When can a child consent to medical transition?

Questions for the legal, medical and social work professions.
Summary

Over recent years, considerable debate has arisen over the efficacy and consequences of medical intervention which aims to allow ‘gender dysphoric’ children to ‘transition’ from the body into which they were born, to better reflect their perceived ‘gender identity’.

The criteria used in DSM-5 to identify Gender Dysphoria requires “clinically significant distress or impairment in . . . important areas of functioning” such as social, school, or occupational settings. While hormonal and surgical procedures may enable some to “pass” as the opposite sex, such procedures bring physical, psychological, and social risks. There is no procedure that can enable an individual to perform the reproductive role of the opposite sex.

The Tavistock appealed in June 2021 and the judgment of the Court of Appeal upheld the Tavistock’s appeal on 17 September. Given this judgment it is important for others to understand how we got here, and where we might go.

Regardless of the decision on appeal, the concern remains that this treatment is simply unlike any other. There are varying views about both the cause of gender dysphoria and what response it requires. The evidence of long-term positive outcomes for children who medically transition is sparse and the majority of children diagnosed will in fact ‘desist’ by puberty or adulthood if not treated. There is no current test to distinguish children who will desist from those who will not.

A policy of ‘affirmation’ has become cemented over time, which focuses on medical/human rights arguments, but diminishes the importance of therapeutic intervention and the evidence of social contagion, which is demonstrated by the sudden increase of child and adolescent gender dysphoria over the last twenty years in North America and Europe. Attempts to challenge this policy are often met with accusations of ‘bigotry’ or ‘transphobia’.

The signs are hopeful now of more general willingness and openness to discuss these very important issues. The Cass Review was commissioned in 2020 to carry out an independent review into gender identity services for young people. Its terms of reference focus on the assessment, diagnosis and care of children with gender incongruence and will be wide ranging in scope.

We wish to assist the debate by examining what has been said up until now about children’s ability to consent to such treatment and what we suggest is important for all to keep in mind, including clinicians, social workers, lawyers parents and children. We conclude by suggesting a way forward for the treatment of ‘gender non-conforming’ children, which must be based on the fundamental principle of ‘first do no harm’ and must allow for open and transparent discussion.

We shall examine

1. Child development and ability to consent
2. The legal test for a child’s consent
3. The environment in which the legal test operates
4. Keira Bell – the initial judicial review and appeal
5. How we assess children’s competence to consent to medical transition

When can a child consent to medical transition?
What does research on child development say about their understanding of ‘gender identity’ and ability to consent?

We use the definitions for sex and gender from the WHO.

... Sex, which refers to the different biological and physiological characteristics of females, males and intersex persons, such as chromosomes, hormones and reproductive organs

Gender refers to the socially constructed characteristics of women and men, such as norms, roles, and relationships of and between groups of women and men. It varies from society to society and can be changed.”

Brunskell-Evans argues that the suggestion children have some innate sense of ‘gender identity’ which is fixed at an early age is an ideological one. It is not supported by the findings of specialists in child development, who note that the sense and understanding of sex and gender develops and matures as the child does.

That a child has a fixed gender identity is at the core of the treatment model for gender dysphoric children, aka, “trans” children as practiced in the UK and USA. This concept underpins the gender affirmation treatment model because, if it is generally and erroneously accepted that the gender identity of the child is immutable, it allows for the possibility that the gender dysphoria that accompanies this fixed gender is also a fixed and permanent part of childhood, rather than being a condition that will naturally desist as the child matures. The fallacy of the fixed gender identity then allows the argument that the child needs medical treatment for this permanent, disabling medical condition.

If a child is not born with a gender identity where does it originate? The WHO definition of gender, as a social construct, gives a clue. As a construct the child adapts to ‘gender’ by taking on parts which fit at different times in their development. Fortunately, how this process occurs has been studied for many decades by child development scientists and from this empirical research a clear narrative has evolved about how a child’s sense of gender develops as they grow up.

