# Representative organisation consultation on puberty blockers - TransActual Response

| Question | Response |
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| Which type of organisation are you responding on behalf of? | LGBT+ Organisation |
| To what extent do you agree or disagree with making the arrangements in the emergency order permanent?<br>Please explain your answer. | Strongly disagree .<br><br>The ban on puberty blockers is a misuse of laws designed for use with medicines that have been demonstrated to cause serious harm. There is no evidence that puberty blockers cause serious harm to trans young people. This decision seems to rely on a distorted reading of the recommendations of the Cass Review, the methodology of which has been widely criticised – including by academics at Yale Medical School. The BMA are currently reviewing the Cass Review and have asked for the implementation of its recommendations to be halted until it has published its findings – this request has been ignored. The Cass Review did not call for a ban on puberty blockers and Baroness Cass has indicated she did not recommend a ban i.<br><br>Instances where politicians interfere with an individual's medical care should be based entirely on actual, documented harm or strong and irrefutable evidence that harm will occur. It is not a step that should be taken lightly, or based on weak evidence. **There is no such strong evidence implying harm or documented harm from puberty blockers,** which should bear considerable weight given **they have been prescribed for at least 30 years**.<br><br>Implying that someone having a trans identity is a harmful outcome is openly discriminatory and in breach of the Equality Act. It is wrongly implying a causation when the diagnostic criteria for puberty blockers means that the individual being prescribed them is highly likely to be trans.<br><br>**If the medication was truly harmful, it should be banned for everyone, not just for** |

| | **trans children.** |
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| In your experience, what have been the positive impacts of the emergency order? Please provide evidence to support your answer. | There have been none. |
| In your experience, what have been the negative impacts of the emergency order? Please provide evidence to support your answer. | There have been significant negative impacts on patient safety. For the patient group targeted by the ban, these impacts have been around mental health, unwanted physical changes as a consequence of puberty, increased use of unregulated care, and the use of alternative GNRHAs which have adverse side effects. Some of these patients had purposefully chosen to take their time to fully consider taking puberty blockers and, just when they were ready to pursue a course of treatment, have had that option taken away from them – many will now never have access to them via the NHS, as they are unlikely to be seen by an NHS gender clinician until they have completed puberty. Recent FOI data shows that, while around 500 patients were added to the new NHS clinics' waiting lists between April and July, only 8 patients were seen in that time, meaning that the new system is also failing the needs of patients.<br><br>Continuation of care for those who'd previously accessed private puberty blocker prescriptions has been functionally non-existent. This group has experienced similar impacts to the group of patients targeted by the ban. There has, of course, been the additional mental health impact of having paused puberty and having it re-start due to the lack of access to care.<br><br>***The removal of puberty blockers means that a young trans person has no option but to go through an unwanted puberty, causing significant and often debilitating mental distress and often requiring a number of invasive and costly surgeries to minimise in adulthood. Some pubertal changes cannot be undone, such as the depth of someone's voice. This then places trans people at a permanent risk and fear of being identifiable as trans, placing them at increased risk of harassment, discrimination and hate crime. Data from GIDS shows that puberty blockers were being prescribed only to those understood to have persistent gender dysphoria leading to a strong likelihood that a trans identity would persist into adulthood.*** |

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| | Communications during the rollout of the emergency ban were poor, particularly the communication about who would be legally able to continue accessing puberty suppression. Clarity was only provided as a consequence of pre-action correspondence relating to the Judicial Review into the emergency ban. However, the majority of those who had previously accessed an EEA prescription for puberty blockers have had their request for continuity of care refused by their GP. **We are only aware of one GP in the UK who has been willing to provide continuity of care for this patient group.** GPs are already hesitant to prescribe to trans people and increasingly unwilling to even prescribe hormones to trans adults upon the recommendation of an NHS clinic, so this does not come as a surprise.<br><br>TransActual were contacted by the father of a 15 year old trans girl who had previously been prescribed puberty blockers by Gender GP. They sought continuation of care via their GP but the practice refused. Upon pursuing the matter with the ICB, the Chief Pharmaceutical Officer told them that the GP is not legally allowed to prescribe blockers to the girl – a clear demonstration of the lack of clarity around the law.<br><br>**Mental health**<br>The mental health impacts of the ban have been significant – for both trans children and young people and for their parents and carers.<br><br>TransActual heard from the parent of a trans girl who started taking puberty blockers at the age of 12, when puberty started. The parent reported that the announcement of the emergency ban had impacted her daughter's sleep and caused her to have panic attacks. Taking blockers allowed her to be herself, to feel happy and comfortable when she looks in the mirror, to be confident going out with her friends. This has now been taken away and they fear that she is going to be forced to detransition. The family have very real fears for their daughter's self-esteem, her future, and of the very real risk of suicide.<br><br>We have also heard from the parent of a young person who has been waiting more than 5 years to access NHS gender services. As a result of their gender dysphoria, they struggle with eating, going to school and socialising, and experience chronic stress-related |

