The new 'rules' on gender and children

What you need to know

Independent review of gender identity services for children and young people: Final report

Report by Dr Hilary Cass OBE (April 2024)

After four years of gathering and analysing data, the publication of the Cass Review marks the most comprehensive report ever done on the subject of gender identity, as it relates to children and young people. The official remit of the Cass report is solely for England, yet its impact has already been felt in Scotland[1] and Ireland,[2] and there are now calls for the Report's recommendations to be followed in the United States.[3]

The Review recommends that the routine prescription of puberty blockers be ended, at least for the foreseeable future, while the use of sex change hormones should not be administered to under-16s. The Review recommends an "extremely cautious clinical approach" when providing sex change hormones before the age of 18.

In recent years, many parents and others have felt ongoing concerns about how the NHS has allowed children and young people to be given drugs to block puberty, as well as prescribing sex change hormones. Critics of these medical practices have been subjected to hostility, intimidation, smears and threats for highlighting how these interventions are inappropriate for children, medically dangerous, and can be irreversible. These interventions were sold to the public as being safe and effective. Detractors were told they were bigoted and transphobic. Yet the Cass Review demonstrates an astonishing lack of good science supporting these medical treatments, while the evidence fails to demonstrate that they are safe and effective.

Unless indicated otherwise, all references to the Cass Review are to the final report.

It is not necessary to read the entire section below to understand the main 'takeaways'. You may choose from a selection of the Qs and As.

Qs and As

7. **Aren't adolescents too immature to make life-changing, medically risky, irreversible decisions?**
8. **What does the Review say about detransitioners?**
9. **What about free speech?**

Qs and As

1. **Who is Dr Hiliary Cass?**

She is a consultant paediatrician and served as President of the Royal College of Paediatrics and Child Health between 2012 and 2015.[4] She chaired the four-year Review into gender identity services for children and young people. Her interim report, *Independent review of gender identity services for children and young people* was published in 2022.[5] Recently, her final report was published.[6]

2. **What is the background to and remit of this Report?**

The Cass Review was commissioned by NHS England and NHS Improvement in September 2020 to provide recommendations about NHS services for children and young people (those under 18) who are questioning their gender identity or experiencing gender dysphoria.[7] The Review was driven by the exponential increase in referrals of children and young people to the NHS for gender issues. When the Gender Identity Development Service (GIDS) began in 1989 (created by the Tavistock and Portman NHS Foundation Trust in London), fewer than 10 children were seen annually.[8] Twenty years later, referral numbers were still relatively low at 97 but by 2017-2018, they had reached 2,519.[9] Whereas originally, most patients accessing the service were biological males, there was subsequently an increase in biological females.

Following much protracted and public controversy about children being inappropriately administered with puberty blocking drugs and sex-change hormones, alongside increasing reports of detransitioners – people who painfully regret their gender transition – this led to a climate of concern among parents, the general public and medical experts alike. Many felt that children were not being safeguarded and were often being driven along a path of medical harm.

The NHS and other medical authorities had already recognised that medical treatments for gender transition were weak in their scientific and research foundation, with both known and unknown medical harms and risks about the future side effects of drugs. Some practitioners at the Tavistock clinic had reportedly felt the weight of ideological pressure from activists, while being subjected to intimidation on social media. The Care and Quality Commission issued an "Inadequate" rating to GIDS in early 2021. They had concerns about the service's clinical practice, safeguarding procedures, assessments of capacity and consent to treatment.[10]

The Review was tasked[11] with setting out its findings and recommendations in relation to a catalogue of objectives including: how the current clinical approach should be improved; what the future referral criteria should be; issues connected to the use of puberty blockers, and masculinising/feminising hormones (otherwise known as sex-change hormones); exploring the reasons for the increase in referrals, and why there has been such a disproportionate increase in the numbers of biological females seeking treatment.

In her foreword, Dr Cass states: "This Review is not about defining what it means to be trans, nor is it about undermining the validity of trans identities, challenging the right of people to express

themselves, or rolling back on people's rights to healthcare. It is about what the healthcare approach should be, and how best to help the growing number of children and young people who are looking for support from the NHS in relation to their gender identity." This means that the Review concerns itself, among other things, with looking at the healthcare approach that children and young people should receive. In principle, the Cass Review is not against the option of medical transition for children and young people. However, it provides much data and analysis showing the notable lack of rigorous science underlying this field of healthcare, and a failure in demonstrating that the medical interventions (puberty blockers and/or sex change hormones) are both safe and effective.

