talked about the lack of clinical evidence about these drugs, stating that we cannot make an informed decision about the long-term benefit or cost of treatment.

Dr Carmichael, GIDS director and consultant clinical psychologist, may have claimed that the effect of the puberty-blocker is fully reversible.

But then she did admit that we know nothing about the long-term effects on the brain or other organs in the body.

Another real concern is that quite a high proportion of patients who have medical interventions — such as the puberty-blocking hormones — go on to have sexual reassignment surgery.

And although it is often claimed that patients react positively after transitioning, as I say, I know differently from my own experience.

We're also navigating uncharted territory. Where there used to be a particular profile for those being referred (mostly male, with a long-standing idea — often since early childhood — that they were the wrong sex), of the 2,519 young people referred to Tavistock's GID service in the last financial year, more than 70 per cent were born female.

Some parents have expressed a fear that a plethora of social media videos featuring young people (especially those born female) discussing their decision to opt for physical intervention was, at least in part, driving the trend.

There is also evidence of a contagion effect in close peer groups.

In my 40 years in psychiatry, I have learned that closing down debate and discussion creates silos that resist thoughtful examination of important issues.

This is a particularly worrying approach by the GID service. They are treating highly vulnerable individuals who are making decisions which will often have, as yet unknown, consequences for the rest of their lives.

Considering the lack of clinical evidence for the drugs used, one might question why the national service (which has been going for 30 years) hasn't yet undertaken a research study or even collected basic follow-up outcome data?

It is important to state here that I'm not suggesting that changing gender through medical intervention is never the right decision. Only that this should take place at the end of a long process of deepening engagement with the child and their family.

I have been asked whether I think the GID service should be closed down. The answer is no. All I am seeking is a change of attitude that might create an atmosphere more open to thinking critically about the approach.

We urgently need a new regulator that has oversight to ensure a more clinically rigorous, balanced and ethical approach.

There should also be more clinics nationwide so that children and their families are not left waiting in a distressed state to be seen.

Little wonder, if they have waited sometimes two years, that they feel their need for interventions is so urgent once they arrive at the GID service's base.

The young people who attend the clinic often turn up in great distress. We owe it to them to explore their reasoning in forensic detail — before hurrying them down the path of no return.

Marcus Evans is the author of *Making Room For Madness In Mental Health* (Routledge).

Reproduced for educational purposes only. Fair Use relied upon.

ADVERTISEMENT

Share or comment on this article: Former governor says he fears we're hurrying children down a transgender path

