

Gendered Intelligenceⁱ Position statement – Puberty Delaying Treatmentⁱⁱ

Introduction

This position paper sets out the position Gendered Intelligence takes on the matter of the assessment for, and the administering and monitoring of, *Puberty Delaying Treatment* for young trans, non-binary and gender diverse people.ⁱⁱⁱ

While the term ‘puberty blockers’ is in common usage, at Gendered Intelligence we recognise a more appropriate expression for this treatment is ‘puberty delaying treatment’ as the treatment does not ‘block’ puberty permanently. Rather, the treatment works to delay physical puberty in order to reduce distress caused by the feminisation or masculinisation of secondary sex characteristics.

Background

Over the last 2 years, Gendered Intelligence has held workshops with its staff members and Youth Board to consider what we as a team thought about ‘medical transitioning and young people.’ With significant focus on puberty delaying treatment in the public domain, our focus at Gendered Intelligence has gravitated here. In October 2020, we have seen the High Court case *Bell v Tavistock*. Gendered Intelligence chose to intervene in the Appeal to this case^{iv}. Following the *Bell v Tavistock* outcome, the World Professional Association for Transgender Health (WPATH) formed a joint statement with other organisations working across global jurisdictions about the treatment of adolescent trans people.^v In March 2021, there was another case in the family courts regarding parental consent, which allowed for partial movement from the original *Bell v Tavistock* outcome.^{vi}

This has given us an opportunity to engage more fully with the research and acknowledge the complexity of medical treatment for young trans, non-binary and gender diverse people. Young people — and their parents and carers — who access our services have told us about the important impact puberty delaying treatment has had on their everyday lives, as well as the ways in which the Judicial Review has impacted on them directly.^{vii viii}

Our stakeholders, at Gendered Intelligence, have diverse views about medical transitioning, not least concerning a misplaced emphasis from across mainstream platforms on the medicalisation of trans people and ‘wrong body’ narratives. There are also more political views held by some here at Gendered Intelligence about the pharmaceutical industry at large. At Gendered Intelligence we value this diversity of views, welcoming and engaging with a wide range of opinions. At the same time, we recognise a need to provide guidance and a framework for all staff and volunteers to engage further with our young people, community members, clients and members of the general public. This position paper therefore sets out our shared organisational view.

Gendered Intelligence Position Statement

- All young people are entitled to timely, age appropriate, high-quality healthcare under the NHS.^{ix}
- Not all young trans, gender diverse and gender questioning young people will want to use puberty delaying treatment, but for those that do it can be highly valuable and life affirming. Gendered Intelligence will continue to support all young people in pursuing their right to receive the healthcare that they are entitled to.
- We stand behind the NHS protocol of offering puberty delaying treatment to those young people who are deemed to benefit from it; and at the point that puberty has started.^x
- We believe that young people should be at the front and centre of any decision making regarding their health, with the support and consent from parents/ carers and under the supervision of an appropriate professional working in trans health care.
- The principles of 'informed consent' discussed in adult trans health care should not exclude children and young people. The use of Gillick competence is a key root to empower young people to have agency over their healthcare^{xi}.
- We understand that support and consent to puberty delaying treatment from parents and carers is appropriate and desirable, but those young people who do not have the support of their parents and carers should not be left behind.
- Research tells us - and we know from working with young trans people for over 12 years, as well as from our own lived experiences as a trans led organisation - that supporting people with their social transition is most important.^{xii} We also know that the best support comes from a place of understanding and that being educated about gender diversity is key to reaching that understanding.
- All transitions – medical, social, and legal – are unique to the individual. Young people need careful, kind and supportive environments *and* conversations that will help them make decisions that are right for themselves.
- Young people need access to the latest, up-to-date, accurate information, including the risks, to inform their decisions. They need the space to weigh up what is the right thing to do for themselves, with the support from, and alongside, a wide-ranging set of trusted adults.^{xiii}
- We acknowledge the lack of timely NHS provision prompts people to seek other routes for medical support. Routes that follow the WPATH guidelines (as the NHS does) can form part of the picture, but they create a two-tier system which is inaccessible to many and are no substitute for adequate NHS provision.
- We recognise that some people have more than one transition. This 'retransitioning' should not be judged negatively, instead thorough and holistic support should continue to be offered.
- Being trans is not a mental health condition and trans healthcare should not be framed in any way as belonging within a pathological model^{xiv}.
- We do not believe any child or young person should be restricted in expressing their gender in any way they see fit, be it through names, pronouns and gender markers used; through clothes, hair styles and makeup; through behaviours and mannerisms; or through hobbies, toys and interests.
- Trans people should not be positioned as reinforcing gender norms if they go through a medical transition.
- We seek to challenge gender norms and stereotypes and believe that gender diversity, in all its forms, should be celebrated in society.