3. What steps were taken following the interim report?

Following much public controversy, GIDS was decommissioned in March 2024. In its place, eight new regional centres based within children's hospitals are planned across the country over the next two years. To date, two such centres for children and young people have been set up. Previously, GIDS operated only in London and Leeds. The idea behind establishing these new centres in different geographical locations across England is designed to manage the huge increase in referrals.

4. What are some of the Review's key findings on:

Among its many findings and recommendations, these are a few of the most important ones:

Puberty blockers

The original rationale behind puberty suppression was primarily about 'buying time'. The theory is that a child is given extra time to explore the issue of their identity, so that any later decision about gender transition may be taken with more apparent confidence. This belief is rejected by the Review: "… given that the vast majority of young people started on puberty blockers proceed from puberty blockers to masculinising/ feminising hormones, there is no evidence that puberty blockers buy time to think …"[12]

Shortly before the final Cass report was published, NHS England announced it would stop the routine prescribing of puberty blockers.[13] They stated: "We have concluded that there is not enough evidence to support the safety or clinical effectiveness of PSH [puberty suppressing hormones] to make the treatment routinely available at this time."

Prior to the report's publication, it was already feared that administering puberty blockers to children had become the dominant response to treatment. The Review states how: "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. The intent of psychosocial 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 or not the young person subsequently proceeds on a medical pathway."[14]

Dr Cass, citing key research that informed the Review's findings, states that while puberty blockers do the job of suppressing puberty, they also compromise bone density. She notes that the research into the use of these drugs found "no changes in gender dysphoria or body satisfaction". There was, she said, "insufficient/inconsistent evidence about the effects of puberty suppression on psychological or psychosocial wellbeing, cognitive development, cardio-metabolic risk or fertility." This distinct verdict will help validate the concerns previously voiced by parents and scientists alike, while disappointing those who saw these treatments as a panacea to all their woes.

In 2023, the Review advised NHS England that, due to the potential risks to neurocognitive development, psychosexual development and longer-term bone health, and limited benefits in narrow

contexts, puberty blockers should only be offered under a research protocol. In her final report, Dr Cass notes that this recommendation has since been implemented. This now means that only in very limited and rare cases, can puberty blockers be used for children, and if used, must form part of a stringent research framework. While this move has not totally ended the practice, the overall shift in pausing routine use of these drugs is a hugely positive and welcome step. Children will now be better safeguarded from harm.

Currently, the NHS prescribes puberty blockers to less than one hundred children.[15] VfJUK understands that some or all of these children began receiving this treatment prior to the new NHS England rules that ended their use.

Sex change hormones

The Cass Review recommends that while the use of sex change hormones is still available from the age of 16, there should be an "extremely cautious clinical approach and a strong clinical rationale for providing hormones before the age of 18." This position is to be welcomed and marks a huge policy shift. While there are continuing concerns about older adolescents still being in receipt of these risky treatments, the net of eligible young people who receive sex change hormones has narrowed considerably and this will safeguard children from harm.

Autism and mental health

The Review recommends the need for children and young people who present with gender issues to be screened for "neurodevelopmental conditions, including autism spectrum disorder, and a mental health assessment."[16] Studies have shown notable correlations between autism and gender dysphoria. What is unknown is whether the issues around gender incongruence in certain patients are caused by or merely linked to their autism or not.

Multiple studies also demonstrate the relationship between poor mental health and transgender issues/identity. Put simply, the Review understands that when a child or young person experiences gender problems, this should not automatically be viewed as transgenderism. Rather, this may be the result of other, pre-existing psychological problems not connected to gender identity. If this is the case, the Review notes that such a child or young person may benefit from other support not involving 'transition'. Again, this position is to be welcomed. Children and young people should, for example, be given therapy, if this is sought.

Scientific evidence supporting gender transition treatment

In her interim report, Dr Cass stated that: "The Review is not able to provide definitive advice on the use of puberty blockers and feminising/masculinising hormones at this stage, due to gaps in the evidence base."[17] In her final report, disappointment is expressed by the "lack of evidence on the long-term impact of taking hormones from an early age…".[18] The Review notes the "lack of high-quality evidence" in the treatments offered to children and young people who experience gender dysphoria.

Dr Cass notes that adult gender service providers declined to cooperate with University of York researchers. The University was commissioned by the Review to conduct its own extensive reviews of the existing science to help inform the Review's recommendations. More recently, these service providers have relented and are now ready to cooperate.[19] Inevitably, this obstruction handicapped some of Dr Cass's efforts in being able to fully assess the data connected to youth and gender-related healthcare.

