5. Defining and naming themes and subthemes, which provide structure to the analysis
6. Writing up results, providing a narrative summary of the relationship between codes, subthemes and themes, including examples from the data to illustrate the essence of each theme

Identifying sources of evidence

Respondents in some instances included references to articles, publications and web-based material to support their arguments or to signpost to sources of evidence. All references of this type were collated in order to provide a comprehensive list to NHS England as part of the analysis process. This list is provided in Annex B of this report.

Quality Assurance

TONIC is committed to developing and maintaining the highest standards of quality assurance at every stage of our research. Our quality assurance mechanisms for this project were:

- **Sampling**: Our senior analyst conducts regular testing of a representative sample of coded responses by all analysts to ensure quality and accuracy of the analysis completed.
- **Inter-rater reliability**: All analysts receive training and guidance for each analysis project. Results for different analysts analysing similar data sets were compared to guarantee reliability and consistency between different analysts and across the various questions.
- **Controlling for bias**: We put in place a number of research processes to control for and minimise bias in our analysis:
    - All our analysts are qualified to at least degree level in a relevant discipline and receive regular training in thematic analysis, research methods and unconscious bias
    - Our analysis process follows the six steps of thematic analysis, ensuring in our coding practice that each individual response is fully considered in isolation
    - Multiple analysts conducted the analysis, and we conducted tests for inter-rater reliability
    - The draft code frames produced are peer reviewed as part of our quality assurance process, which includes controlling for bias through reflexive practice and group discussions
    - Quoted excerpts from responses used in the report were selected by the lead analyst as being typical examples of the responses containing the specific theme

  These processes combine to create a systematic approach to enhance the reliability and validity of the findings and to ensure that there is no bias in our findings. This is underpinned by the fact that TONIC are an independent research organisation with guiding principles from the British Psychological Society's Code of Ethics and Conduct (2021)[i].

Data cleansing

Prior to analysis taking place, the data cleansing process was carried out in Microsoft Excel in the following ways:

1. **Duplicates**: The raw dataset was assessed for duplicate responses by: examining all IP addresses from which a consultation response was submitted; checking qualitative answers for identically worded responses; and analysing the demographic information provided for similarities and differences.

2. **Blank submissions**: Entirely blank submissions were removed – i.e., responses from those who provided only demographic information but failed to answer any questions. In total, there were five such empty responses.

3. **Blank answers**: Content-free qualitative answers which consisted entirely of comments such as "I don't know", "no comment", "n/a", "yes"/"no" or contained simply hyphens or dots were removed and are not included in the figures illustrating response rates.

Notes on reading the consultation analysis report

Participation in the consultation was on a self-selecting basis. The findings in the report, therefore, carry the unavoidable risk of self-selection bias and are, therefore, not generalisable.

In some cases, analysis of a respondent's data resulted in multiple references to the same theme. This was particularly the case for longer responses. The report generally refers to the number of respondents that replied to a question or that had at least one reference belonging to a given theme within a question. The qualitative analysis drew on all the references coded to a theme.

Results for each of the consultation questions have been reported in line with the consultation headings used in the materials available to respondents.

The order of themes has been determined by the proportion of respondents coded under each coding theme. Themes with the highest number of respondents have been reported first, with all the others in descending order.

It is worth noting that the quantitative results presented in this report should be considered in the context of the accompanying qualitative response themes and explanations, and that the figures, in and of themselves, do not provide a complete picture.

It is worth noting that the number of respondents raising a theme does not necessarily correspond to the importance of the issues being put forward. Response frequencies, therefore, are included solely as a guide, not as an indication of priority.

Unless displayed otherwise percentage figures are rounded to the nearest whole number and therefore may not always add up to 100%.

Section 3. Detailed Summary of Responses

Question 1 – Has all the relevant evidence been taken into account?

This question was answered by 4,036 respondents, with 1,144 (28%) answering "yes" and 2,892 (72%) answering "no".