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| | headaches. They have previously tried to access mental health support locally via CAMHS but the referrals were rejected because so many young people are seeking support from the service. Accessing blockers privately was the only route they could take and they were about to commence on this. They are now unable to access puberty blockers privately and the change to the law means that now this young person no longer has access to the care that gave them hope for a happy adulthood.<br><br>The mother of another trans girl told us that the distress associated with the breaking of her voice and facial hair development resulted in suicidal ideation to the extent of planning a suicide attempt. As puberty has progressed, the girl's self-harm by cutting worsened – she told her mother that she self harms when she finds her dysphoria overwhelming. As a consequence of their daughter's extreme distress, the family sought out private care from Gender GP. After discussions with clinicians, the girl decided to wait until the age of 15 before going on puberty blockers. She was expecting to start puberty blockers in July this year and was yet to have her capacity to consent appointment when the ban was introduced. As a result, she has been unable to access puberty blockers. The mother describes the ban as having had a profound and damaging impact on her daughter. Shortly after the announcement of the blocker ban, there have been several incidents of the girl self-harming in a manner that is likely to cause permanent scarring and that carried risk of infection. The girl's feelings of suicidality have become more frequent and the family hold a genuine fear that she will attempt to take her own life. In addition to the mental and physical harm, the girl has had to have time off school – as a consequence her education is also being impacted by the ban.<br><br>In addition to the mental health impacts being experienced by trans young people, there has been a knock-on effect on their parents' mental health. This has been due to the stress and fear associated with their children's deteriorating mental health, but also in weighing up decisions on if/how to best support their distressed children – decisions that have significant financial implications and which could risk the involvement of social services in the family's life.<br><br>In our court case challenging the initial emergency ban, we included five coroners' reports into deaths of young trans people since the ban was introduced, all of which alluded to the decline in the young person's mental health. |

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| | **Unwanted physical changes**<br>Puberty can contribute to a trans person's feelings of dysphoria due to the unwanted changes in the body that it brings about. Some of these changes - for example breast development, development of the Adam's apple and thickening of the facial bones - can only be reversed by surgery . Whilst Speech and Language Therapy can help a trans woman or non-binary person whose voice has broken during puberty, many people find that it does not help enough, and they seek vocal surgery. All surgeries carry clinical risk, including risk of death. T**hese surgeries, sought out by trans people as a result of inappropriate puberty, are known to carry a more significant level of clinical risk than the Cass Review asserts that puberty blockers may carry.**<br><br>Data from TransActual's 2022 Transition Access Survey can shed light on the prevalence of surgeries that could have been prevented by puberty suppression. Of transmasculine respondents that had undergone surgery, 93% had undergone mastectomy. Of those yet to access surgery, 54% wanted a mastectomy.<br><br>One transmasculine person told the TransActual Transition Access Survey:<br>"My chest dysphoria was debilitating. I struggled with eating disorders and never wanted people to look at me. Having to wait for something I needed so badly was terrible for my mental health. It felt like the wait would never end and I'd have to be miserable forever".<br><br>Of transfeminine respondents that had undergone surgery, 23% had had facial feminisation surgery and 11% had had a tracheal shave. Of those yet to access surgery, 68% hoped to access facial feminisation surgery and 20% hoped to access tracheal shave.<br><br>A trans woman told the TransActual Transition Access Survey:<br>"Before I got FFS [facial feminisation surgery] every single day was a struggle for me. It was difficult to impossible to find work, it was hard to make friends, it was difficult to even just leave the house because of how people treated and interacted with me. I learnt very quickly how vulnerable I was and I still live with the mental and physical scars left from that".<br><br>Facial feminisation surgery, tracheal shave, and vocal surgery are not available on the NHS. |

Transfeminine people pursue these privately, often overseas and at great financial cost.