Jean Piaget – continuous adaptation and schemas

S.A. McLeod provides a useful summary of Piaget’s theory:

Jean Piaget’s theory of cognitive development suggests that intelligence changes as children grow. A child’s cognitive development is not just about acquiring knowledge, the child has to develop or construct a mental model of the world. Cognitive development occurs through the interaction of innate capacities and environmental events, and children pass through a series of stages.

Piaget noted 4 distinct stages of a child’s developing cognition, from birth to about 24 months, from aged 2-7, from 7-11 and ages 12 and up.

For Piaget the child was a key actor in their own development and a child’s sense of their own gender (their gender schema) would go through the process of adaptation when new information that was relevant to gender entered their world. This new information would require assimilation. Then the processes of accommodation, equilibration and equilibrium would take place. Thus the child’s schema of their own gender is a constantly evolving cycle of adaptation as the mind responds to new information.

Lawrence Kohlberg’s Theory of Gender Development

The following extracts have been taken from An Overview of Gender Constancy by Arlin Cuncic. She explains Kohlberg’s use of the idea of schema:

A gender schema model proposes that children develop their gender identity (sic) through internal motivation to conform to what society expects based on their biological sex. However, Kohlberg argued that this motivation was first dependent on the child passing through a number of stages of cognitive development.
This pattern of cognitive development was seen to take place between the ages of two and seven years old, during which time children grow to understand that their sex cannot be changed. Once children reach this stage of development, Kohlberg argued that they would be motivated to watch how they were expected to behave and act in accordance with that gender role. In this way, Kohlberg maintained that children would not develop an understanding of gender roles until they had learned that sex remains constant throughout life.

**Stage 1: Gender labelling (by age 3)**

In the gender labelling stage, children can say whether they are a girl or boy as well as the gender of other people. However, they do not understand that this is a characteristic that can't change over time, like the length of someone's hair or the clothes that they are wearing.

**Stage 2: Gender stability (by age 5)**

In the gender stability stage, children start to realize that boys will grow up to be dads and girls grow up to be moms, etc. However, they still don't understand that gender can't be changed by changes in appearance or choice of activities.

**Stage 3: Gender constancy (by age 7)**

By about age 6 or 7, children begin to understand that sex is permanent across situations and over time. Once they develop this understanding, they begin to act as members of their sex.

As Katie Alcock comments, until about the age of 7, most children think that if something changes its appearance, its underlying reality changes too.

The ‘social learning approach’ is also of interest, which suggests that children’s gender development is a product of their social experiences. This theoretical approach focuses on reinforcement of gender-typed behaviour by parents and peers, and on children’s observation of gender stereotypes in the world around them. Again this is a highly dynamic framework for gender development and explains how social experiences can quickly impact on the sense of gender. This theme is explored by Lisa Littman in her paper on Rapid Onset Gender Dysphoria.

We have seen that there is wide agreement, across different models, over many decades and in different countries, that a child’s sense of their own gender develops in line with their body and their mind throughout childhood and adolescence. The sense of gender is not detached from other processes of maturation, it is intricately bound in with them. There is nothing fixed about the sense of gender at all, instead the process of developing a sense of one’s own gender is incredibly dynamic and is subject to all kinds of changes and influences – both internal and external.

We echo the words of Drs Hutchinson and Midgen:

On the other hand is the belief that no one has a gender identity that is discrete and separate from the rest of their identity/personality. The body we are born into is, therefore, just that. People with gender dysphoria usually exist within a healthy body, regardless of how they feel about it. From this position, the gender identity, however conceptualised, must have been formed through the developmental processes that the young person has undergone. If we believe this, then the only sane and morally congruent way to alleviate the distress is to explore their past and ongoing developmental processes in order to help them make sense of, and influence, their distressing feelings. We would consider the use of therapy to help alleviate this distress as virtually mandatory, as this is what we usually apply to distress. From this position, it would be unethical to intervene at the level of the physical body at all, as this is not the problematic feature.
What is the legal test for a child to consent to medical treatment?