Explaining the problems involved in producing good-quality research, she says: “This is an area of remarkably weak evidence, and yet results of studies are exaggerated or misrepresented by people on all sides of the debate to support their viewpoint. The reality is that we have no good evidence on the long-term outcomes of interventions to manage gender related distress.” She goes on to explain how it “often takes many years before strongly positive research findings are incorporated into practice.”[20]

Dr Cass highlights a single Dutch study called the “Dutch Protocol” that initially suggested puberty blockers may improve the psychological wellbeing of gender dysphoric children but only for a narrowly defined group. Based on this single study, she explains that the practice spread rapidly to other countries, following which sex change hormones were administered to mid-teens. It should be noted that the pool of adolescents eventually receiving these hormones was far wider than that allowed for by the original criteria established by the Dutch study. Dr Cass explains how some practitioners subsequently abandoned the normal clinical approaches that would normally be expected for patients. In other words, the professional standards applied to trans patients enabling them to transition were lowered.

Of the University of York’s findings, Dr Cass concludes that their “systematic reviews demonstrated poor study design, inadequate follow-up periods and a lack of objectivity in reporting of results.” It is also concluded that evidence for the uses of puberty blockers and sex change hormones in adolescents are “unproven and benefits/harms are unknown.”[21]

Dr Cass rightly recognises that it’s insufficient for a child or young person to be informed about the risks involved in medical transition, thus enabling them to give their consent to treatment. She highlights that adolescence is a dynamic, unsettled period and explains: “The duty of information disclosure is complicated by many ‘unknown unknowns’ about the long-term impacts of puberty blockers and/or masculinising/feminising hormone during a dynamic developmental period when gender identity may not be settled.”[22]

What does Dr Cass say about social transition in children and young people? This is when someone may adopt changes to their name, pronoun, clothing and hair. Social transition may lead to medical transition involving some or all of the potential medical and/or surgical interventions that are possible for a legal change of gender.

The University of York found in their systematic review of the publications on this topic that there was no clear evidence that childhood social transition provides either negative or positive outcomes for mental health. The further found there was weak evidence for any effect in adolescence. But notably, Dr Cass states that children “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.”[23] However, she explains that it is not possible to know whether the studies show that social transition was “causative” in leading to medical transition.

While acknowledging that these are the current conclusions of the Review, VfJUK understands that in order to ensure children are fully safeguarded from harm, social transition should not be encouraged in children. We should note that current Department for Education draft guidance on gender questioning children in schools and colleges states there is no general duty to allow a child to ‘social transition’.[24] Furthermore, the guidance recognises that parents should not be excluded from decisions taken by schools or colleges connected to a child’s request to socially transition, and that there should be a period of ‘watchful waiting’ before requests may be acted upon.

Unfortunately, the Review fails to issue advice against childhood social transition: "Avoiding premature decisions and considering partial rather than full transitioning can be a way of ensuring flexibility and keeping options open until the developmental trajectory becomes clearer.[25]

People will inevitably be asking what criteria GIDS used when referral decisions were made to administer puberty blockers or sex change hormones to children or young people. The scandalous verdict reached by Dr Cass is stated in a matter of fact, undramatic way: "The Review was unable to obtain clear criteria from the GIDS team on their criteria for referral for endocrine [hormonal] intervention."[26]

Dr Cass states: "Nobody should feel the need to invalidate their own experience for fear it reflects badly on other identities and choices." Her statement seems capable of meaning three different things. First, for people who identify as trans, their right to this identity should not be seen to invalidate the paths of others for whom the trans identity is not for them. Second, a person with gender dysphoria has the right not to choose the trans identity and others should not assume automatically they are trans. Third, some people who went through the trans journey but now believe that this was a mistake, and are working to come to terms with what they see as their real identity, namely, they seek to align themselves with their biological sex.

A common narrative that has gained traction is that unless transgendered youth receive gender affirming treatment, they will be at higher risk of suicide. The Review points out that there is no evidence to support this position, and while suicide rates of trans youth is above the national average, the Review demonstrates that there is a range of other complex psychological factors indicative of mental illness that could account for this.

Recently, Prof Sir Louis Appleby, the government's adviser on suicide prevention responded to the claim made by activists that, unless children are allowed to change gender, they will be at risk of suicide. He said: "Invoking suicide in this debate is mistaken and potentially harmful."[27]

Detransitioners

Dr Cass appears to recognise that the trans identity is not a fixed phenomenon, at least for some people: "Young people's sense of identity is not always fixed and may evolve over time." She offers caution to those who reject the 'watchful waiting' approach: "Whilst some young people may feel an urgency to transition, young adults looking back at their younger selves would often advise slowing down."

