sex-matters.org

Response to NHS England consultation on **Interim Clinical Policy: Puberty suppressing hormones for children and adolescents who have gender incongruence/dysphoria**

30th October 2023

1. In what capacity are you responding?

Other – NGO

2. Are you responding on behalf of an organisation?

Yes – Sex Matters

3. Has all of the relevant evidence been taken into account?

No – the NHS interim clinical policy proposes to stop routinely commissioning puberty-suppressing hormones (PSH) for treatment of children and adolescents who have gender incongruence or dysphoria, because of low quality of evidence and evidence of harm. However, it proposes for PSH to be prescribed for children with gender dysphoria as part of clinical trials and for a range of other "exceptional" reasons. **We do not think this use is justified or ethical.**

Puberty involves physical development, sexual maturation, brain and cognitive development, social and personality development. Freedom from torture (including forced sterilisation), protection of private and family life and the right to form a family are human rights (protected under Article 3, Article 8 and Article 12 of the European Convention on Human Rights) and

should only be curtailed in life-threatening situations. Feelings of gender incongruence (which are likely to resolve naturally with puberty) are not such a situation.

There is no clear rationale for treatment of gender dysphoria with puberty-blocking drugs explained in this consultation.

Evidence that should have been considered:

1. **Placebo effect.** The NICE review considered the impact of PSH on gender dysphoria, mental health, quality of life, and body image. It found that there is insufficient evidence to show the safety or benefit of this intervention. These studies are rarely placebo-controlled, but evidence from separate medical trials should also be considered. Placebo effect on mental-health outcomes are large and significant. Comparing findings from studies on PSH/hormones with data from comparable studies on teenagers' mental health suggests that they are no better (and possibly worse) than placebo at alleviating distress.[1]

2. **Animal studies.** No animal studies are cited in the systematic reviews, despite the fact that several studies have demonstrated harmful effects on the adolescent animal brain. This is one of the greatest risks that puberty suppression may carry – that of harmful effects on the developing adolescent human brain.

3. **The medical pathway to cross-sex hormones.** Almost all children who take puberty-blockers go on to hormone treatment.[2] Given the high rate of progression to cross-sex hormones it does not make sense only to consider PSH and exclude the evidence of the impact of cross-sex hormones. The NICE review on hormone treatment came to similar conclusions about the poor quality of evidence.

4. **The rationale and core impacts of PSH and hormone treatment.** The NICE systematic review lacked a clear conceptual framework and did not evaluate the rationale and aims of treatment with PSH. Puberty blockers are given to gender-questioning children for three main reasons: to stop them feeling distressed as a result of body changes in puberty, to give them time to decide whether to undertake further medical interventions and to make it easier, later, for them to "pass" as the other sex. Children who do not go through puberty will not develop adult sexual function. Thus the explicit deal that this treatment pathway offers to a child is that they will be sterilised and have their sexual function impaired in order to look more attractive and convincing as a member of the opposite sex.[3]

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[1] Matilda Gosling (2022). *Technical paper: Gender-questioning teenagers: puberty blockers and hormone treatment vs placebo.* Sex Matters.

[2] Tessa Brik, Lieke J. J. J. Vrouenraets, Martine C. de Vries & Sabine E. Hannema (2020). 'Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria'. *Archives of Sexual Behavior,* 49, 2611–2618

[3] Kanthi Bangalore Krishna, John S. Fuqua, Alan D. Rogol, Karen O. Klein, Jadranka Popovic, Christopher P. Houk, Evangelia Charmandari & Peter A. Lee (2019). 'Use of gonadotropin-releasing hormone analogs in children: update by an international consortium'. *Hormone Research in Paediatrics,* 91(6), 357–372.

5. **Ethical questions.** The NHS must address whether sterilising children in order to achieve cosmetic appearance goals is ethical, consistent with child safeguarding or human rights. The NICE review did not consider whether children can understand and meaningfully consent to make choices that will have significant consequences for their future adult life and relationships, at an age when they cannot understand what they are giving up. Nor did it consider the ethical questions attached to giving treatment that harms physically healthy bodies based on symptoms, for a condition (an internal dissonant sense of gender identity) that cannot be seen or verified. There is no other branch of medicine that does anything similar.