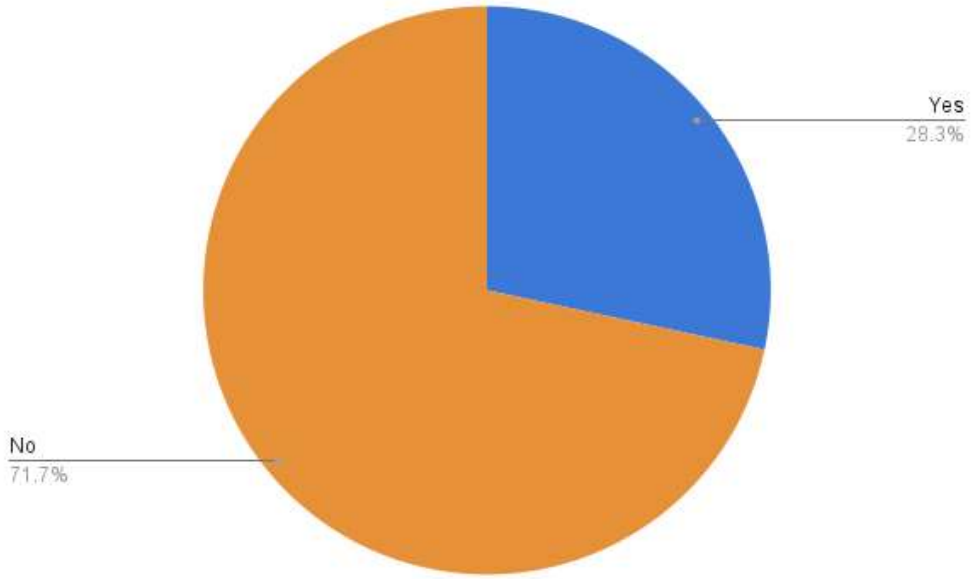

Figure 2. Has all the relevant evidence been considered?

There was some variation among the different respondent groups, with parents, clinicians and family members of transgender children and young people being slightly more likely to agree that all the relevant evidence had been considered, while trans adults, friends/allies, and members of the public were slightly less likely than other groups to agree.

All groups, however, were significantly more likely to state that additional evidence should be considered, as follows:

Table 3. Has all the relevant evidence been considered? by respondent type

Respondent type	Yes	No	Total
Member of the public	238 (23.7%)	768 (76.3%)	1,006
Patient	260 (28.7%)	646 (71.3%)	906
Parent	310 (35.7%)	559 (64.3%)	869
Trans adult	85 (21.5%)	311 (78.5%)	396
Ally	82 (23.4%)	269 (76.6%)	351
Clinician	76 (36.7%)	131 (63.3%)	207
Family	45 (34.6%)	85 (65.4%)	130
Service provider	33 (28.4%)	83 (71.6%)	116
Organisation	15 (27.3%)	40 (72.7%)	55
Total	**1,144 (28.3%)**	**2,892 (71.7%)**	**4,036**

Qualitative (free text) responses

In total, 2,634 respondents provided further detail for why they felt not all the relevant evidence was considered. A large number of references, papers, articles, studies, and other sources were put forward, as well as suggestions and thoughts regarding the evidence NICE had considered, the use of PSH, issues affecting gender dysphoria in general, and the proposed interim clinical policy.

In this question and across all questions the total number of respondents recorded in the theme tables sums to less than the total number who provided an answer. This is due to:

a) not all respondents being identified as belonging to either of the two groups; and

b) not all respondents providing answers that addressed the question.

Where possible, responses which addressed issues unrelated to a particular question have been included in the summary of themes for question 3 (“Any other changes or additions?”).

Summary of themes raised by Group A respondents (n=2,183)

Group A respondents said...	Number
Insufficient studies were included, and many other studies should have been considered	1,065
The primary evidence should come from transgender people and experts in the field	825
Studies which rated PSH positively were ignored	620
There was no evidential review of transgender children who had been denied PSH	486
The review ignores evidence that PSH are used safely for other conditions	312
Evidence and advice from leading international bodies such as WPATH was ignored	310
International studies and studies not in the English language weren't included	112
The review misunderstands the intended purpose or impact of PSH treatment	67
The review lacks data from those treated at Tavistock	31

Insufficient studies were included, and many other studies should have been considered

Almost half of Group A respondents stated that the evidence review should have included significantly more than nine studies and that there existed many good quality studies which should have been included. Some felt that the exclusion criteria were too strict and that any requirement for a qualifying study to include a randomised control group was both inappropriate and unethical for the subject of research into the use of puberty suppressing hormones by children and young people, given that some participants would have been "randomly denied" the treatment they desired.

Some Group A respondents also believed that good quality qualifying studies had been excluded on the grounds that psychological support had also been provided, resulting in PSH treatment not being a single variable. This was considered inappropriate as psychological support would always be deemed essential for this cohort and that it would be unethical to remove it.

Some respondents felt that good quality and informative post-factum studies on transgender adults who had used PSH as children had been unfairly disregarded, as were meta analyses and literature reviews which had shown PSH to be safe and to provide highly positive results for gender dysphoric children and young people. For some Group A respondents this was perceived as representing an aspect of unfair bias which, for them, appeared to be politically motivated and expressly designed to deny PSH treatment to transgender youth – particularly as PSH had been made available for the

treatment of other conditions such as precocious puberty and prostate cancer, yet studies which showed PSH safe for these treatments had not been included.

