



Independent Review into Gender Identity Services for Children and Young People

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## Gender medicine for children and young people is built on shaky foundations. Here is how we strengthen services

Improving the evidence base for young people is an essential next step, writes Hilary Cass, as her independent review into gender identity services for children and young people is published

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Medicine is a science of uncertainty and an art of probability

—William Osler

William Osler's much quoted aphorism is well known to every medical student. Living with medicine's many uncertainties would be intolerable for both doctors and patients without some coping mechanisms. In Osler's time, doctors relied on a mix of knowledge, custom, and paternalism to hide uncertainties from patients, and provide treatments they had learnt from their mentors. Nowadays we have the three pillars of evidence based medicine to lean on: the integration of best available research evidence with clinical expertise, and patient values and preferences.

My independent review into gender identity services for children and young people is published today.<sup>1</sup> When conducting the review, I found that in gender medicine those pillars are built on shaky foundations.

I took on this review in full knowledge of the controversial nature of the subject, the polarisation and toxicity of the debate, and the weakness of the evidence base. Gender care for children and young people had moved from a “watchful waiting” approach to treatment with puberty blockers from Tanner stage 2 for those with early onset gender incongruence, followed by masculinising or feminising hormones from age 16. My review launched while the Divisional Court was considering the case of *Bell v Tavistock*, which focused on whether young people under 18 have the competence or capacity to give consent to endocrine treatments.<sup>2</sup> Competence or capacity are only one part of the process of informed consent. My review also had to consider the other components: the evidence underpinning the treatments, and the clinical judgements which might lead to recommending an endocrine pathway.

Since my interim report was published in March 2022, the review has commissioned the University of York to conduct a series of systematic reviews appraising the evidence on the characteristics of the population of children and young people presenting to gender services, and the outcomes of social transition, psychosocial interventions, and endocrine treatments.<sup>3–5</sup> The review also commissioned an appraisal of international guidelines and a survey of international practice.

The findings of the series of systematic reviews and guideline appraisals are disappointing. They suggest that the majority of clinical guidelines have not

followed the international standards for guideline development.<sup>6</sup> The World Professional Association of Transgender Healthcare (WPATH) has been highly influential in directing international practice, although its guidelines were found by the University of York's appraisal to lack developmental rigour and transparency.<sup>6</sup> Early versions of two international guidelines—the Endocrine Society 2009 and WPATH 7—influenced nearly all other guidelines, with the exception of recent Finnish and Swedish guidelines; the latter were the only guidelines to publish details of how developers reviewed and utilised the evidence base, and the decision making process behind their recommendations.<sup>6–8</sup>

The rationale for early puberty suppression remains unclear, with weak evidence regarding the impact on gender dysphoria, mental or psychosocial health.<sup>9</sup> The effect on cognitive and psychosexual development remains unknown.<sup>9</sup> The clearest indication is in helping the small number of birth registered males, whose gender incongruence started in early childhood, to pass in adult life by preventing the irreversible changes of male puberty.

The use of masculinising / feminising hormones in those under the age of 18 also presents many unknowns, despite their longstanding use in the adult transgender population. However, the lack of long term follow-up data on those commencing treatment at an earlier age means we have inadequate information about the range of outcomes for this group.<sup>10–11</sup> In particular, we lack follow up data on the more recent cohort of predominantly birth-registered females who frequently have a range of co-occurring conditions including adverse childhood experiences, autism, and a range of mental health challenges. Filling this knowledge gap would be of great help to the young people wanting to make informed choices about their treatment.

A key message from my review is that gender questioning children and young people seeking help from the NHS must be able to access a broad-based holistic assessment delivered by a multi-professional team. Notwithstanding the pressures on CAMHS and paediatric services, these young people should not receive a lower standard of care than other similarly distressed adolescents. This means access to a wide range of services, including autism diagnostic services, psychosocial support, and evidence based interventions for commonly co-occurring conditions such as depression, anxiety, and eating disorders. Regardless of whether or not they chose a social or

medical transition in the longer term, they need support to help them thrive and fulfil their life goals.

The challenge of the assessment process is that while it may direct a broader care plan, it does not give certainty about which young people will ultimately develop a long term trans identity and which will resolve their gender-related distress in other ways. Young people are in a state of neurocognitive and psychosexual development into their mid-twenties. Some mature faster than others, and we have no way of knowing when the majority will be in a settled identity. The review has spoken to young adults who are happy and empowered by their decision to medically transition and others who have regrets.

The ethical challenges are great. Some young adults have told us that they wish they had known when they were younger that there are many more ways of being trans than following a binary medical transgender pathway. The fastest growing identity under the trans umbrella is non-binary. There is almost no research on this group, many of whom want a spectrum of treatments falling short of full medical transition. This raises questions about what medicine can do, what medicine should do, and more specifically what the NHS should do.

Improving the evidence base for this population of young people is an essential next step. Fortunately, because this review has been an iterative process with interim recommendations, the new regional services which are being established to expand provision for the population will have a research structure embedded from the outset, data collection will be integral to the service model, and a prospective puberty blocker study is already in development.

I very much hope that this strong multi-disciplinary team model, with networked service delivery and embedded research will encourage more clinicians with experience in child and adolescent health to work in this evolving area of clinical practice.

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Provenance and peer review: not commissioned, not peer reviewed.

- 1 Web address to follow – c/o Sara Geater.
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