Foot Notes

ⁱ Gendered Intelligence, established in 2008, is a registered charity that works to increase understandings of gender diversity and improve the lives of trans people. We are a trans-led and trans-involving grassroots organisation with a wealth of lived experience, community connections of many kinds, and an exemplary depth and breadth of trans community knowledge, backed with rigorous academic thinking and knowledge to PhD level.

Gendered Intelligence imagines a world where people are no longer constrained by narrow perceptions and expectations of gender, and where diverse gender expressions are visible and valued. We believe everyone can be intelligent about gender. Trans experiences provide a valuable lens through which we can examine our cultural perspective on gender, and we believe it enhances everyone's life to open up more possibilities and options and remove unnecessary gender-based constraints. We work with trans communities and those who impact on trans lives; we particularly specialise in supporting young trans people aged 8-30.

Our work aims to better trans lives through: the delivery of professional educational services such as trans awareness training and consultancy; a large youth service; a support line; mentoring in education; affecting public policy, working with the media and carrying out research; as well as many other projects and services.

ⁱⁱ '*Puberty blockers*' is the well-known term for GnRHa, which is a medication that delays physical puberty – the development of secondary sex characteristics. GnRA is administered to a small minority of young people who are experiencing significant distress due to 'Gender Dysphoria'. The treatment for this group of individuals has been adopted since the mid-1990s; the medication has been used to treat young people with diagnosed precocious puberty since the 1970s. (See Growing up Transgender for a comprehensive literature review: <https://growinguptransgender.com/>)

The treatment is only prescribed to young people who have reached at least Tanner Stage two – i.e. puberty has started, which is usually around the age of 11-13.

Current estimates are that 400 young people in England and Wales are receiving puberty delaying treatment. This is 0.0059% of 10-19 year olds in England and Wales, per latest [population estimates](#).

Any young person receiving puberty delaying treatment will attend the Gender Identity Development Service (GIDS), which is a national psychological service for young people who experience 'gender dysphoria' or are questioning their gender identity throughout England and Wales. It is part of the Tavistock Trust and the service is commissioned by NHS England Specialised Services. Clinicians at GIDS are responsible for assessing young people and referring them to an endocrine team.

Endocrinologists are the practitioners who are responsible for supporting clients with decision making, administering and monitoring of puberty delaying hormones.

The National Health Service describes 'Gender Dysphoria' as "a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity" (<https://www.nhs.uk/conditions/gender-dysphoria/>).

Gender dysphoria is a clinical term that allows access to relevant health care. Treatment options include counselling, puberty delaying treatment, gender affirming hormones, gender reassignment surgery. In order to gain legal recognition and to amend gender markers on UK passports, currently a person must have a diagnosis of gender dysphoria. Should they wish to, it will also allow trans people to transition legally through the Gender Recognition Act 2004 (when they are 18). Although not necessary, a diagnosis of gender dysphoria may also support a person's social transition in their education, workplace and at home, as it may lend perceived legitimacy to their circumstances.

In 'Gender Dysphoria Services: A Guide for GPs and other Healthcare Staff' (Apr 2013) it states:

"It should be emphasised that Gender Dysphoria and Transsexualism are not considered, in and of themselves, mental illnesses in any essential sense. The associated pressures of unmanaged dysphoria and/or the social stigma that can accompany gender diagnosis and transition may, however, result in clinically significant levels of distress."

This statement recognises that being trans in and of itself does not cause poor mental health – it is society's response that is the key factor. However, although life can be challenging and difficult for trans people, and that should not be dismissed or taken lightly, it is important not to cast trans people as victims. Many trans people can and do live positive, happy and fulfilled lives. That should be possible for everyone, and changing how we treat trans people, working towards full inclusion plays a major part in making that a reality.

