Gay Men's Network

GMN Response

Interim Clinical Policy: Puberty suppressing hormones for children and adolescents who have gender incongruence/dysphoria

Table of Contents

1 IN WHAT CAPACITY ARE YOU RESPONDING? 1

2 ARE YOU RESPONDING ON BEHALF OF AN ORGANISATION? 1

3 HAS ALL THE RELEVANT EVIDENCE BEEN TAKEN INTO ACCOUNT? 1

4 DOES THE EQUALITY AND HEALTH INEQUALITY IMPACT ASSESSMENT REFLECT THE POTENTIAL IMPACT THAT MIGHT ARISE AS A RESULT OF THE PROPOSED CHANGES? 4

5 ARE THERE ANY CHANGES OR ADDITIONS YOU THINK NEED TO BE MADE TO THIS POLICY? 6

1 In what capacity are you responding?

We are a non-for-profit gay men's Advocacy group

2 Are you responding on behalf of an organisation?

Yes. The Gay Men's Network (https://www.gaymensnetwork.com/)

3 Has all the relevant evidence been taken into account?

No.

We welcome the NHS interim clinical policy inasmuch as it does not recommend puberty supressing hormones ("PSH") as a routine commissioning option, and we note the reason for this is that the "*the quality of evidence for all these outcomes was assessed as very low certainty*". Despite this positive development, there remain two ways in which PSH might be administered; a clinical trial and where approved in "exceptional cases".

We have previously expressed the gravest of concerns regarding PSH or so-called "puberty blockers" for reasons that can be summarised thus:

- PSH have never been licensed for the treatment of gender dysphoria anywhere in the world.
- The 2021 the UK National Institute for Health & Care Excellence (NICE) published a systemic evidence review, concluding that 'puberty blockers' lead to little or no change in gender dysphoria.
- The Tavistock's 2011 Early Intervention Study indicates that PSH are not a temporary 'pause button' but rather the entry point to a lifelong medical pathway as 98% progressed to cross-sex hormones.

Allowing natural puberty to occur helps to reduce or resolve gender dysphoria for the overwhelming majority of young people who may well grow up to simply be lesbian, gay or bisexual.

© 2022 Gay Men's Network

We further note international concerns regarding the use of PSH and highlight the following:

- Finland, 2020: The Finish Health Authority (Palko / COHERE) issued new guidelines stating psychotherapy should be first-line treatment, not 'puberty blockers'.
- Sweden, 2021: The Karolinska Institutet (Sweden), long considered the 'gold standard' in transgender healthcare, ended the use of 'puberty blockers' outside of research settings.
- US, 2021: Dr Marci Bowers, leading transgender surgeon and board member of The World Professional Association for Transgender Health (WPATH) states: "I'm not a fan of blockade at Tanner Stage 2* anymore, I really am not… Maybe we zigged a little too far left in some cases."
- Canada, 2021: Health Canada issued a warning that Lupron can lead to 'pseudotumor cerebri' in paediatric patients (pressure building inside the skull, resulting in headaches, blurred vision or vision loss).
- Sweden, 2022: Sweden's National Board of Health & Welfare issues a national policy update mirroring the Karolinska Institutet.
- France, 2022: France's National Academy of Medicine urges "the greatest caution" when administering PSH for gender dysphoria.
- US, 2022: the FDA added a warning to the labelling of PSHs. The warning applies specifically to their use in disrupting puberty and informs users of the risk of brain swelling and vision loss.
- New Zealand, 2022: The Ministry of Health withdrew its advice that "Puberty blockers are a safe and fully reversible medicine."

Issues with a clinical trial

In simple terms, we can see no circumstances in which a trial involving children with PSH could possibly be ethical.

