

The Cass Review – initial analysis

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The Cass Review of gender-identity services for children and young people has published its final report and recommendations.

Sex Matters says: This is a breakthrough. It's a huge step forward, with multiple implications that will be hugely consequential.

Highlights

Dr Hilary Cass succinctly explains how the medicalised treatment of youth with gender distress went so badly off course worldwide.

She traces how a **false global consensus** was manufactured, according to which puberty blockers were safe and effective. This false consensus also regarded children as having stable gender identities and being best off on medical treatment pathways if they expressed any sort of gender incongruence.

“It often takes many years before strongly positive research findings are incorporated into practice.... Quite the reverse happened in the field of gender care for children. Based on a single Dutch study, which suggested that puberty blockers may improve psychological wellbeing for a narrowly defined group of children with gender incongruence, the practice spread at pace to other countries. This was closely followed by a greater readiness to start masculinising/feminising hormones in mid-teens, and the extension of this approach to a wider group of adolescents who would not have met the inclusion criteria for the original Dutch study.” (p 13)

In the UK, the **whistleblowers have been vindicated**. Gender distress has been treated within the NHS in a way that is different from other sorts of distress, to the detriment of vulnerable children and adults.

“Some practitioners **abandoned normal clinical approaches** to holistic assessment, which has meant that this group of young people have been exceptionalised compared to other young people with similarly complex presentations. They deserve very much better.” (p 13)

“We have to start from the understanding that this group of children and young people are just that; children and young people first and foremost, not individuals solely defined by their gender incongruence or gender-related distress.” (p 15)

Identity formation is, the report says, fluid and multifactorial. **Clinicians told Dr Cass they can't tell who would benefit from a medical pathway and who would not** – and they know that the majority grow out of gender distress if not medicalised. That means children have been given treatments that there's no evidence to support – that are in fact harmful – and in particular, the NHS has done this. **Dr Cass dismisses any notion that puberty blockers or indeed hormones have any part in standard treatment for under-18s.** The report explicitly says that the medical pathway will not be right for most young people with gender issues.

“Young people's sense of identity is not always fixed and may evolve over time.”
(p 21)

“Clinicians have told us they are unable to determine with any certainty which children and young people will go on to have an enduring trans identity.”
(p 22)

“The focus on the use of puberty blockers for managing gender-related distress has overshadowed the possibility that other evidence-based treatments may be more effective.” (p 31)

There's a reminder that the **WPATH evidence and the standards of care are of the lowest medical quality**, with the pyramid showing standards of medical evidence on p 55. In the summary, the report says:

“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 appraisal process to lack developmental rigour.” (p 28)

“The findings raise questions about the quality of currently available guidelines. Most guidelines have not followed the international standards for guideline development, and because of this the research team could only recommend two guidelines for practice – the Finnish guideline published in 2020 and the Swedish guideline published in 2022.” (p 27)

There's a strong challenge to the **Memorandum of Understanding** that currently commits British practitioners of counselling and psychotherapy to an affirmative approach. “Professional bodies must come together to provide leadership and guidance on the clinical management of this population. taking account of the findings of this report.” (Recommendation 31).

Dr Cass decisively refutes the idea that **suicide prevention** is a reason for medicalising gender distress in youth, saying:

“It has been suggested that hormone treatment reduces the elevated risk of death by suicide in this population, but the evidence found did not support this conclusion.” (p 33)

She proposes steps to reduce access to **private prescriptions for puberty blockers** or hormones. She:

- recommends that GPs and other clinicians do not get involved in shared care with private providers
- reminds pharmacists that they are responsible for the suitability and safety of what they’re dispensing, reminding them that they could be criminally liable
- suggests that the Department of Health should outlaw the provision of puberty blockers from clinicians from pharmacies that are not licensed or from doctors that are not licensed in the UK.

She warns families that if they get puberty blockers privately they will not be eligible for an NHS puberty blockers trial.

The **description of GIDS** is absolutely damning in several ways:

1. The clinic deviated from its agreed service specification, which limited it to medicalising only the tiny cohort who matched the early Dutch studies.
2. The record-keeping was so bad that there should probably be referrals to the General Medical Council (p 136–137).
3. Both GIDS and the adult gender clinics flatly refused to cooperate with Cass on a long-term follow-up study. They “thwarted” her attempts. That’s a disgrace because there’s no high-quality data on long-term outcomes worldwide and her review was attempting to provide it. (Appendix 12 is a letter to the head of specialist NHS commissioning, explaining why she hasn’t been able to publish the expected findings of the investigation into longer-term outcomes for the puberty-blocked children.)
4. GIDS’s handling of its long-promised puberty-blockers trial fell far below acceptable standards:

“The adoption of a treatment with uncertain benefits without further scrutiny is a significant departure from established practice. This, in combination with the long delay in publication of the results of the study, has had significant consequences in terms of patient expectations of intended benefits and demand for treatment.” (p 25).

There is extensive analysis of the **changing patient profiles** and some exploration of the possible causes for this. The report concludes that cross-sex hormones will rarely be right for anyone under 18.

Strikingly, Dr Cass goes outside her remit to suggest that **there should be specialised follow-on services for 18 to 25 year olds**, for two reasons: currently, the transfer from child to adult services is a point of vulnerability, and brains are not fully developed until 25.