In the article, "Is puberty delaying treatment 'experimental treatment'?" Simona Giordano & Søren Holm state:

'The treatment is not normally prescribed either to young children, or to those who identify as simply gender diverse, and is even less likely to be prescribed to those who might just be perceived as gender diverse by others.'

Not all children who have non-congruent gender expression also suffer dysphoria and there is significant variability in gender expression, both in cisgender children and transgender children (Gülgöz et al., 2019). Many cisgender children express behaviors that are perceived as gender non-congruent in the culture of belonging. These are not the children who would typically be treated medically.

...

Since the mid 1990s, puberty delaying medications have been prescribed to some adolescents (not prepubertal children) with severe and persistent gender dysphoria, in cases in which such distress was aggravated by pubertal development.'

iii People who use the word trans include those who:

- Identify with the 'opposite' binary gender
- Have identities that are both male and female, neither male nor female or who have another sense of gender
- Have a fluid gender identity and may move between different genders
- May express different gender-related aspects of themselves at different times / places
- Don't experience a sense of gender

There is a wide range of identities and approaches to gender which may involve being both male and female, or neither male nor female, or which take other approaches to gender that don't align with traditional binary ideas.

People with these experiences of gender sometimes use terms such as 'non-binary' (because their experiences fall outside the typical male / female 'binary' experiences) or 'genderqueer' to describe themselves. There are people who have a fluid gender identity and may move between different genders. They may use terms such as 'gender fluid'.

There are people who may express (through cultural cues such as clothing, name, speech, mannerisms etc) different gender-related aspects of themselves at different times or in different places. They may use terms such as 'cross-dresser' or 'dual role'. And there are people who don't experience a sense of gender, or very little sense of gender. They may use terms such as 'agender'.

iv The following text has been provided by the international law firm, Simmons and Simmons as a legal analysis:

'Judicial review exists so that the way in which decisions are made by public bodies can be challenged to ensure that they comply with relevant procedures, regulations, laws and so on, in order that their decision-making process is fair. The Court does not consider the merits and / or outcome of the decision itself during judicial review. This means that even if a Court finds that a public body has come to a decision unlawfully, the outcome of that decision might not ultimately change as long as, when it is revisited, proper procedure is followed.

Judicial reviews can be brought by any individual or organization that has sufficient interest in the decision or issue in question (referred to as proper "standing").

In October 2020 a Judicial Review was heard at the High Court *Bell and Mrs A versus Tavistock*. It centred on whether young people can meaningfully consent to the administering of puberty blockers.

The Claimants brought this judicial review on two grounds:

(A) Children and young people under the age of 18 are not capable of giving valid informed consent to the administration of Puberty Blockers (PBs) (the "competence issue"). This was the Claimants' primary case: that children and young people going through puberty are not capable of properly understanding the nature, effect and consequences of PBs, which they argued should be classed as an experimental treatment.

(B) The information given by Tavistock and the Trusts about PBs is misleading and inadequate to allow informed consent to be given (the "information issue").

The Court did consider evidence about treatments available for Gender Dysphoria, however it was not being asked to rule on their appropriateness. Instead, as the Court stated: "*The sole legal issue in the case is the circumstances in which a child or young person may be competent to give valid consent to treatment in law and the process by which consent to the treatment is obtained.*"

On Tuesday 1st December 2020, the High Court handed down its judgment stating that it is "highly unlikely those 13 and under would ever be Gillick competent to give consent to being treated with [puberty blockers]", that it's "highly doubtful" 14 and 15 year olds could sufficiently understand the long-term risks and consequences of treatment and whilst 16 year olds are presumed to be Gillick competent, the judgment stated that clinicians may wish to seek court approval before commencing treatment regardless.

The implementation of this judgement means that once clinicians have deemed their client as benefiting from puberty delaying treatment, families will need to obtain a best interest order from the courts to seek permission to obtain the treatment.

However, the judgement was declared ‘stayed’, which means current procedures could continue until the Tavistock have exhausted all options of legal appeal.

Despite this NHS England released their amendments to the service specification on the same day saying that a clinical review of each client currently receiving puberty delaying treatment will be carried out in order for them to be put forward to obtain a best interest court order. It was decided that there would be no new prescribing prior to the appeal. However, those in current treatment will continue to receive treatment.