- The evidence suggests that to conduct such an experiment would:
- Concertise a cross sex identification in a cohort where the overwhelming majority of children, if left alone, would simply desist. The evidence shows that PSH "locks in" an identification with vast numbers progressing to cross sex hormones.
- Deprive children of sexual function and fertility at a time where their Gillick competence to consent to such is open to question. We note Dr Cass' concerns regarding diagnostic overshadowing, high rates of autism and other co-morbidities, these factors further undermine the proposition that children might be Gillick competent to consent to the loss of adult concepts like sexual function and fertility.
- Expose to children to serious and as yet unknown serious adverse health effects ranging from osteoporosis, loss in IQ points, cognitive harm, depression and cardiovascular risk

© 2022 Gay Men's Network

(all of which are evident from animal studies and studies for precocious puberty, sex offender research, prostate cancer and endometriosis work).

Issues with "exceptional cases"

The NHS Interim policy states that "*On an exceptional, case by case basis any clinical recommendation to prescribe PSH for the purpose of puberty suppression outside of research and in contradiction to the routine commissioning position set out in this policy must be considered and approved by a national multidisciplinary team*". While some reassurance is offered by the ordinary meaning of the word "exceptional" and the involvement of the national MDT, it remains unclear to us what the word "exceptional" means in this context. Given the concerns we raise regarding clinical trials and the effects of these experimental drugs, we repeat that we cannot conceive of circumstances where it could be proper (and arguably lawful re Gillick) to prescribe in such circumstances.

We must also raise a concern regarding ideologically motivated clinicians and their effect on children in this area. The regrettable history of the Tavistock GIDS service demonstrates that ideological lobby groups placed pressure on clinicians and that some clinicians actively worked with such groups. This much was laid plain in Dr Bell's internal report of 2018. Sonia Appleby's safeguarding whistleblower's case and the comments of mental health nurse Sue Evans who reported her "*alarm at the speed of assessment and feared that treatment plans were being influenced by groups such as Mermaids, a transgender advocacy charity… Ms Evans said: "When you work in the area of gender dysphoria you begin to see that many of these children have other areas of concern or difficulty, such as depression, autism, trauma, childhood abuse, internalised homophobia, relationship difficulties, social isolation and so on.*" Recently investigatory work by Kathleen Stock for the online publication Unherd suggests that ideologically motivated staff opposed to the Cass review and recommendations remain influential within the relevant successor services.

As a gay rights advocacy group, we have long raised concerns that the Tavistock GIDS was, in effect, performing what staff there compared to a new form of gay conversion therapy. We are concerned that ideologically motivated staff might capitalise on any imprecision in the new policy, (such as doubt around the meaning of the word "exceptional") to continue a practice that we believe amounts to a serious homophobic medical scandal.

Deficiencies in the evidence base

We take the view that further evidence should be considered, namely:

- Homophobia as a safeguarding concern in gender medicine. In 2018 Dr Bell's report at GIDS claimed openly homophobic parents were attending services seeing a trans identification as modern-day conversion therapy solution to the "problem" of a gay child. There is nowhere in the evidence base any attempt to deal with this alarming and serious safeguarding risk despite multiple instances of GIDS staff raising this issue. We consider this a grave and serious deficit. Given the pronounced overrepresentation of same sex attracted youth in gender medicine it cannot be right that this factor is ignored in the wider cultural context of the prescription of experimental drugs.
- It is not clear why the research into the use of PSH for other indications such as precocious puberty and prostate cancer was not considered by NICE. These studies should be considered.
- The NICE evidence review did not consider physical effects of PSH focusing instead on psychological matters. Given what we say above regarding a clinical trial we consider this a serious omission, particularly given the Gillick issue we raise.
- As 98% of children at the Tavistock GIDS went from PSH to cross sex hormones the effects of prescribing PSH cannot properly be considered by reference to PSH studies alone. We would therefore urge the evidence base be expanded to the NICE review of cross sex hormones.
- We remain concerned that the voices of detransitioners are completely absent generally in this field of medicine. Any evidence base ought to consider treatment outcomes such as this and a strategy to learn from the experiences of this cohort is an essential part of a complete picture.

4 Does the equality and health inequality impact assessment reflect the potential impact that might arise as a result of the proposed changes?