The primary evidence should come from transgender people and experts in the field

Many Group A respondents believed that decisions about puberty blockers should be informed predominantly by the experiences and perspectives of transgender individuals and experts in the field, expressing concern that the voices of those who have first-hand experience of PSH have not been adequately included in the decision-making process. Respondents believed that social studies and qualitative data should be used to balance the clinical and quantitative evidence predominant in the current review.

Respondents suggested it would be particularly important to engage with transgender adults who had been denied access to puberty blockers during their youth, as this would offer valuable insight into the impact of such denial.

In addition, University College London Hospital Endocrine suggested the use of Patient Reported Outcome Measures (PROMs) to track and measure treatment satisfaction from the patients' perspective.

There was no evidential review of transgender children who had been denied PSH

Group A respondents highlighted the lack of research regarding gender dysphoric children and young people who had been denied treatment with PSH (or otherwise been unable to utilise PSH) and who had therefore entered and gone through an undesired puberty. Respondents believed such studies either did or would show deterioration of mental health, increase in suicide rates, and decrease in overall quality of life – particularly in the cases of biological males who experience more pronounced and difficult to reverse physical changes at puberty.

Respondents suggested that in order to better understand the effects and results of PSH treatment future evidence reviews should include comprehensive comparison studies between those who use PSH and those who opt instead to undergo purely psychological treatment.

International bodies and studies, and non-English language studies were ignored

Many Group A respondents believed that NHS England and the NICE evidence review should have drawn upon work already undertaken by international bodies such as WPATH, ASIAPATH, EPATH, PATHA, and USPATH, highlighting their exclusion and apparent dismissal of international guidelines such as WPATH's Standards of Care (SOC 8) as limiting the insight into effective and safe treatment pathways for transgender youth.

Respondents also felt that the exclusion of non-English language studies omitted important data and raised concerns about the comprehensiveness of the evidence review.

The review misunderstands the intended purpose or impact of PSH treatment

Some Group A respondents felt that the statement "Overall, there was no statistically significant difference in gender incongruence, mental health, body image, and psychosocial functioning in children and adolescents treated with PSH" failed to grasp the intended results of PSH treatment, arguing that PSH treatment is designed as the initial step in a comprehensive treatment plan rather than as a standalone solution.

Respondents emphasised the view that PSH treatment's primary purpose is not to immediately improve mental health or alleviate gender dysphoria in childhood but rather to pause physical changes associated with puberty and allow individuals more time to make informed decisions about further interventions, such as cross-sex hormones and surgeries. Benefits, therefore, may not be immediately visible during childhood but will manifest in adulthood – hence the sentiment that focusing on immediate results and excluding data from transgender adults omits valuable information that may reveal longer-term advantages.

In addition, Group A respondents felt that the review was overly focused on the use of PSH in isolation failing to consider its role as part of a holistic treatment plan. It was argued that the effectiveness of PSH should be evaluated within the context of broader care, including psychological therapy and hormone replacement therapy (HRT).

The review lacks data from those treated at Tavistock

Some Group A respondents highlighted the lack of data from the children and young people who had received PSH treatment through the Gender Identity Development Service (GIDS) at Tavistock. Respondents believed that data from GIDS would contain valuable insights and real-world patient experiences over a long period that should have been integral to a comprehensive evaluation of puberty suppression treatments. The omission of this data was suspected as being due to negative bias and raised doubts regarding the completeness and representativeness of the evidence considered in shaping clinical policies. Respondents again emphasised the importance of inclusive, unbiased evidence reviews that encompassed a diverse range of sources, including those who have been directly involved in the provision of gender-affirming care in England.

Summary of themes raised by Group B respondents (n=123)

Group B respondents said...	Number
The review should include more studies demonstrating harm caused by PSH	114
The review omits animal studies	64
The evidence included is influenced by pro-transgender beliefs	54
The review omits experiential evidence from detransitioners	43
It lacks evidence that researches the causes of gender dysphoria	37
The review lacks evidence that gender dysphoria exists	24
The review does not show the long-term harm of gender-affirming treatments	14
It does not include studies that show that PSH treatment leads to medical transition	10
The review does not include research on the psychological treatment of gender dysphoria	7

The review does not highlight the harms caused by PSH or the importance of puberty

Like Group A respondents, Group B respondents also believed that the evidence review lacked sufficient studies and was not as comprehensive and thorough as it should have been. Group B respondents pointed particularly to what they felt was the review's lack of emphasis on the potential harm caused by PSH and the importance for young people to undergo a natural puberty. Respondents believed that the evidence failed to sufficiently highlight the detrimental effects of

PSH, such as concerns regarding bone density, infertility, and genitourinary issues. The focus on potential harms was underscored by references to warnings issued by the U.S. Food and Drug Administration (FDA) regarding blindness and brain swelling linked to PSH, as well as policy changes in Finland and Sweden.