On 22nd December 2020 the Tavistock made an application to appeal to the Court of Appeal. On 18th January 2021 that application was granted. The Good Law Project – a grouping of legal experts - launched a large-scale fund for trans-specific court cases and raised £130K. Some of that money has been used to support the application of an intervention on the appeal. A coalition of relevant organisations - Brook, the Endocrine Society and Gendered Intelligence - applied for, and were subsequently granted permission to, intervene in the appeal.

An intervention is where third parties with an interest ask to be heard in a case, – alongside the main parties. Intervenors are permitted by the Court to file evidence and / or make representations because they have an interest in, or may be affected by, the outcome. The Endocrine Society are the international body that advocates and affects policy for the practice of endocrinology; Brook are involved from the perspective of being experts around Gillick Competency. GI is a trans-led organisation with over 12 years’ experience of delivering youth work practice to young trans and gender questioning people. As part of GI’s involvement in the coalition of intervenors we organised a crowd sourcing approach to gather all published evidence and findings that respond to the key points set out below. We are grateful to the National Trans Youth Network, Mermaids, the Proud Trust, the Trans Organisations Network at the LGBT consortium, and key staff at Gendered Intelligence for supporting this process. See Young Trans Healthcare Bibliography v1.0 June2021.

The appeal is to take place at the Royal Courts of Justice on 23rd and 24th June 2021. In an appeal no new evidence is allowed to be submitted as the process is about forming a legal argument. The judgment will be handed down later in the year, either around end of July or October.

^v Following the Judgment, the World Professional Association for Transgender Health (WPATH) and its European chapter (EPATH) issued a joint statement expressing their disagreement, supported by other regional chapters (USPATH, AsiaPATH, CPATH, AusPATH and PATHA), stating:

“Treatment of transgender adolescents involving gender affirming medical interventions (puberty suppression and subsequent gender affirming sex hormones) has become the most widely accepted clinical approach in specialized transgender clinics around the world and is accepted best practice amongst specialist clinicians. For this reason, it forms part of the two main international guidelines in the field: the WPATH’s Standards of Care as well as the Endocrine Society’s Clinical Practice Guidelines...

Indeed, no professional association with expertise in the field has opposed the use of these medical interventions; instead, there is professional consensus – based on clinical experience and empirical evidence that medical interventions for carefully selected individuals are helpful and potentially lifesaving for transgender youth before the age of 16 ... These treatments are therefore not typically viewed by professionals with expertise in this area as radical or ancillary treatments but, when administered by a trained provider following thorough assessment, as important and commonly accepted practices which support the well-being of transgender youth.” De Vries et al (2021) “Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274: Weighing current knowledge and uncertainties in decisions about gender-related treatment for transgender adolescents”, International Journal of Transgender Health, DOI: 10.1080/26895269.2021.1904330, p.2: <https://www.tandfonline.com/doi/full/10.1080/26895269.2021.1904330>

^{vi} On 26th March 2021 there was a private law case in the family courts involving two parents who agreed to the continuation of blockers for their 14 year old. The outcome was that parents can consent to their children being treated to puberty blockers whether or not the child is considered to have capacity to consent.

The judgment affirms the general right of parents to consent to medical treatment on behalf of their children (defined as a person under the age of 18) and confirms that there is no general rule that puberty blockers should be placed in a special category by which parents are unable in law to give consent.

Parents retain the right to consent to medical treatment on the child’s behalf even where the child is Gillick competent to make that decision, but the parents don’t have the right to “trump” the Gillick competent child’s decision.

The case quoted from Re Aysha King [2014] EHQHC 2964 (Fam), Family specialist Lord Justice Jonathan Baker who stated:

“... it is a fundamental principle of family law in this jurisdiction that responsibility for making decisions about a child rest with his parents. In most case, the parents are the best people to make decisions about a child and the State – whether it be the court or any other public authority – has no business interfering with the exercise of parental responsibility unless the child is suffering or is likely to suffer significant harm as a result of the care given to the child not being what it would be reasonable to expect a parent to give”.

^{vii} Following the family court case, NHS England have made further amendments to their service specification

They are now accepting that parental consent for existing patients under 16 can be given in order for the young person to be put forward for puberty delaying treatment. This is providing the views of the young person, their parent(s) and clinicians are aligned and the process resulting in the recommendation to continue prescribing has been considered and supported by a new and independent multi-professional review group.