6. **Legal and societal questions.** The implicit rationale for treatment with PSH and cross-sex hormones is that it is possible for a person to be completely integrated into society as if they were the opposite sex, and that this can be undertaken more successfully if steps are taken in childhood to make their cosmetic appearance more congruent with the sex they wish they were. This assumption is increasingly questioned. The degree of accommodation for transition is not just a personal choice or a medical procedure, but depends on rules and laws which must be consistent with other people's human rights. The Department for Education has struggled to provide clear, practical, legally sound guidance to schools on questions such as whether children who identify as transgender should be allowed to use opposite-sex facilities, play sports as if they were the opposite sex or compel others to refer to them as if they were the opposite sex.[4] Such questions also extend beyond school and childhood to other rules-based situations such as the workplace, single-sex services, official records, sport, prisons, situations involving intimate bodily contact and sexual consent. The answers cannot be dependent on cosmetic appearance, but require clear policies and rules that are consistent with everyone's human rights. Thus the hoped-for promise of medically assisted "passing" may simply not be possible in a world where other people's rights are taken seriously. This situation must be explained to any person undergoing medical treatment so that they are not mis-sold an impossible transition.

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

No. We agree with the overall conclusion of NHS England that no direct or indirect discrimination arises from the removal of PSH from general commissioning for children with gender dysphoria.

However, the EHIA should recognise that the policy will have a beneficial protective effect on the groups who would otherwise have had their puberty suppressed, including teenage girls, children in care, children with neurodiversity, children with mental-health problems, and children and young people with emergent same-sex sexual orientation. We think that the EHIA should

[4] Sex Matters (2023). *Why social transition in schools is not possible and government guidance should say so clearly.*

give greater recognition to these positive effects and less emphasis on the imagined negative effect promoted by organisations such as Mermaids and Stonewall which do not recognise the harm caused by PSH.

We do not think that being enrolled in a clinical trial will be beneficial to children as they will be exposed to the harm of being sterilised and left with impaired adult sexual function in order to pursue cosmetic goals. This is not justifiable. Children given this treatment are not being given the same standard of care and safeguarding as other children.

Evidence suggests that in most children early-onset dysphoria will be resolved by puberty. There is no reliable means to predict whether a child will grow up to continue to wish to present as if they were the opposite sex as an adult. Children enrolled in a trial are being exposed to harm. To the extent that these effects are concentrated on members of particular protected-characteristic groups (young people, those with the protected characteristic of gender reassignment, gay and bisexual children, those with autism etc.) it will increase health inequality. This is because of the adverse outcome of the treatment in general.

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

We welcome the decision to remove puberty blockers from routine treatment, due to a lack of evidence on safety and effectiveness.

However, we do not support the proposal to continue providing access to PSH to children and young people with gender incongruence/dysphoria as part of research trials or for other exceptions.

Prescribing PSH in a research setting means that children and young people will be experimental subjects in an intervention with profound effects on their physical, psychological and sexual development. There is no clear scientific rationale for this treatment and clear evidence of harm. It is highly doubtful that children can give informed consent.

The plan of establishing a clinical trial into puberty suppression is not consistent with the context that children also have a right to education, and schools have a responsibility to keep all children safe.

Guidance being developed for schools in England is likely to establish that children are not able to meaningfully "socially transition" at school (since it is not fair or safe for a school to pretend that a boy is a girl or vice versa).[5] In order to keep children safe and make sure they understand rules and expectations, schools will need to explain to children and to their parents that they cannot play along with fiction that a child is the opposite sex.

[5] Sex Matters (2023). *Why social transition in schools is not possible and government guidance should say so clearly.*

If children cannot socially transition at school, it is not at all clear what the rationale for puberty blockers would be, or the means of identifying which children with early-onset dysphoria could be eligible for the puberty-blockers research trial.

Similarly we do not think initiating or continuing PSH prescription in the other "exceptional" situations is justified because of the balance of harms, risks and benefits presented by the treatment. No examples of what would count as an exception have been given. **We think there should be no exceptions.**

While this policy concerns NHSE commissioning policies, the EHIA recognises the risk that more children and young people may seek treatment from private sources. Although private prescribing is not explicitly part of this policy the safeguarding risk must be considered by NHSE. This policy should raise the issue of private prescription with a view to an overall ban.[6]

[6] Sex Matters (2023). *Policy proposal: Legislation to ban modern conversion therapy*.