No

It is a matter of serious concern that the equality and health impact assessment (EHIA) says of sexual orientation "We do not hold data on the sexual orientation of individuals who are referred to or seen by the NHS commissioned service". It is a further matter of concern that the data available in the EHIA refers to a 2012 "trans mental health study" by a partisan lobby

group which includes gender identity ideological terms such as “BDSM/Kink”, “Asexual” “Queer” and “Pansexual” alongside the terms lesbian, gay, bisexual. It hardly needs to be said that “BDSM/Kink” is not a sexual orientation or that the term “Queer” (which we regard as offensive) is unclear as to whether it is describing a heterosexual, a homosexual or a bisexual.

The lack of data in this area is alarming given sound evidence to suggest that this field of medicine is riddled with homophobia. We evidence that claim with reference to the schedule of homophobic incidents connected to the Tavistock GIDS included as Appendix 1 to our response to the Interim Service Specification consultation available at https://www.gaymensnetwork.com/letters-and-responses. We note the EHIA shows some awareness of our concerns as it quotes from Dr Cass’ interim remarks of her team having encountered “young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as lesbian rather than transgender.”

The 2012 study of referrals to the Tavistock indicated that in girls 67.6% were lesbian and 21.1% were bisexual. Of the boys, 42.3% were gay and 38.5% were bisexual. While we welcome the commitment in the EHIA to a return to the routine collection of demographic data we must emphasise that it is shocking in 2023 that a service might be dominated by a same-sex attracted cohort and there be no collection of robust data to evidence that fact or wider consideration as to why so many same-sex attracted youth are cross sex identifying, particularly where such youth share characteristics such as autism or are looked after children.

We have long campaigned against the ideological medicalisation of homosexuality in gender medicine and compared it (like Tavistock staff) to a modern form of gay conversion therapy. Every study available suggests that gender non-conforming behaviour in youth statically correlates with those who grow up to be gay or lesbian. Given gender non-conforming behaviour is at the very essence of the diagnostic criteria said to constitute gender dysphoria it is imperative that the EHIA takes modern gay conversion by gender seriously and builds robust strategies to mitigate against the safeguarding risk of homophobia.

Boys who will grow up to be homosexuals referred to gender services are at particular risk because, (i) generally speaking, boys are more likely to be encouraged or “affirmed” into cross sex ideation than girls because of homophobia and the great social acceptance of girls being accepted as “tomboys” and (ii) PSH stops genital development in boys. Given the almost 100% progress to CSH, It is unknown whether and when cessation might allow for

normal natural development. All the signs suggest PSH are in effect irreversible in this respect and leave young men seriously harmed.

5 Are there any changes or additions you think need to be made to this policy?

We are concerned that homophobia is once again overlooked as a serious risk in this field of medicine. There is presently no explanation or curiosity as to why so many same-sex attracted youth are adopting cross sex identities and whether that might be because of precisely what Dr Cass encountered in her interim report where she described meeting young lesbians feeling under pressure to adopt such identities. As a Gay advocacy group, we are deeply concerned that mounting evidence suggests that this field of medicine is riddled with homophobia and yet this risk is nowhere reflected in policy. We repeat that we believe a modern gay conversion therapy has taken place at the Tavistock GIDS and we believe there are ideologically driven clinicians who will seek to repeat that at the successor hubs. Any policy serious about protecting homosexuals and bisexuals should acknowledge this grave risk and make it the centrepiece of safeguarding, general practice guidance and the equalities assessment.

We further take the view the prescription of PSH in any circumstances related to psychological distress can only properly be considered as an unethical experiment. As we have made clear above, the adverse mental and physical effects are serious and profound and cannot be considered in isolation to the almost inevitable progression to CSH. We repeat our concerns regarding *Gillick* competence and we query whether it could ever be lawful for a parent to give consent given the safeguarding factors we advert to regarding homophobic parents. We repeat that we are concerned as to the complete absence of detransitioners voices in informing policy or research in this area.

© 2022 Gay Men's Network