Young people who are currently receiving puberty delaying treatment will continue to have that treatment, until the new independent multi-professional review group and the review framework is in place and that decision will be reviewed. No new patients are being referred to the endocrinology team but remain in the GIDS system. No applications to the court for best interest declarations have been made. They will only do so in the absence of parental consent or there is a dispute as to the child's best interest.

There is a current 2-3 year waiting list for any new young people being referred into GIDS.

^{viii} From speaking to young people and parents of young people affected, staff from our Youth Services tell us that so young people have described it as offensive to be told they cannot have autonomy over their own bodies. Our biggest concern in the youth service centres around supporting young people to feel some element of control in their lives again. The same also applies for our parents/carers.

Jake Kelly, co-Head of Youth Services states:

"Feeling a lack of control is one of the key considerations when supporting care-experienced young people and we know from that body of evidence what control-seeking behaviours it can elicit from young people."

At Gendered Intelligence, we are also concerned about the ways in which these messages are being internalised by young people and their families as 'there's something wrong with me' and 'the world hates me'. This is interpreted as a punishment. Research in the field of psychology tells us how damaging shame and internalised hatred can be

In short, there is both a material impact by some of our young people and their families with regards to the delays in access to services and treatment. There is also a more far-reaching, symbolic impact which leads to feelings of low self-worth, internalised hatred and shame and consequential mental distress.

^{ix} The Children's Rights Alliance for England (CRAE) created a briefing paper called 'Children speak out on transgender issues' stating among other things that all the rights in the Convention on the Rights of the Child (CRC) apply to transgender children including 'the right to the best possible healthcare (article 24)'. In the document it lists waiting times and access to services as key: 'Whilst waiting for treatment children said they often struggled with depression, self-harm and self-destructive behaviours and had nowhere to turn for support.'

^x Whilst there are a range of options for any young person to explore their gender, transition and/ or express their gender diversity, for a young person who will go onto receive puberty delaying treatment they will undergo the following steps. They will:

- have - and start to share - feelings about their gender identity as being different to aligning with the gender given to them at birth and/or in early childhood.
- get support from a range of trusted adults such as parents and carers, grandparents, aunts and uncles; staff in educational settings such as teachers, SLT members and student support services; local mental health providers such as CAMHS, school councillors, educational psychologists; primary care providers such as GPs and nurses; youth workers and third sector providers such as sports coaches, Scout leaders, local authority youth service providers and professionals from an LGBT+ Youth Service.
- be referred to the NHS specialist service called the Gender Identity Development Service and they are next added to the waiting list. Currently this is between 2-3 years.
- have an initial conversation with GIDS to triage and signpost to other services if needed before the first appointment at GIDS is made.
- attend their first appointment as part of the GIDS assessment phase, which is composed of at least 6 sessions over a period of 4-6 months.
- be referred to the endocrine team if, or once, they have reached at least Tanner Stage 2 – i.e. their puberty has started and if there is consensus between the young person, the parents/carers and the clinicians at GIDS that puberty delaying treatment is appropriate
- attend a first appointment with a range of professionals from GIDS and the Endocrine team to discuss treatment.
- have bloods tests which are carried out at the first appointment.
- receive a decision 2-3 months later, at a follow up appointment around puberty delaying treatment.

Key points:

- No one receives Puberty Delaying Treatment prior to Tanner Stage 2 – the start of puberty.
- No one receives Gender Affirming Hormones until 16+ and, if under 18, only when they have been on Puberty Delaying Treatment for a year.
- No one receive surgical intervention under the age of 18 in the UK.

- It is not a quick process.
- There is a current crisis in waiting times to access services. For instance, if you are about 15 years old and you wish to be referred to Gender Identity Development Service, you are more likely to end up at in Adult Services (17+) before attending your first appointment.

^{xi} There is a pre-existing legal test for children under 16, known as “Gillick competence”, which Courts can use to assess whether a child is able to consent to medical treatment. It requires them to be able to demonstrate “sufficient” understanding of the “salient” facts around the treatment they are seeking, and to understand “the essential nature and quality of the transaction”. This was established in the case of *Gillick v West Norfolk and Wisbech AHA and Department of Health and Social Security* [1986] QB 581 Def of Gillick Competence. (Text provided by legal advisors.)