The development of facial hair and body hair for transfeminine people (as a consequence of puberty) is only partially reversed by medical transition as an adult. As a consequence, the NHS provides access to hair removal. This can be incredibly painful and often the number of NHS sessions offered are insufficient. Many trans women shave their face twice a day due to the distress caused by the appearance of stubble on their face.

The cost to both the NHS and the individual of undertaking these clinical interventions post-puberty is significant, and could largely be avoided for those who were able to take puberty blockers.

**Unregulated care and alternatives to banned medications**
Some parents have sought puberty blockers via black market routes in order for their child to continue to take puberty blockers or to enable them to start taking puberty blockers. Accessing medication in this way carries significant clinical risk – lack of clinical oversight, lack of access to blood testing and increased risk of counterfeit or unsafe formulations of the medication. This is a last resort decision taken by families who understand that the greater risk lies is not doing anything - the alternative is their child being at real risk of complete social isolation, self-harm and suicidal ideation.

There is increasing awareness amongst young people and their families about the availability of other medications that have the impact of inhibiting puberty and which are not covered by the ban. There is less evidence on the safety and efficacy of these medications than there is for the banned GnRH analogues.

**Fear**
Since the ban on puberty blockers and the announcement of a review into adult gender services, we have been contacted by countless trans adults who are afraid that they too will have their access to transition related care removed. This is a rational fear, given that the justification for the blocker ban is based solely on an unsupported over-reach of a methodologically flawed, widely discredited report (which does not recommend banning puberty blockers). As a result, the mental health of trans adults has also been impacted by the introduction of the ban on puberty blockers.

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| | While the ban appears to be based on concerns of unknown long-term risks of prescribing puberty blockers, no consideration has been given to the known risks, both short-term and long-term, of not prescribing puberty blockers. Doing nothing is not a neutral act, a statement repeated in the interim report of the Cass Review. NHS England appears to tacitly acknowledge this by including a number of suicide prevention hotlines in its “support” document for those impacted by the ban. |
| In your experience, are there benefits in making the arrangements permanent?<br>Please provide evidence to support your answer and explain how you think those benefits could be maximised? | No.<br><br>There were no benefits to a temporary ban and there are no benefits to a permanent ban. |
| In your experience, are there risks in making the arrangements permanent?<br>Please provide evidence to support your answer and explain how you think those risks could be mitigated? | Yes<br><br>Making the arrangements permanent carries significant risk. Puberty does not wait, unless inhibited by puberty blockers, but trans children and young people have no choice but to wait years to access NHS gender services. This is why they have sought access to puberty blockers via private healthcare providers. Even if they were able to wait, the proposal is that access to puberty suppression will only be available to those eligible for and willing to consent to a research trial. It is ethically problematic to consider such a trial if the medication has been deemed dangerous enough to consider banning it. Additionally, nobody should be co-erced into taking part in research. Those who don’t wish to be part of it should have access to their (often life saving) medication through another legal route. It has also taken years to initiate the proposed research and there is still no proposed start date, framework or ethical approval of the proposed research. It is entirely possible such research is ethically impossible to start. It is immoral to ban medication on the basis that it might be available through a research programme without knowing that the research programme will start immediately, if not in a timely manner<br><br>As discussed in the answer to a previous question, there are families already turning to the black or grey markets to access puberty blocking medication. Many who have not yet done so, as it is a last resort, have been waiting in the hope that the new Government will drop the ban. However, if a ban were to be made permanent, it is realistic to expect that there will be |