The approach of the law mirrors the findings with regard to the developmental stages of children discussed above. The age and understanding of the child is directly relevant to the child’s ability to consent to medical treatment.

The Family Law Reform Act 1969 provides that children aged 16 and over are presumed to be able to consent to treatment as if they were an adult, although this presumption can be rebutted; for example court has been willing to intervene in cases of older teenagers who have refused life-saving treatment.

When considering children under 16, it is uncontroversial to state that very young children are unable to consent to anything beyond simple day to day decisions about what they would like to eat or wear, as they simply have not developed sufficient cognitive ability to weigh and understand information.

Most neuro typical children will develop greater abilities to retain and weigh information as they grow and mature. By their teenage years we would expect children to have the capacity to make increasingly serious decisions, reflecting the ‘formal operational stage’ of their development as identified by Piaget.

However, the greater cognitive capacity of the adolescent also has to be seen in light of the particular potential emotional vulnerability of this cohort. For example, see the case of London Borough Tower Hamlets v B [2016] EWHC 1707 (Fam) (13 July 2016) in the context of religious radicalisation.

The case of Gillick v West Norfolk and Wisbech AHA [1985] UKHL 7 (17 October 1985) determined that it was lawful for a doctor to prescribe contraception to a child under 16, provided that the child had a proper understanding of what was involved. The court held that the assessment about the child’s competence was fact specific and as they grew in age and understanding, there was a corresponding reduction in the parents’ ability to veto their decisions – what starts with a parental right of control ends with little more than advice. The child’s ability to consent independently of his or her parents has thus become known as ‘Gillick competence’.

It is important to emphasise that assessments of ‘Gillick competence’ are highly fact specific and require careful analysis of both the child, the surrounding circumstances and the nature of the decision to be made. Care must be taken to avoid ‘pre-loading’ any circumstance with an assumption that it is negative or positive, which will inevitably damage the integrity of any assessment.

We argue that there is a danger to children’s welfare when the test of ‘Gillick competence’ is applied in an environment where a variety of lobby groups and charities promote childhood transition as something inherently positive which must not be challenged, only supported.

Some seek to avoid the complexities posed by the issues of children’s malleability, vulnerability to suggestion and capacity to consent, by the simple expedient of making no distinction at all between children under 16 who are Gillick competent and those who are not. For example, in 2019 the legal adviser to the Mermaids charity attempted to erase entirely any distinction between very young children and those with ‘Gillick competence’ by commenting:

….someone’s gender identity, at any age, must be respected. A child identifying as trans, whether it has been submitted this is as a result of harm or not, is identifying as trans and that must be respected throughout proceedings…More often than not, if a child says they are trans, they will be trans.

This view has found favour in a decision of the High Court, Lancashire County Council v TP & Ors (Permission to Withdraw Care Proceedings) [2019] EWFC 30. The Judge found nothing curious about two unrelated children in the same foster care placement, apparently expressing a wish to transition aged 4 and 7. For further discussion of this case and the consequences of failing to consider children’s capacity to consent, see https://www.transgendertrend.com/transgendering-of-preschool-children/
Examination of the environment in which the legal test operates.

We argue there are 3 significant influences on this environment which impact negatively on an objective appraisal of a child’s welfare.

1. The medical treatment offered is potentially irreversible, and there is a lack of a reliable evidence base to support its efficacy.
2. There is a dearth of specialist services and considerable waiting lists.
3. Once a child is referred for treatment, it appears that there is little challenge to or exploration of the wish to transition – this is known as the ‘affirmation path’.

Current NHS advice with regard to puberty blockers and cross sex hormones states that little is known about the long-term side effects of either treatment. Although some claim that puberty blockers are a physically reversible treatment, the psychological effects are not known. There are concerns about potential impact on the brain or bones. For boys, ‘pausing’ puberty may mean they do not develop enough penile or scrotal tissue to undergo later construction of a neo-vagina. Cross sex hormones may cause irreversible changes to the body – such as breast growth or deepening of the voice and temporary or permanent sterility.