The article ‘*Bell v Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274: Weighing current knowledge and uncertainties in decisions about gender-related treatment for transgender adolescents’ published in the *International Journal of Transgender Health* states:

‘Even when they do not yet have the legal right to give their own consent to treatment, research has demonstrated that many minors possess the cognitive and emotional abilities to understand the consequences of their decisions, including decisions concerning health care. In fact, minors as young as 12 years of age frequently possess this ability (Hein et al., 2015; Redding, 1993). A recent study using a standardized measure (MacCAT-T), determined that 90% of the transgender adolescents about to receive puberty suppression are assessed to be competent to consent (Vrouenraets et al., submitted).

...

Finally, given the extensive diagnostic and counseling work that precedes decisions around gender affirming medical treatment to minors, we are convinced that the determination of the ability of a particular adolescent to give consent should be made by a competent health provider who has evaluated the adolescent, and not by a court of law. Current guidelines already recommend that this competence is assessed by a specialized health professional prior to the start of treatment (Coleman et al., 2012; Hembree et al., 2017).’

With reference to the judgment in the case *Tavistock versus Bell*, Simona Giordano, Fae Garland and Soren Holm state in their article ‘Gender dysphoria in adolescents: can adolescents or parents give valid consent to puberty blockers?’ published in the *Journal of Medical Ethics* Published Online First: 10 March 2021, Giordano S, Garland F, Holm S. state:

‘It is one thing showing that some children and adolescents are not Gillick-competent in relation to a particular decision, quite another to show that no child, no adolescent and no parent or guardian can ever be competent in relation to that class of decisions.

(doi: 10.1136/medethics-2020-106999)

^{xii} In the article ‘Transgender health in medical education’ Tommy Hana, Kat Butler, L Trevor Young, Gerardo Zamora and June Sing Hong Lam state: ‘Social transition, including for children and young people, has been found to be associated with improved mental health outcomes and quality of life measures.’ They cite ‘Connolly MD, Zervos MJ, Barone CJ 2nd, Johnson CC, Joseph CLM. The mental health of transgender youth: advances in understanding. *J Adolesc Health* 2016 Nov; 59(5): 489-95. Doi:<http://dx.doi.org/10.1016/j.jadohealth.2016.06.012> PMID:27544457

^{xiii} In the article ‘Is puberty delaying treatment ‘experimental treatment’?’ published in *International Journal of Transgender Health*, 2020, 21(2), 113–121. Simona Giordano & Søren Holm state:

‘GnRHa has been used in the treatment of gender dysphoria since the mid 1990s, and their efficacy in delaying puberty in adolescents is documented by numerous studies and scientific publications. (Cohen-Kettenis, Schagen et al., 2011; Cohen-Kettenis, Steensma et al., 2011; De Vries & Cohen-Kettenis, 2012; Coleman et al., 2012; Desforges et al., 1991; Costa et al., 2015; Delemarre-van de Waal & Cohen-Kettenis, 2006; Kreukels & Cohen-Kettenis, 2011; De Vries et al., 2011, 2014; Edwards-Leeper & Spack, 2012; Hembree et al., 2009; Hembree, 2013; Hewitt et al., 2012; Khatchadourian et al., 2014; Nakatsuka, 2012; Shumer & Spack, 2013; Spack, 2013; Vrouenraets et al., 2015, 2016; Wylie et al., 2016).’

<https://doi.org/10.1080/26895269.2020.1747768> [Taylor & Francis Online], [Google Scholar]

Concerns around the treatment of puberty delaying treatment are generally around the effects on bone density, the effects on fertility, the notion that puberty delaying treatment inevitably leads to gender affirming hormones and surgical interventions in adulthood, and other consideration around unknown side effects and longterm impact.

Simona Giordano & Søren Holm ‘unpack and analyse the claim that prescribing puberty delaying medications is experimental and [they] show that provision of puberty delaying medications to adolescents with gender dysphoria is not experimental, or at least not any more experimental than standard paediatric practice when there are no licensed treatment options for a paediatric patient population.’

They conclude: ‘Thus the puberty delaying efficacy of GnRHa in adolescents with severe gender dysphoria is well evidenced and not experimental.’