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| | an increase in the number of people turning to the black or grey markets. As previously discussed, there are significant risks associated with that. Provision of such medication under the NHS reduces risk, which is why trans people fought for years to have such provision under the NHS.<br><br>Other families, those who can afford to, have travelled abroad to seek treatment. Not only are there significant financial implications, it also means that young people miss time from education in order to attend appointments overseas. However, the mental health impact of not accessing puberty suppression is likely to be far greater and have a more significant impact on a child or young person's academic attainment and progress than a few days off to attend overseas appointments.<br><br>Regardless of how pubertal suppression is accessed, it is likely that families will be afraid that NHS providers or school staff will raise a safeguarding concern about the child or young person accessing puberty blockers. As a result, we fear that parents or carers with a child taking puberty blockers via a non-NHS route will be more likely to withdraw them from school and seek alternatives to NHS healthcare more broadly. For the majority of children and young people this will not pose a safeguarding risk. However, there are some children and young people who will be at risk – not because of their access to puberty blockers or support for their social transition, but for other reasons. The decreased number of touchpoints will make it harder for safeguarding concerns to be available.<br><br>The primary risks to those children and young people with no access to puberty suppression are to their mental health (as detailed in a previous answer) and, as a consequence, to their education. If a child or young person is struggling with their mental health and/or struggling socially when at school, this of course will result in them being less likely to achieve their academic potential and make the progress they would be otherwise capable of. The risk to the children and young people once they achieve adulthood should not be underestimated – these can be in relation to the risks associated with surgery (for example mastectomy) as well increased chance of discrimination, harassment, and abuse (for example, trans women with a deep voice).<br><br>The need to access surgery, hair removal and/or speech therapy as an adult also comes with a cost to the NHS. Mastectomy costs £8,000-£10,000, an hour of laser hair removal |

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| | costs £70-£140, speech therapy costs at least £25 per hour. The costs to the NHS will also come through the cost associated with providing support to people with mental heath difficulties that come as a consequence of their dysphoria – for example with eating disorders, anxiety and depression, self-harm, suicide attempts.<br><br>The widely discredited and internationally condemned Cass Report was used to justify the introduction of the emergency ban on puberty blockers, despite not recommending a ban. The BMA have since called for the implementation of its findings to be paused until they complete their own review. Making the ban on puberty blockers permanent sends a strong message to trans children, young people and adults, and their families and friends, that the Government doesn't care about them, their wellbeing, or what the evidence actually says about their healthcare. |
| Do you think the accompanying equality impact assessment (EQIA) appropriately reflects the potential impact on protected groups which might arise from the proposal to make the order permanent?<br>Do you have any further comments or evidence about the potential impact on protected groups? If yes, please specify. | No.<br><br>We have a number of concerns about the EQIA.<br><br>In relation to disability, the suggested mitigation is Children and Young People's Mental Health Services. However, CYPMHS professionals often lack the cultural competence to support trans children and young people, and certainly have not been trained to support young people who are having to re-start an unwanted puberty that they'd previously been able to delay. Further there is no consideration of the considerable delays in accessing CYMPHS, or the ability for such professionals to be able to undertake any meaningful interventions.<br><br>There are no considerations to make in relation to sexual orientation. The demographic data from TransActual's 2022 Transition Access Survey indicates that the majority of trans adults are LGBQ+ - just 4.3% were heterosexual (ie trans men attracted to women, or trans women attracted to men).<br><br>The assumption that white people are more likely to be disadvantaged by a ban on blockers because the majority of people accessing GIDs were white is completely flawed. There will be a number of reasons that young Black trans people and young trans People of Colour are under-represented in the GIDs data – the increased barriers to healthcare for BPOC in the |

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| | UK are well documented. Furthermore, there may be challenges around cultural heritage, local community and faith in relation to the support young trans BPOC receive (or don't receive) from their families. This does not mean that these children and young people would not be impacted by the ban and that it is something that mainly impacts white people. There is no acknowledgement of the ethnicity pay gap – Black people in the UK earn less than people of other ethnic groups, and as such Black trans children and young people may be less likely to be able to afford to take their children abroad to access puberty suppression, therefore a ban is likely to have increased detrimental effects on Black people<br><br>Economic inequalities have been completely ignored by the EQIA. A permanent ban would exacerbate inequalities for children and young people from families on a low income. Regardless of the ban, those with financial means will try to find a way to access puberty suppressing medication for their children. Trans children and young people from affluent families will have access to medication that has the potential to support their mental health and wellbeing and allow them to thrive socially and at school. As adults, they will not suffer the consequences of an inappropriate puberty – for example increased risk of employment discrimination. Those trans children and young people from low income families unable to afford to seek overseas care will be at a distinct disadvantage in adolescence and well into adulthood.<br><br>**There is clear Gender Reassignment discrimination at play within the proposed ban**. **If the medication was truly harmful, it should be banned for everyone, not just for trans children and young people.** The justification for not banning puberty blockers for children and young people experiencing precocious puberty (that they have been used for 25+ years) overlooks entirely that puberty blockers have been used to treat gender dysphoria since the mid 90s (20+ years) (Giordano, S., & Holm, S. (2020). Is puberty delaying treatment 'experimental treatment'? *International Journal of Transgender Health*, *21*(2), 113–121. https://doi.org/10.1080/26895269.2020.1747768). The EQIA completely fails to acknowledge the benefits that trans children and young people experience from taking puberty blockers – mental health benefits, prevention of worsening dysphoria, prevention of dysphoria in adult life, preventing the need for surgery, hair removal or speech therapy in adult life. The EQIA focuses on puberty blockers being used off-label for trans children and young people, but fails to acknowledge that most medicines are used off label for children and young people – especially those used in hospital treatment (see Allen, H. C. et al (2018). Off-Label |