Group B respondents suggested a number of studies they felt should have been included in the evidence review, including studies of PSH treatment on animals which they believed showed harmful effects such as: reduction in long-term spatial memory; and negative impacts on learning and the development of social behaviours.

The evidence included is influenced by pro-transgender beliefs

Some Group B respondents felt that NICE's evidence review and the interim clinical policy both showed signs of having been influenced by transgender beliefs. Phrases such as 'sex assigned at birth' were felt to be unscientific and raised questions of impartiality, while study authors such as Johanna Olson-Kennedy (considered for the evidence review, but not included) were described as being 'known activists' within the field.

Some respondents also stated that there was no evidence provided to support the existence of gender dysphoria, and that NHS England should 'not be allowed to build clinical practice upon an unevidenced belief that some children are born in the wrong body'.

The review omits experiential evidence from detransitioners

Some Group B respondents felt that the review lacked evidence about and from detransitioners – in particular, regret rates, side effects, and real life experiences of the potential harms of delaying puberty and the claimed reversibility of PSH. Detransitioners' experiences were seen as an essential component in providing a fully rounded picture of the impact and consequences of PSH treatment, as well as many other aspects of gender dysphoria in children and young people.

The review lacks evidence that researches the causes of gender dysphoria

Some Group B respondents felt that the evidence review lacked explorations and analyses of the potential causes of gender dysphoria beyond affirming gender identity, pointing to a deficiency in

research addressing comorbidities such as autism and ADHD, as well as insufficient investigation into social contagion, the role of sexuality (noting that gender dysphoric children often eventually identify as gay), the impact of trauma, the influence of schools, and the dynamics within families and friend circles.

Respondents cited specific studies to support these claims (listed above), as well as historical data from GIDS that was believed to evidence the prevalence of same-sex attraction among gender dysphoric individuals, and the psychological and social challenges in children referred for gender-related concerns.

Also deemed to be lacking were expert witness statements emphasising the effectiveness of talking therapy as a treatment for gender dysphoria.

The review does not show the long-term harm of gender-affirming treatments

Respondents believed that the NICE evidence review omitted evidence on the long-term harms associated with the gender-affirming treatment approach, contending that substantial physical, cognitive, and psychological risks have been shown to outweigh the potential benefits. They believed that the origins of gender dysphoria were psychological and, as such, should not be subject to physical treatment with puberty blockers. It was stated that gender dysphoria is the only disorder where treatment involves affirming a mental health condition, likening this approach to affirming a person with anorexia's body dysmorphia.

It does not include studies that show that PSH treatment leads to medical transition

Some Group B respondents suggested that the review should have included studies that showed that PSH treatment had led to patients progressing to medical transition in cases when they may otherwise have naturally grown out of gender dysphoria. The use of PSH, it was believed, sometimes mistakenly solidified a young person's desire to progress on the path to transition and made it more difficult for them to acknowledge or recognise that their feelings may have changed.

The review does not include research on the psychological treatment of gender dysphoria

Some Group B respondents felt that the evidence review should have included studies and research supporting psychological treatment as the preferred option in cases of gender dysphoria over PSH treatment. They believed that good quality studies had shown that psychological evaluation and counselling resulted in high levels of desistance and resolution of gender dysphoria, and that extensive literature reviews overwhelmingly pointed to underlying psychological and social issues as the causes of gender dysphoria in children and young people.

Summary of themes raised by all respondents

All respondents said...	Number
Other specific evidence should have been included in the review	846
Recent evidence has not been included	36

Recent evidence has not been included

Respondents from both groups proposed that there had been significant new evidence and areas of study undertaken in 2023, and that these papers and analyses should be included in the evidence review given that they are the most up to date and that such important decisions would require the best quality evidence.

Respondents also stated that all new evidence should be monitored as it emerged and incorporated into an ever-evolving clinical policy, until such a time as the position on PSH and other aspects of gender dysphoria treatment was ascertained with certainty.

Suggestions of further references for review

Many respondents suggested papers, studies, articles, websites, books, blogs, videos and news reports that they felt should have been considered in the evidence review. Some of these were studies included in the NICE review and some had been listed by NICE as having been considered but ruled out of inclusion in their review. Many suggestions were opinion pieces and other articles which drew on secondary evidence. However, a total of 73 references, papers, analyses and surveys were suggested. These have been listed and summarised in Appendix B.

Question 2 – Does the equality and health inequality impact assessment (EHIA) reflect the potential impact that may arise as a result of the proposed changes?

This question was answered by 4,035 respondents, with 734 (18%) answering "yes" and 3,001 (82%) answering "no".