The blogsite Growing up Transgender states:

‘Puberty blockers have been used since the 1970s for children with precocious puberty’. There has been extensive research with these children. Findings with regards to children with precocious puberty are ‘there were no abnormalities in reproductive function’; ‘Bone mineral density decreases during GnRHa treatment but recovers to normal afterwards, and peak bone mass formation through bone mineral accretion during puberty is not affected’; ‘Some studies have reported decreases in psychosocial problems after GnRHa treatment. Overall, GnRHa seems effective and safe for CPP patients, based on long-term follow-up studies.’ (<https://growinguptransgender.com/>)

Simona Giordano & Søren Holm tell us ‘There is no evidence that GnRHa induces people to cross genders. There is for example no evidence in those treated for precocious puberty that they are more likely than others to identify as transgender.’

In the article ‘Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274: Weighing current knowledge and uncertainties in decisions about gender-related treatment for transgender adolescents’ published in International Journal of Transgender Health article of 5 April 2021, De Vries et al. states:

‘The follow-up studies after puberty suppression from the Netherlands show that the rate of adolescents that stop the reversible blockers because they no longer wish to transition is very low; 1.9% (Wiepjes et al., 2018) and 3.5% (Brik et al., 2020) in two respective studies. This is not surprising since treatment is only started in those for whom gender incongruence is thought to be very likely to last into adulthood. However, this does not mean that, as the UK court ruling erroneously suggests, adolescents ‘automatically’ go on to gender affirming hormone treatment after puberty suppression; nor does it mean that puberty suppression somehow causes adolescents to pursue further treatment. Hormone treatment is a carefully considered next step for which adolescents (and their parents) provide separate informed consent after having received information about the effects, limitations, and potential side effects of this treatment, with particular emphasis on fertility. By the time adolescents are eligible for this treatment they are usually around the age of 16 years (and sometimes younger; Hembree et al., 2017) and better able to foresee the consequences of this partially irreversible step. It is not reasonable to require adolescents to already foresee and weigh up all consequences of cross-sex hormone treatment at the time they start puberty suppression as the High Court suggests, since each step is clinically distinct.’

In the statement by WPATH, et al. referred to earlier, it stated that puberty delaying treatment ‘allow the adolescent time to carefully consider whether or not to pursue further transition when they are eligible. It is part of the two main international guidelines: the WPATH’s Standards of Care as well as the Endocrine Society’s Clinical Practice Guidelines.’ It goes on to say that clinicians take a ‘step wise approach’ and that ‘it is not the case that one stage invariably leads to the next’. It also states that for those progressing to gender affirming hormones those young people and their parents ‘provide separate informed consent after having received information about the effects, limitations, and potential side effects of this treatment’. Finally, ‘We consider puberty blocking treatment and treatment with gender affirming hormones as two separate treatment steps each requiring informed consent at the time such treatment is to be started.’

It is also important to consider the wider context where medical treatment for children is often unlicensed or off label. This is due to having limited testing protocol because of various ethical dilemmas around testing on children. In a tweet from Trans Actual, they draw on a statement from the NHS:

‘Unlicensed and off label use of medicines in children range from 11% in the community to about 90% in specialist areas such as Neonatal Critical Care and on average 50% of children admitted to hospital receive either an unlicensed or off label medicine’ - (NHS, 2017)

<https://twitter.com/TransActualUK/status/13793885611459174>

In the article ‘Is puberty delaying treatment ‘experimental treatment?’’ the authors states:

‘The fact a drug or medical intervention have unknown side effects does not entail that prescribing the drug or performing the intervention can be described as experimental in any meaningful way.

...

We are rarely in a position where we can predict an individual’s response to a particular drug with absolute certainty. Most drugs have side effects, and most have some rare but serious ones, but our inability to predict whether this particular patient will experience a serious side effect does not make the prescription ‘experimental’. If it did all prescription, even of Aspirin would be experimental.’

^{xiv} The World Health Organisation talks of the need to depathologise trans health: "trans-related and gender diverse identities are not conditions of mental ill health, and classifying them as such can cause enormous stigma". It goes on to add that "Inclusion of gender incongruence in the ICD should ensure transgender people’s access to gender-affirming health care."

See: [https://www.who.int/news/item/18-06-2018-who-releases-new-international-classification-of-diseases-\(icd-11\)](https://www.who.int/news/item/18-06-2018-who-releases-new-international-classification-of-diseases-(icd-11)) ; <https://www.bbc.co.uk/news/health-48448804>