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| | Medication use in Children, More Common than We Think: A Systematic Review of the Literature. *The Journal of the Oklahoma State Medical Association*, *111*(8), 776–783).<br><br>The underlying assumption made in the EQIA is that the Cass Review is a reliable source of information and that it provides evidence that puberty blockers cause harm to trans young people. However, the Cass Report has been widely criticised – for example, by academics at Yale Medical School (McNamara et al (2024). An Evidence-Based Critique of “The Cass Review” on Gender-affirming Care for Adolescent Gender Dysphoria. https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf) . The Cass Review makes a number of spurious, unevidenced claims – for example, that porn causes people to be trans and that boys and girls have an innate propensity to play with certain toys. It makes claims about brain development based largely on one paper, which has not been peer reviewed and is widely derided by neuroscientists such as Dr Dean Burnett. Critics of the review state that it oversimplifies matters relating to brain development and that it supplies insufficient evidence on the matter for its recommendations to be used to inform policy (Grijseels, D. M. (2024). Biological and psychosocial evidence in the Cass Review: a critical commentary. International Journal of Transgender Health, 1–11. https://www.tandfonline.com/doi/full/10.1080/26895269.2024.2362304). Whilst selectively using spurious ‘evidence’, the Cass Review rejected peer reviewed evidence that puberty blockers are beneficial for trans children and young people. However, regardless of its quality, **the Cass Review does not recommend that puberty blockers ought to be banned for trans children and young people**.<br><br>It is incorrect for the EQIA to state that risk would be reduced for children and young people as a result of a ban on puberty blockers. As discussed in our responses earlier in this consultation, **the ban significantly increases the risk to trans children and young people.** Mitigations around continuity of care for those on private prescriptions have been entirely ineffective and just a third of young people on the waiting list for Children and Young People’s Gender Services waiting list have taken up the offer of a mental health assessment from CYPMHS. The lack of take up is thought to be a consequence of a lack of trust in CYPMHS, which already has year-long waiting lists and questionable competence in this area, to competently support trans young people, and a fear that those children and young people still on puberty blockers via overseas, black market or grey market routes will be referred to social services. |

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| To what extent do you agree or disagree that the proposal to make the order permanent risks impacting people differently with reference to their protected characteristics, as covered by the public sector equality duty set out in section 75 of the Northern Ireland Act 1998? | Strongly agree.<br><br>We do not consider that EQIA does not appropriately address the Section 75 duty. In addition to the issues highlighted with the EQIA more generally, there is no evidence that trans children and young people have been consulted when conducting it, or that there are plans to consult with them. |
| If you have any additional evidence (including clinical or patient feedback) you wish to provide, please outline it here. | Achille, T. Taggart, N.R. Eaton, et al. Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results Int J Pediatr Endocrinol, 2020 (2020) 83<br>Allen, H. C. et al (2018). Off-Label Medication use in Children, More Common than We Think: A Systematic Review of the Literature. *The Journal of the Oklahoma State Medical Association*, *111*(8), 776–783<br>Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al. (2021) Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLoS ONE 16(2): e0243894. https://doi.org/10.1371/journal.pone.0243894<br>Coleman, E. et al (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health*, *23*(Suppl 1), S1–S259. https://doi.org/10.1080/26895269.2022.2100644<br>de Vries, A. L. 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*, *22*(3), 217–224. https://doi.org/10.1080/26895269.2021.1904330<br>de Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. The journal of sexual medicine, 8(8), 2276–2283. https://doi.org/10.1111/j.1743-6109.2010.01943.x |