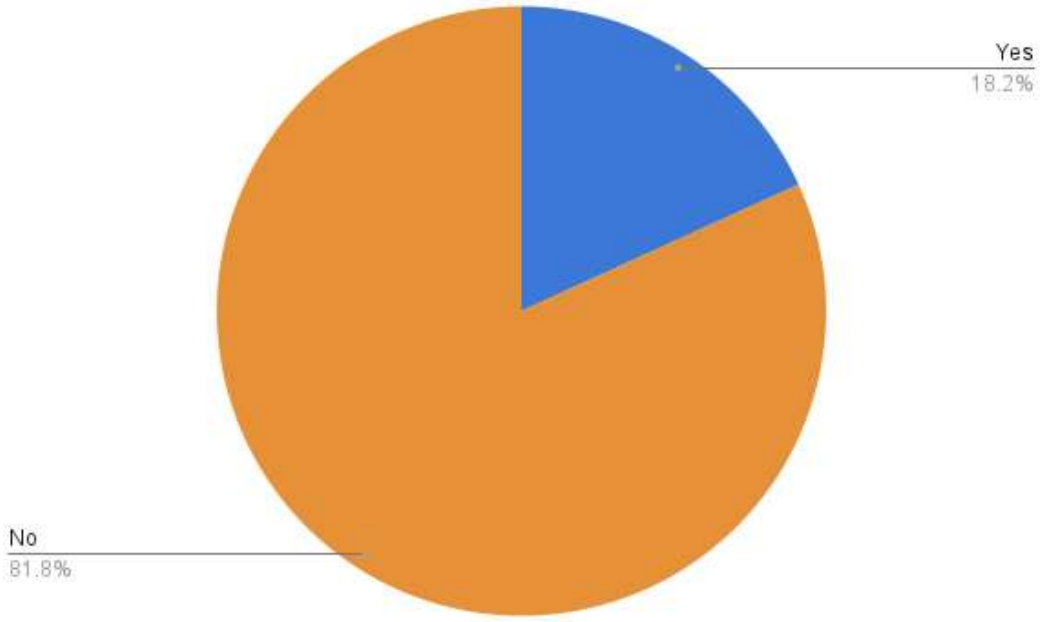

Figure 3. Does the EHIA reflect the potential impact that may arise as a result of the proposed changes?

As in responses to question 1, there was some variation among the different respondent groups, with parents and clinicians somewhat more likely to answer "yes" than other groups, and trans adults and friends/allies significantly more likely to answer "no". In addition, those who responded on behalf of an organisation were much more likely to answer "no" than "yes", with almost 93% believing that the EHIA did not accurately or sufficiently reflect the impact of the proposed changes.

As before, all respondent types were significantly more likely to disagree that the EHIA reflected the impact of the proposed changes, with at least 71% of each group answering "no".

Table 4. Does the EHIA reflect the potential impact that may arise as a result of the proposed changes? by respondent type

Respondent type	Yes	No	Total
Member of the public	149 (14.8%)	856 (85.2%)	1,005
Patient	152 (16.8%)	754 (83.2%)	906
Parent	249 (28.7%)	620 (71.3%)	869
Trans adult	39 (9.8%)	357 (90.2%)	396
Ally	32 (9.1%)	319 (90.9%)	351
Clinician	60 (29%)	147 (71%)	207
Family	26 (20%)	104 (80%)	130
Service provider	23 (19.8%)	93 (80.2%)	116
Organisation	4 (7.3%)	51 (92.7%)	55
Total	**734 (18.2%)**	**3301 (81.8%)**	**4,035**

Qualitative (free text) responses

In total, 2,897 respondents provided qualitative responses to this question, with a large majority (2,444 – 84%) from Group A respondents. Perhaps due to the technical nature of the EHIA, however, a large number of respondents did not directly address the issue of the equality and health inequality impact assessment. The adjusted number of qualitative responses which provided themes and suggestions for this question, therefore, was 2,457.

As above, where possible these responses have been included in the summary of themes for question 3 ("Any other changes or additions?").

Summary of themes raised by Group A respondents (n=2,136)

Group A respondents said...	Number
The EHIA fails to assess the impact on transgender children denied PSH treatment	1641
The requirement for taking part in a research trial is discriminatory	1189
The protected characteristic of gender reassignment is insufficiently addressed	242
It does not acknowledge the income on children from low income homes	175
It fails to address the future impact on transgender children forced to go through puberty	119
The EHIA fails to recognise the impact on patients who will access unregulated sources	119

The EHIA fails to recognise that it denies bodily autonomy	117
Autistic and neurodivergent children and young people are discriminated against	113
The terms 'early onset' and 'late onset' have not been defined	52
The protected characteristic of age is insufficiently addressed	27
There is no mention of how transgender youth of colour will be protected	22
The impact on those currently receiving PSH treatment is not mentioned	20
The EHIA does not mention those from unsupportive families	13
There is no consideration for children and young people with low health literacy	7
The section on sex does not address the additional difficulties faced by biological males	3
The protected characteristic of religion does not address potential negative impacts	2
Homeless transgender youth are not addressed in the assessment	2
There is no plan in place regarding the protected characteristic of pregnancy	1