Dr Cass advises: "For some, the best outcome will be transition, whereas others may resolve their distress in other ways. Some may transition and then de/retransition and/or experience regret. The NHS needs to care for all those seeking support." Detransitioners are those who now regret their earlier gender transition. Typically, they say they were not told about the full health risks and harms following the administering of puberty blockers and/or sex change hormones. In other cases, these risks and harms may have been conveyed to them, but they now believe they were unable to consent because they were too young, cognitively immature and vulnerable, enabling them to make life-changing decisions. In general, detransitioners believe that the experts failed them in not 'pausing' the transition process, and therefore acted irresponsibly.

It is to be welcomed that the Review recognises this population of people who regret their earlier transition decision. By contrast, trans activists are at pains to deny or make light of the validity of such experiences. Sometimes activists deny the existence of this group of people altogether, arguing that: "they were not really trans in the first place." The undeniable reality is that, increasingly, voices of

detransitioners are growing. The game-changer is that mainstream news media are now willing to report on their experiences of pain, regret and feelings of betrayal from the experts who failed to safeguard their patients.

Dr Cass recommends that detransitioners must be given support if they seek help. This apparently positive step is problematic for two main reasons. First, feeling betrayed by the experts, many detransitioners often feel they can no longer trust these same experts who previously helped ruin their life and, therefore, are unable to now help them reclaim what they see as their true identity.

Such a reversal process may involve having to live with the painful realisation of an unwanted mastectomy and removal of a vagina for a woman; while for a man, his penis and scrotum may have been surgically removed and replaced with a cosmetic 'vagina'. Legally, surgical interventions can only be performed on those aged 18 and above.

Those undermining or making light of the experiences of detransitioners should note the knowledge gap cited by the Review: "… many clinicians who the Review has spoken to nationally and internationally have stated that they are unable to reliably predict which children/young people will transition successfully and which might regret or detransition at a later date.[28] This uncertain endorsement of success rates is another reminder how this field of healthcare is filled with doubt.

Loss of Fertility

The Review does not highlight the question of fertility as part of its findings. However, within the wider body of the Review, it cites "fertility preservation" as an answer to the problem of not losing fertility for people who go through medical transition. For people considering the medical gender-transition path, there are major pitfalls because of multiple legal rules, plus little-known medical factors. There are also financial costs involved in the storage of eggs or sperm, paid for by the NHS or the individual. Before July 2022, egg or sperm could be stored for up to 10 years. The new rules have extended this limit to 55 years.[29]

What remains unknown is whether egg or sperm quality is damaged during decades-long storage. Officially, this process is deemed safe. What is known is that frozen eggs that are later used for a potential pregnancy see a low success rate. Depending on which stage of fertility treatment is cited, success rates vary between one in every hundred to one in five.[30] Alongside this, the process of IVF resulting in a live birth has, according to the NHS, a varying success rate: for women aged under 35, this is 32%, but success rates plummet to 4% for women aged over 44.[31]

Dr Cass stops short of recommending an outright ban on medical interventions for under 18s, but advises caution: "The option to provide masculinising/feminising hormones from the age of 16 is available, but the Review would recommend an extremely cautious clinical approach and a strong clinical rationale for providing hormones before the age of 18. This would keep options open during this important developmental window, allowing time for management of any co-occurring conditions, building of resilience, and fertility preservation, if required."

5. What is the Review's 'stance' on trans issues?

Dr Cass states that the report's focus is on the clinical services for children and young people who seek help for their gender-related distress, and it's not the Review's role to take a position on the beliefs underpinning cultural and societal debates. The Review is independent of the NHS and Government.

Dr Cass is not against the principle that children and young people may receive medical transition 'treatment' though this may only be in done exceptional cases, as noted earlier. In this sense, she is

open in principle to a gender-affirmative stance that leads to transition but because the current science is inadequate, the Review stops short of endorsing an outright permissive approach.

She provides an overview[32] of the people she consulted as part of her work for this report: trans adults who, she says, are "leading positive and successful lives, and feeling empowered by having made the decision to transition." Then there are detransitioners, and the "many parents, with very different perspectives." Included here are parents who, she says, fought to get their child onto a medical pathway, as well as parents who felt this path was the wrong decision. She notes how some parents were dismayed by actions taken without their consent.

Dr Cass also consulted clinicians and academics holding a range of opinions: from those who believe that medical transition should be available at an early stage, to those who "feel that we are medicalising children and young people whose multiple other difficulties are manifesting through gender confusion and gender-related distress."