The National Institute for Health and Care Excellence (NICE) has concluded that any potential benefits of gender-affirming hormones must be weighed against the largely unknown long-term safety profile of these treatments in children and adolescents with gender dysphoria. Other jurisdictions, such as Sweden, Finland and Australia are also raising concerns about the quality of the available evidence.

There is little doubt that the current specialised NHS service provision for gender variant patients is overwhelmed. Children wait about 18 months just for an initial appointment, and adults wait up to four years. A variety of organisations and charities are therefore lobbying, not unreasonably, for better access to such health care and there is a clear risk that children may turn elsewhere while they wait.

NHS England has responded to issues raised by the Cass Review to establish ‘interim regional professional support services’ to bring together specialists from a range of different clinical backgrounds and looking to co-ordinate transfer to adult services when children reach the age of 17½ years.

This pilot scheme was discussed in the documentary Transitioning Teens in August 2021.

We await the recommendations of the Cass Review, but it seems likely that waiting lists for specialist services for children will remain high for some time to come.

The ‘affirmation path’.

The lack of effective critical evaluation of the affirmation path, or even willingness to engage in any discussion about it, appears to stem from the confluence of a variety of organisations, including parent activists, lobby groups, charities and clinicians in private practice. Some assert that concern over the impact of medical transition on children is simply a disguised and illegitimate attack on the ‘existence and validity’ of gender variant children.

The group Gendered Intelligence claims the reason why some adults are concerned about the decisions children and adolescents make about their own bodies is because “there is an undercurrent in our societal thinking that trans is wrong.”

Watchful waiting’ is seen as ‘doing nothing’. In order to speed up the service for children, there are calls for specialist services to be replaced by GPs, otherwise this is ‘discrimination’ against ‘trans youth’.

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The ‘affirmation’ path was given further impetus in 2017 when a ‘memorandum of understanding’ re ‘conversion therapy’ was signed by all major health, counselling and psychotherapy organisations in the UK, including the NHS, the Royal College of GPs and the UK Council for Psychotherapy. The guidance appears to have been interpreted to prevent any challenge to children who express a wish to transition; even those as young as 6.

Attempts to discuss the guidelines by the ‘Thoughtful Therapists’ organisation were ignored by the signatories after Dr Igi Moon, who took the lead on behalf of the British Psychological Society, directed there should be no response. A petition raising concerns that ‘essential and exploratory’ therapy may end up being criminalised gained over 10,000 signatures in July 2021 and the Government responded to promise a consultation on the issue.

It is a matter of concern that the signatories to the MoU appear to conflate a political position with the welfare of children, particularly when this is considered alongside the growing unease that the recent and rapid surge in children seeking referrals to the Tavistock may indicate at least some element of social contagion, rather than a diagnosis of gender dysphoria. Referrals to the Gender Identity Development Service (GIDS) at the Tavistock have shown a staggering increase in recent years; from just 97 in 2009/10 to 2,519 in 2017/18.

From 2014/15 to 2015/16, referrals increased by over 100% and from 2015/16 to 2016/17 they increased by 41%. Ages at referral seen by the service ranged from 3 to 17 years old. As Transgender Trend commented, the majority of the children were registered female at birth. This is an unexplained ‘flip’ from earlier years, where the majority of children registered were male.

The stark figures about the increase in female referrals have been explained by two experienced clinicians in this way:

_We posit that there are multiple, interweaving factors bearing down on girls and young women that have collided at this particular time causing a distress seemingly related to gender and their sex. These factors comprise both the external world (i.e. the social, political and cultural sphere) and the internal (i.e. the emotional, psychological and subjective). The external and internal interact and feed each other._

Worse than the lack of willingness to investigate these issues, is evidence that such investigations have been actively stalled. A recent example is the legal action brought by Sonia Appleby, the Named Professional for Safeguarding Children and the Safeguarding Children Lead at the Tavistock,

She raised a complaint at an employment tribunal, that Tavistock management directed that safeguarding concerns should not be brought to her attention and clinicians were discouraged from reporting safeguarding concerns to her, over allegations around Ms Appleby’s ‘transphobia’. In September 2021 Ms Appleby was awarded £20K as damages for “significant” injury to her feelings. The tribunal concluded that the trust’s handling of the matter damaged Ms Appleby’s “professional reputation” and “prevented her from proper work on safeguarding”.