The EHIA fails to assess the impact on transgender children denied PSH treatment

A large number of Group A respondents believed that the EHIA had failed to assess the potentially significant impact on the physical, emotional and mental health of transgender children who would be denied PSH treatment. They stated that there was no acknowledgement that the proposals of the interim clinical policy would directly affect patients who were already struggling with their mental health and who were at significant risk of self-harm and suicide, and that these changes would likely exacerbate the negative aspects of this situation. These unrecognised negative impacts were seen as having far-reaching consequences which would affect children and young people into their adulthood, potentially requiring treatments decades in the future.

It was noted by some that the equality and health inequality impact assessment had recognised the potential for harm by acknowledging that potential distress may be experienced and that there may be an increase in risk taking behaviour, however the level of acknowledgement was seen as insufficient, understating the seriousness of the issues, and appearing to mitigate that the risks of such harm was acceptable.

Group A respondents also objected to the repeated statement that the potential impact on transgender children and young people would be alleviated by other modes of specialist clinical support being made available. They argued that the assessment should explicitly address the potential negative impact of withdrawing access to PSH treatment, regardless of alternative

treatments, and felt that the reference to other treatments ignored ongoing issues in being able to access healthcare in a timely fashion. Wait lists for such services were predicted to be inordinately lengthy, with backlogs meaning that some young patients would be unable to receive treatment for several years, and beyond the period that they needed it most.

Respondents also noted that there was no mention of the potential impact on those who were currently receiving PSH treatment but who may be forced to stop treatment due to the proposed changes in the clinical policy.

The requirement for taking part in a research trial is discriminatory

Some Group A respondents felt that the requirement to take part in a research trial in order to receive PSH treatment was discriminatory. It was pointed out that other medical treatments do not require participation in a research study and that this policy suggested a form of segregated healthcare that denied bodily autonomy and disproportionately impacted transgender youth. The EHIA's statement that the policy wasn't discriminatory was deemed to be erroneous given the inequality between the healthcare treatment of transgender and non-transgender individuals.

The perception of discrimination was seen as problematic not only in the immediate sense and with regard to the interim clinical policy, but it was also feared that it would contribute to a negative societal impact by sending a message of exclusion that would increase the level of demonisation of transgender people, potentially fuelled by media portrayal.

As above, these impacts and risks were seen as having gone unrecognised in the EHIA.

The terms 'early onset' and 'late onset' have not been defined

Some Group A respondents felt that the statement that "The definition of 'early onset' and 'late onset' will be developed by the clinical study team in due course" meant it was not possible to provide a valid response to questions involving these currently undefined terms. Furthermore, it was believed that there could be no clinical or scientific basis for these terms, and that there could be many independent factors and personal characteristics that would confuse and confound efforts to arrive at such definitions, which did not appear to have been considered. Any definitions arrived at, therefore, would run the risk of being either arbitrary or ill-informed, and would have the potential

consequence of negatively impacting any children and young people who may be denied treatment on the basis of these "arbitrary and unscientific" definitions.

The impact on those currently receiving PSH treatment is not mentioned

Some respondents felt that the EHIA lacked information on how the interim clinical policy would affect patients who are currently being treated with PSH but who may be forced to cease treatment, either due to the policy or due to the individual decisions of their supervising clinicians. They said there was no mention of the potential physical and mental impacts of stopping gonadotropin-releasing hormone agonist (GnHRa) prescriptions suddenly and without a treatment plan based on HRT.

Respondents also wondered whether endocrinologists and other supervising clinicians would receive training in preparation for such scenarios, feeling that any plans for how to deal with these circumstances should already have been put in place and therefore would have featured in the EHIA.

Protected Characteristics

Certain protected characteristic groups were highlighted by Group A respondents as being insufficiently or incorrectly represented and reflected in the EHIA, as follows:

Gender reassignment

Regarding the protected characteristic of gender reassignment, Group A respondents felt that the EHIA misinterpreted the breadth of the characteristic and discriminated against those who had socially transitioned but not medically transitioned. Respondents referenced the Equality Act 2010, which states that "a person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing, or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex". There is, therefore, no requirement for medical treatment to have taken place in order to be covered by the protected characteristic gender reassignment.

Disability

Regarding the protected characteristic of disability, Group A respondents felt that the EHIA had failed to recognise the potential for the interim clinical policy to discriminate against neurodivergent children and young people by unfairly excluding them from research and PSH treatment. There was no case, it was stated, to conclude that those with diagnoses and conditions such as autism, ADHD, learning difficulties, or low IQ would be unable to recognise their own gender identity and make their own decisions, or that they should be denied PSH treatment and steered into purely psychological treatments on the basis that they experienced psychological conditions in conjunction with their sense of gender dysphoria.