Whatever side of the fence one stands, it is clear that Dr Cass seeks to convince the reader that all stakeholders have been listened to: "One thing unites all these people; they all believe passionately in what they have told me, and those with either parental or clinical responsibility for children and young people are trying their very best to do what they feel is the right thing to support them."

One of the Review's primary concerns is that, whatever treatment is offered, it's done according to what she sees as a sound and safe, scientific foundation. Also, much of her report focuses on what sort of professional oversight must be developed so that professional standards remain high, and on a par with other fields of healthcare. In other words, there should not be different standards for healthcare when it comes to trans issues.

Interestingly, the Review recognises the pressures from transgender activists, who seek to limit or erase rules of medical oversight and place the onus of decision-making about gender treatment solely with the person it concerns. The Review states: "Although some think the clinical approach should be based on a social justice model, the NHS works in an evidence-based way." Dr Cass is stating that the framework within which the subject of gender can be addressed can only be evidence-based, as opposed to ideological and driven by social justice. It should be noted that what she or other professionals may deem as "evidence-based" is not itself in a vacuum, but will inevitably be guided by a worldview or ideology.

In her interim report, Dr Cass stated that the act of social transition is "not a neutral act".[33] She added that: "It should also be recognised that 'doing nothing' cannot be considered a neutral act." True, doing nothing, as she puts it, isn't neutral. However, while a child should have opportunities to receive therapeutic support for gender dysphoria if required, 'doing nothing' medically should not be deemed negative, but safeguarding a child from lifelong, medical harms, both known and unknown. VfJUK believes that safeguarding should always be paramount in all situations.

6. What is the legal status of the Review's recommendations?

Dr Cass's recommendations are not law per se. However, there is a clear professional expectation that all practitioners will abide by its recommendations. The nature and effect of the recommendations make it similar to professional guidance. Therefore, failure to comply with the Review's recommendations and standards for patient safety will likely be treated by a court as unlawful. Courts normally uphold professional standards and official professional positions established by medical authorities.

7. Aren't adolescents too immature to make life-changing, medically risky and irreversible decisions?

Dr Cass recognises that, contrary to previous conventional wisdom, the teenage brain does not stop developing in adolescence but continues into the mid-twenties.[34] Therefore, given the lack of adolescent brain maturity, the question remains: should life-changing, irreversible medical decisions around gender transition ever be permitted for children and young people?

It is natural for children and young people to explore their sense of identity and, during this journey, to also experience doubt and vulnerability about who they are and what their place will be in the world. And their brain, because it is undergoing maturation, has yet to fully master risk-taking. Therefore, even when a child is informed about the known and unknown medical risks of transition, awareness of this knowledge is insufficient, because their brains are not yet developed enough adequately to assess the risks involved.

The NHS already warns about the medical harms, and the known and unknown risks of medical interventions: "Little is known about the long-term side effects of hormone or puberty blockers in children with gender dysphoria."[35] The NHS further warns that common risks of long-term cross-sex 'hormone treatment' include: blood clots, gallstones, weight gain, acne, dyslipidaemia (abnormal levels of fat in the blood), elevated liver enzymes, polycythaemia (high concentration of red blood cells) and hair loss or balding.[36] The NHS also gives warnings about infertility: "Long-term cross-sex hormone treatment may also lead, eventually, to infertility, even if treatment is stopped."[37] There are also risks of osteoporosis and bone fracture.[38]

8. What about free speech?

Sadly, but unsurprisingly, Dr Cass states: "There are few other areas of healthcare where professionals are so afraid to openly discuss their views, where people are vilified on social media, and where name-calling echoes the worst bullying behaviour. This must stop."[39] Since the Review's publication, Dr Cass has been subjected to abuse and threats.[40] While online platforms include uncivil behaviour inevitably coming from all ends of the spectrum, it goes without saying that future research that seeks to highlight the medical harms of transition will be challenging to produce, given the intimidation scientists may be subjected to online, e.g. being accused of transphobia. This is clearly an area of research that is unlike any other, and unfortunately, child welfare gets 'caught in the crossfire'.

Sources

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[5] https://cass.independent-review.uk/
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[7] In her report, Dr Cass uses the terms 'gender dysphoria' and 'gender incongruence'. Both have similar meanings. She also uses the term, 'gender-related distress'. The World Health Organization defines gender incongruence

as “a marked and persistent incongruence between an individual’s experienced gender and the assigned sex”. See pp. 18-19.
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[34] p. 102.
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