So great are the tensions inherent in any attempt to discuss rationally the evidence base for the affirmation approach towards children with gender dysphoria that discussion itself is seen by some as an issue of personal safety.

For example on 12th July 2021 it was reported that a ‘Trans Tool Kit’ written by Stand Against Racism and Inequality (SARI) had been challenged by the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group, who wanted to remove references to the use of hormone blockers in young people, for the document to recognise sex as a protected characteristic and remove the assertion that “doing nothing or delaying treatment CAUSES HARM.”
SARI felt it could no longer contribute to the discussion and no longer sought endorsement from the CCG, claiming that they could now not participate ‘safely’ in any discussions. The Bristol Education Research Group responded to say:

“The CCG would be abdicating its responsibility if it were to endorse the toolkit, which was full of misinformation, biological inaccuracy and lack of regard for women and girls. Many people expressed concerns, including a group of clinicians.”

This inability or unwillingness from the adherents of the ‘affirmation path’ to discuss its possible dangers, suggests there is a serious risk that this will operate to damage or even remove entirely, the effectiveness of any test of Gillick competence, as all ‘gender non-conforming children’ are bundled up into a single cohort. There is clearly a crucial distinction between those children who are diagnosed as ‘gender dysphoric’ and those children who express intermittent or less significant discomfort about their sex or gender identity.

Gender dysphoric children may benefit from serious medical intervention if this alleviates their dysphoria but those children who experience some lesser ‘incongruence’ or rejection of stereotypes, almost certainly won’t. Research suggests between 70-80% of ‘gender non-conforming’ children will not persist with a wish to ‘change sex’ after puberty.

Further, there are also serious concerns that promotion of the ‘affirmation path’ has normalised routes to obtain medication outside of official and regulated structures. Organisations such as Mermaids and the Gender Identity Research and Education Society (GIRES) have been campaigning since 2000 for the NHS to make medication available to ‘gender non-conforming young people’ and to achieve ‘a more benign approach regarding cross-sex hormones and care for young people who have obtained medication from overseas clinics or via the internet’.

Selling prescription-only medication to anyone without a prescription is illegal under the 1968 Medicines Act and carries a maximum custodial sentence of five years. However, in 2018 the Daily Mail investigated one company, Quality Health Inc (QHI), which sold oestrogen via its website with no age checks or consultation. It is still possible for children to get hormones online from unregulated outfits such as Gender GP.

One of the founders of Gender GP is Dr Helen Webberley who was barred from practising in the UK after she was convicted of running an unlicensed practice treating 1,600 transgender patients and gender dysphoric children from her home. She was fined £12,000 in December 2018 after findings that she refused to follow the law and posed a risk to patient safety. Between March 2017 and February 2018 she had operated without a licence after it was refused by watchdog Healthcare Inspectorate Wales. Despite the guidance that cross sex hormones should not be prescribed to children under 16, Dr Webberley provided hormones to children as young as 12.

Her appeal against her initial suspension in 2018 makes for a sobering read. The Tribunal found she had lied to investigators. “She has deeply engrained attitudinal flaws which make it impossible for her to reflect in any real sense. She does not show any recognition of proper governance. She is unsuitable.”

Gender GP claims as one of its founding principles that ‘informed consent is the key to gender affirming care’ but equally that therapy should never be to ‘challenge’ a person’s identity but rather to explore it.