Age

Regarding the protected characteristic of age, some respondents felt that the EHIA had not sufficiently reflected on how the interim clinical policy could potentially discriminate against young people by negating their individual autonomy and making the assumption that they aren't capable of knowing themselves or their own minds.

Issues of age were also linked to questions regarding the definitions of 'early onset' and 'late onset' gender dysphoria, and how some transgender youth may be discriminated against because their ages would be unreasonably linked to these so-called "arbitrary definitions" and that they would therefore be impacted by missing out on potentially beneficial treatment.

Some respondents also felt that the EHIA should have mentioned Gillick competency, and how this is viewed and applied by NHS England with regard to transgender children and young people.

Race, pregnancy and religion

Respondents pointed out that there were no mentions of how the protected characteristics of race, pregnancy and religion would be impacted by the interim clinical policy, nor any mentions of plans for how these groups would be recognised and supported.

Sex

Regarding the protected characteristic of sex, it was pointed out that the EHIA had not sufficiently reflected on how the denial of PSH treatment would differently and negatively impact biological males going through undesired puberty (for example, in the development of an Adam's apple, or the deepening of the voice).

Other groups

Some Group A respondents mentioned other vulnerable groups who they felt had been insufficiently reflected in the equality and health inequality impact assessment, but who they believed would be adversely and significantly impacted by the proposed changes to the interim clinical policy. These were:

- Children and young people from low income homes who would be discriminated against because they would not be able to utilise treatments from private clinics available to those from more affluent families.
- Children and young people who, having been denied PSH treatment through NHS England (or being unwilling to enrol in a research trial), would choose to access treatments from unregulated sources, with potentially negative consequences.
- Those who either lived with unsupportive families or who lived outside the family home, who would find it more difficult to access services than those who had the support and encouragement of their adult carers.
- Those who, for a variety of reasons, could be considered to have low health literacy
- Homeless transgender youth, who were seen as particularly vulnerable, but who weren't addressed in the impact assessment.

Summary of themes raised by Group B respondents (n=138)

Group B respondents said...	Number
The protected characteristic of sexual orientation was insufficiently addressed	110
The EHIA doesn't adequately reflect the potential negative impact on children	102
The EHIA does not assess the negative impact of using PSH	86
Those who consider themselves gender reassigned shouldn't be guaranteed treatment	74
Studies on transgender youth in care should be completed before treatment is provided	66
The EHIA fails to reflect the impact of those with autism moving towards transition	65
The language used in the EHIA shows signs of pro-transgender beliefs	30
The disproportionate negative impact on girls is not adequately addressed	27
There is no assessment on how others are impacted by gender affirming treatments	21

Protected Characteristics

Most themes raised by Group B respondents addressed specific protected characteristic groups and how they felt the impact and/or reflection of these groups hadn't been adequately addressed in the equality and health inequality impact assessment.

Sexual Orientation

Most Group B respondents who provided an answer to this question believed that the EHIA had inadequately addressed the impact on the protected characteristic of sexual orientation, considering it a troubling and unusual oversight that NHS England had declared that it did not hold sexual orientation data for transgender children and young people. For many Group B respondents some of the primary causes of gender dysphoria among young people were likely to be internalised homophobic impulses and/or mistaken ideas regarding the expression of human sexuality and gender. Group B respondents tended to believe that a large proportion of gender dysphoric young people would become healthy homosexual or bisexual adults if allowed to develop and evolve naturally, and that there was a significant body of evidence that supported this.

Age

In opposition to Group A respondents who promoted the application of Gillick competency and individual autonomy, Group B respondents tended to feel that children under the age of 16 were too young to be able to make such important decisions, and that decisions around PSH treatment and gender transition should be made by parents, carers, and experienced clinicians. If PSH were made available to children under 16, therefore, it was believed that the protected characteristic of age would be negatively impacted and that this should have been more directly addressed in the EHIA.

Gender reassignment

Some Group B respondents believed that the EHIA had inaccurately described the protected characteristic of gender reassignment, stating that, in terms of statute law, expressing a wish to change sex did not qualify a child under 16 for the protected characteristic.

Some Group B respondents also stated that the Equality Act 2010 does not define gender reassignment in relation to children in its main body, but rather only in explanatory notes, and that the Gender Recognition Act 2005 requires those who undergo gender reassignment to be 18 at minimum, and to have lived as the desired gender for two years.

Some respondents highlighted the claim made in the EHIA that “the majority of individuals who will be impacted by the proposals are likely to have the protected characteristic of gender reassignment” as incompatible with statute law, as outlined above, and as unsupported and unevidenced by objective data.