Dr Cass talks about **detransitioners** sympathetically and seriously, suggesting that they need specialised care and possibly not in the same places as the gender clinics. This is the first acknowledgement of detransitioners and their needs in the NHS.

This report totally undermines any case for a legislative ban on **“conversion practices for gender identity”**. It says:

“The intent of psychological intervention is not to change the person’s perception of who they are but to work with them to explore their concerns and experiences and help alleviate their distress, regardless of whether they pursue a medical pathway or not. It is harmful to equate this approach to conversion therapy as it may prevent young people from getting the emotional support they deserve.” (p 150)

Schools were outside Dr Cass’s remit, but she says:

“The importance of what happens in school cannot be under-estimated; this applies to all aspects of children’s health and wellbeing. Schools have been grappling with how they should respond when a pupil says that they want to socially transition in the school setting. For this reason, it is important that school guidance is able to utilise some of the principles and evidence from the Review.” (p 158)

All the justifications that might be used to argue for **allowing a child to socially transition at school** have more or less been taken off the table:

“The systematic review showed no clear evidence that social transition in childhood has any positive or negative mental health outcomes, and relatively weak evidence for any effect in adolescence. However, those who had socially transitioned at an earlier age and/or prior to being seen in clinic were more likely to proceed to a medical pathway.” (p 31)

The review suggests that allowing non-conforming gender expression does not mean hiding a child’s sex. This may be what is meant when the report refers to **partial social transition**:

“The approach taken to social transition is very individual but it is broadly understood to refer to social changes to live as a different gender such as altering hair or clothing, name change and/or use of different pronouns. There is a spectrum from relatively limited gender non-conforming changes in

appearance in adolescence to young people who may have fully socially transitioned from an early age and be 'living in stealth' (that is, school friends/staff may be unaware of their birth-registered sex)." (p 158)

There is a strong suggestion that there should be a **review of what went wrong at GIDS**:

"There are clearly lessons to be learned by everyone in relation to how and why the care of these children and young people came to deviate from usual NHS practice, how clinical practice became disconnected from the clinical evidence base, and why warning signs that the service delivery model was struggling to meet demand were not acted on sooner." (p 74)

Dr Cass talks about **safeguarding** and points out the reckless failure to consider the safety of these children at every level of the NHS, including **changing their NHS numbers**. There's a recommendation that the Department of Health looks at this (Recommendation 28, p 44).

Where the report could have been better

Language: it uses trans male, trans female, cisgender; it says "sex assigned at birth" many times. It occasionally says "gender" when what is meant is sex.

On occasion there is **false balance**, for example claiming that the standard of the evidence on puberty blockers is misstated on both sides, when in fact one side has pushed for experimental, life-changing drugs to be widely available for children and the other was advocating caution in the absence of any evidence that these drugs would help resolve gender distress. Two references to the "toxicity" of the debate give the impression that there is equivalence between people calling for an evidence-based therapeutic approach and aggressive name-calling and closing-down of debate by defenders of the medical pathway.

The report suggests that pre- and post-pubertal children may need different treatment, **implying that social transition may be acceptable for some**:

"There should be a distinction for the approach taken to pre- and post-pubertal children when considering the most appropriate interventions. This is of particular importance in relation to social transition, which may not be thought of as an intervention or treatment because it is something that generally happens at home, online or in school and not within health services. (p 30)

The report leaves open the **possibility that some people have an innate gender identity** that in some unspecified way differs from their sex, and consequently the idea that medical intervention may be right for them. There is a reference to whether people see themselves as "male, female or something else"; the report says non-binary is a growing

cohort which needs consideration. (There is nothing about what their healthcare needs might be.)

There is mention of online and peer influences as drivers of transgender identities or gender confusion but **no mention of schools as a driver**, i.e. that schools are teaching the contested idea of gender identity. More generally, there's a blind spot about the role of schools, both as causes and as recipients of social transition, and at times a **worrying conflation of gender, gender nonconformity and having a special gender identity**. On the idea of "partial social transition", which Dr Cass briefly raises, there is no mention of the impact on other people, particularly other children in school.

Social transition is not defined. The report acknowledges that an early social transition makes puberty more difficult and is predictive of a medical transition. The report suggests partial social transition may be preferable, but does not say what this is.

The strong statements in the interim review about needing holistic care for these children remain, but one wonders why, if that's the case, there are **specialist gender centres at all, as opposed to more CAMHS resources**. One reason may be that, as the report says, people who are on waiting lists for a long time may go off and find their own solutions, which tend to be narrow and singular (i.e. blockers/hormones).

There is **positive endorsement of a clinical trial of puberty blockers**, and of high-quality trials of other treatment protocols. This is somewhat at odds with the clear recognition that most desist and that it is simply impossible to tell which children will persist or desist.

Conclusion

This is a major step forward, dispelling myths on several fronts, and setting out ways to offer better, safer care for children and young people with referrals for gender-related issues. The report is clear that there is much more to do but it provides a strong foundation and emphasises the importance of building a better evidence base. While schools were outside its remit, there are helpful pointers there too.

For more information contact Maya Forstater at Sex Matters: info@sex-matters.org