The clear message appears to be that Gender GP operates from a principle of affirmation and that inevitably sits uneasily with a robust assessment of Gillick competence. Of note, are the arguments made on behalf of the Tavistock in its appeal against the High Court decision in Bell; that doctors could be trusted to assess children as they were subject to high standards of regulation and ethics. But that is clearly not true of all doctors who seek to assess in this field. A Tribunal hearing to consider Dr Webberley’s fitness to practice began on 26th July 2021 and is expected to run for 55 days.
Keira Bell – the initial judicial review and the appeal

The judicial review and its declarations

Keira Bell had been prescribed puberty blockers at the age of 16 after a referral to the Tavistock. She went on to take cross sex hormones and when an adult had a double mastectomy in order to complete her ‘transition’ into living as a man. However, she then regretted this treatment and brought judicial review proceedings against the Tavistock to argue that she had not been given sufficient information in order to make an informed decision about transition.

The proliferation of ‘detransitioner’ accounts on social media, predominantly from young women, indicates that Keira Bell’s experience is by no means unique.

The High Court held that in order for a child to be competent to give informed consent to puberty blockers, the child would have to understand, retain and weigh the following information:

- the immediate consequences of the treatment in physical and psychological terms;
- the fact that the vast majority of patients taking puberty blocking drugs proceed to taking cross-sex hormones and are, therefore, on a pathway to much greater medical interventions;
- the relationship between taking cross-sex hormones and subsequent surgery, with the implications of such surgery;
- the fact that cross-sex hormones may well lead to a loss of fertility;
- the impact of cross-sex hormones on sexual function;
- the impact that taking this step on this treatment pathway may have on future and life-long relationships;
- the unknown physical consequences of taking puberty blocking drugs; and
- the fact that the evidence base for this treatment is as yet highly uncertain.

The Court considered that it was ‘highly unlikely’ that a child of 13 years or younger could give informed consent (the youngest patient referred by the Tavistock for puberty blockers was aged 10 years) and ‘doubtful’ whether a child aged 14 or 15 could. Clinicians were advised to consider seeking court authorisation before treating any child, but that position was clarified in AB v CD & Ors [2021] EWHC 741 (Fam). If the child, their parents and the clinician all agreed that treatment was the best course of action then court authorisation was not required.

The Tavistock appealed on the basis that this was an impermissible interference with a child patient’s autonomy and the obligations on professionals to assess capacity and consent, along with the sheer impracticality of the burden placed on clinicians and the courts to hold ‘best interest’ hearings. These arguments found favour with the Court of Appeal.

But if decision making in this area is simply returned to the clinician, the child and the parents – what is the way forward? The very serious issues underscored by the High Court about the lack of compelling evidence to support medical intervention, and the serious and life-long consequences that follow, cannot be ignored.
Suggestions for how we assess children’s competence to consent to medical transition.

The Tavistock has been grappling with these issues for some time – its first internal inquiry into how children were assessed and treated was held in 2005. This recommended more rigorous research and investigation, but such was not forthcoming. As Professors Lemma and Savulescu argue, (see resources below) the exponential rise in transgender identification since that time demands an urgent and ethical response as to how to best treat ‘gender questioning’ children. Simple ‘acceptance’ without exploration may work against a child’s best interests.

We do not doubt that children exist who are deeply distressed by their physical bodies. Some of these children may be helped by medical intervention. However, we believe that these children will be few in number and therefore it is highly doubtful that any automatic assumption about a treatment path is in the child’s best interests or allows for proper assessment of Gillick competence. Proceeding with medical intervention without clarity as to both issues is unethical.

The role of the parents’ consent in place of their child’s must be considered very carefully and there must be an opportunity to investigate the family dynamics, in particular the child’s relationship with parents and siblings, along with an understanding of any existing co-morbidities. As Professor Levine noted in 2020:

A 2017 study from the Boston Children’s Hospital Gender Management Service program - 23 - reported that: “Consistent with the data reported from other sites, this investigation documented that 43.3% of patients presenting for services had significant psychiatric history, with 37.1% having been prescribed psychotropic medications, 20.6% with a history of self-injurious behavior, 9.3% with a prior psychiatric hospitalization, and 9.3% with a history of suicide attempts.”