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| | Endocrine Society (2024). Endocrine Society Statement in Support of Gender-Affirming Care. https://www.endocrine.org/news-and-advocacy/news-room/2024/statement-in-support-of-gender-affirming-care<br>Giordano, S., & Holm, S. (2020). Is puberty delaying treatment 'experimental treatment'? *International Journal of Transgender Health*, *21*(2), 113–121. https://doi.org/10.1080/26895269.2020.1747768m<br>Grijseels, D. M. (2024). Biological and psychosocial evidence in the Cass Review: a critical commentary. International Journal of Transgender Health, 1–11. https://www.tandfonline.com/doi/full/10.1080/26895269.2024.2362304<br>Horton, C. (2024). The Cass Review: Cis-supremacy in the UK's approach to healthcare for trans children. International Journal of Transgender Health , 1-25. https://www.tandfonline.com/doi/full/10.1080/26895269.2024.2328249<br>Horton, C. and Pearce, R. (2024) The U.K.'s Cass Review Badly Fails Trans Children. Scientific American. https://www.scientificamerican.com/article/the-u-k-s-cass-review-badly-fails-trans-children/<br>Kuper, L.E. al. (2020) Body Dissatisfaction and mental health outcomes of youth on gender affirming hormone therapy. Pediatrics, 145, Article e20193006 84<br>McGregor K, McKenna JL, Williams CR, Barrera EP, Boskey ER. Association of Pubertal Blockade at Tanner 2/3 With Psychosocial Benefits in Transgender and Gender Diverse Youth at Hormone Readiness Assessment. J Adolesc Health. 2024 Apr;74(4):801-807. doi: 10.1016/j.jadohealth.2023.10.028. Epub 2023 Dec 13. PMID: 38099903.; Chelliah P, Lau M, Kuper, LE. (2024) Changes in Gender Dysphoria, Interpersonal Minority Stress, and Mental Health Among Transgender Youth After One Year of Hormone Therapy. J Adolesc Health. Jun;74(6):11061111. doi: 10.1016/j.jadohealth.2023.12.024. Epub 2024 Feb 9. PMID: 38340124.<br>Lee, W.Y. (2024) State-level anti-transgender laws increase past-year suicide attempts among transgender and non-binary young people in the USA. *Nat Hum Behav*. https://doi.org/10.1038/s41562-024-01979-5<br>McNamara et al (2024). An Evidence-Based Critique of "The Cass Review" on Gender-affirming Care for Adolescent Gender Dysphoria. https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf<br>Noone et al (2024). Critically appraising the Cass Report: Methodological flaws and |

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| | unsupported claims. https://osf.io/preprints/osf/uhndk<br>R. Costa, M. Dunsford, E. Skagerberg, et al. Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria J Sex Med, 12 (2015), pp. 2206-2214 82 C.<br>Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. Pediatrics. 2020 Feb;145(2):e20191725. doi: 10.1542/peds.2019-1725.<br>van der Miesen, A. I. R., Steensma, T. D., de Vries, A. L. C., Bos, H., & Popma, A. (2020). Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared With Cisgender General Population Peers. The Journal of adolescent health: official publication of the Society for Adolescent Medicine, 66(6), 699–704. |
| The government is keen to improve the data it gathers in relation to how many children and young people are affected by the order, as well as the impact of the information and guidance provided to them.<br>If you have any thoughts on how this data could be gathered, please outline them here. | It is essential that the Government talks directly to trans children and young people in order to find out how they've been impacted by the emergency bans, their hopes and fears for the future, and what they want from transition related care. This could be through focus groups or via surveys with the support from trusted community organisations. It would also be useful to do a national survey around the mental health of all children and young people – this would help in planning mental health provisions for all children and young people, but would enable comparisons between the mental health of trans children and young people and that of others.<br><br>Other information could be gathered by speaking to the EEA providers that are known to have previously been prescribing blockers to children and young people in the UK. They will of course hold data on how many UK based children and young people they were prescribing for. This does, however, depend on them trusting the UK Government with that information.<br><br>There are a number of organisations offering youth group support and helpline support to trans children and young people – this includes LGBTQ+ specific organisations as well as other support organisations such as Papyrus, SHOUT and Childline. They are likely to have data or case studies that may shed some light on the experiences of trans children and young people. |
| In the future, would your organisation be | We do not offer direct support to under 18s and are not a youth-focussed organisation. |

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| willing to share data, such as the volume of service users and their ages, to support policy making? | However we are happy to share our published research and case studies, and we support adults who are looking for options to correct or mitigate unwanted puberties. |