As Marcus and Sue Evans commented in 2021, a ‘rigid one-size-fits-all’ affirmative approach is unhelpful and patients need services which are ‘insulated’ from political activism. All children are likely to benefit from “a psychotherapeutic model that provides a process of psychological exploration, in which an individual’s personality structure, beliefs, defence mechanisms, and motivations are assessed and examined in a supportive environment.”

We await the recommendations of the Cass Review and hope that they will echo the need for ‘talking therapies’ to assume a greater importance than simply a model of affirmation. This will no doubt place an even greater strain on the existing specialist facilities for ‘gender diverse’ children but we are concerned that the long term impacts of continuing down the ‘affirmation path’ will be extremely serious and investment in our children’s mental health must be a priority.

Keira Bell was ‘affirmed’ as a boy at the Tavistock GIDS, with no exploration of underlying factors which may have led to her gender dysphoria. Thus the ‘affirmative care’ model in itself withholds from the child the very information they need in order to give informed consent; providing only a pre-assumed certainty about the individual child’s motivation and self-understanding and precluding alternative interpretations which may be useful for the child.

Any future treatment should be centred around the developmental phases of children. It must be based upon evidence and there is no reason to revert to experimental treatments. Practitioners and clinics should reflect on the ruling of the original judges in the Bell case, even though the Court of Appeal has rejected the requirement for court intervention to sanction medical intervention. The key intervention must become evidence based therapeutic approaches. Only when it is evidence, rather than ideology, that underpins practice, can we honestly say our approach to treatment of gender dysphoria is driven by the premise “first, do no harm.”
Further resources

Age at which child can access transgender hormone therapy in Europe 2017

‘First Do No Harm’ May 2019 presentation at the House of Lords
https://2d3aa506-25d9-4c0d-b140-7d13f421f96.filesusr.com/ugd/1b54b4_32788a07d22f4fa59e2cab0dfc6971cf.pdf

For discussion about the research in this area on the efficacy of the current treatment regimes, see Jesse Singal “How Science-Based Medicine Botched Its Coverage Of The Youth Gender Medicine Debate”

For an examination of the history of the drive to increase children’s access to puberty blockers and cross sex hormones, see Michael Biggs investigation in 2019 ‘The Tavistock’s experiment with puberty blockers’
https://users.ox.ac.uk/~sfos0060/Biggs_ExperimentPubertyBlockers.pdf

Professors Lemma and Savulescu essay in July 2021 in “To be, or not to be? The role of the unconscious in transgender transitioning: identity, autonomy and well-being”
https://jme.bmj.com/content/early/2021/07/29/medethics-2021-107397

National Centre for Health and Care Excellence [NICE] evidence review of puberty blockers
https://www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3fq%3dtransgender%26s%3dDate

NICE Evidence review of Cross Sex Hormones
https://www.evidence.nhs.uk/document?id=2334889&returnUrl=search%3ffrom%3d2021-03-10%26q%3dEvidence%2bReview%26to%3d2021-04-01

Gender Affirming hormones in children and adolescents BMJ 2019

The decline and fall of science based medicine Andy Lewis July 2021

Gender: A Wider Lens podcast. Therapists Sasha Ayad and Stella O’Malley openly consider gender, identity, and transition
https://www.youtube.com/channel/UCP62aWWtIZV1oVnbMhTR8cg

Transgender Trend
https://www.transgendertrend.com/

An organisation of parents, professionals and academics based in the UK who are concerned about the current trend to diagnose children as transgender, including the unprecedented number of teenage girls suddenly self-identifying as ‘trans’ (Rapid Onset Gender Dysphoria or ROGD). See discussion of the teenage brain
https://www.transgendertrend.com/teenage-brain/

Evidence Based Social Work Alliance
https://www.ebswa.org/

A group of social workers committed to evidence-based practice, a process that involves open discussion and professional curiosity.
No child is born in the wrong body