Some also stated that even if the protected characteristic of gender reassignment was correctly applied this should only ensure that such individuals weren’t unfairly discriminated against, and not that they should be guaranteed treatment.

Young people in care

Some Group B respondents believed that the EHIA had not sufficiently addressed the evidence and research regarding gender dysphoric children and young people who had lived in care, which could lead to a disproportionately negative impact for this group. Respondents believed that the numbers

of transgender youth who lived in care situations was unusually high, and that this therefore suggested that the causes of their gender dysphoria and desire to transition was more likely to be linked to issues such as trauma, unhealthy parental influences, unstable home situations, and other psychological and mental health conditions. More research and study for this group was therefore urged before final decisions are reached.

Disability

Some Group B respondents believed that the protected characteristic of disability had not been fully reflected, particularly with regard to autistic children and young people who, it was felt, were more susceptible than non-autistic children to arrive at the mistaken conclusion that they were transgender and to fix their intentions on transition. According to Group B respondents, such comorbidities and the increased difficulties and risks faced by neurodivergent children and young people should have been more adequately addressed.

Some respondents believed that it is impossible for an autistic person to have a gender identity and, therefore, that they could not experience gender dysphoria. That the EHIA and, apparently, the medical profession has ignored this was seen as discriminatory and in urgent need of review.

Sex

Some respondents felt that the negative impact on young females had not been adequately addressed, and that though the EHIA recognised that more females than males are presenting with gender dysphoria there was not enough acknowledgement of the disparity and potential inequality.

Some respondents also believed that further research into discovering why more females than males currently presented as gender dysphoric was urgently required in order to ensure that young females weren't advanced into treatment for the wrong reasons.

The EHIA does not assess the negative impact of using PSH

Some Group B respondents stated that the EHIA doesn't fully assess or take into account the negative impact and iatrogenic harm of children and young people using puberty suppressing hormones. As mentioned earlier, these perceived and proposed harms included issues with sexual

development and fertility, bone density and physique, and neuro- and psychosocial development, while undergoing puberty was seen as a natural process necessary for physical and mental development.

It was also stated that the EHIA did not acknowledge the increased likelihood of patients who use PSH progressing to a full medical transition route in comparison with those who don't use PSH. Because full medical transition was also seen by Group B respondents as negatively impacting on this cohort, though perhaps in the long-term and in the distant future, it was felt that this should have also been mentioned in the EHIA as a potential negative impact.

The language used in the EHIA shows signs of pro-transgender beliefs

As mentioned in answers to Question 1 with regard to some of the language used in the interim clinical policy, some Group B respondents also highlighted what they considered unscientific and ideological terms such as "sex assigned at birth".

There is no assessment on how others are impacted by gender affirming treatments

Some Group B respondents felt that the EHIA should have reflected on how the interim clinical policy may impact on others – namely, peers, the family of patients, the taxpayer who would ultimately be funding such services, and both young and adult females who may find themselves forced to share previously female-only spaces with biological males, impacting on issues of safety, vulnerability, and comfort.

Summary of themes raised by all respondents

All respondents said...	Number
The potential impact cannot be reflected because the evidence used is inadequate	267
The document and question are unclear	30

The potential impact cannot be reflected because the evidence used is inadequate

A significant number of respondents from both groups believed that it was not possible to accurately comment on the EHIA due to the assessment itself based on inadequate evidence and research.

Respondents argued that the current state of research, particularly regarding the long-term effects of gender-affirming care (including PSH treatment) was insufficient and scientifically questionable.

While some respondents asserted that it was unethical to subject children to drugs without a clear understanding of their safety and long-term effects, others argued that it was unethical to withdraw potentially life-saving treatment without conclusive proof that it causes harm. Likewise, in some cases the same studies were used by both groups to support their points of view (the Dutch Protocol, for example), highlighting that the evidence is inconclusive on which both the interim clinical policy and the equality and health inequality impact assessment were based. Both groups raised concerns regarding the limitations of existing research, selectivity issues, and short follow-up duration.

Ultimately, respondents felt there was a need for a much more robust and comprehensive research base grounded in rigorous scientific evidence before they could deliver an informed and constructive evaluation of the proposed changes and their potential impact.

The document and question are unclear

Some respondents from both groups felt that the EHIA and the question on it lacked clarity and comprehensibility, leaving them frustrated and confused, and unable to provide a meaningful response. Some respondents highlighted the absence of an introduction or explanation of what they were reading and what was expected of them, and it was also stated that they were given scant details regarding the research plan.

Criticism was extended to the use of what was seen as management consultancy language, described as difficult to decipher. The question's wording was challenged as poorly formulated, with some respondents suggesting intentional obfuscation.

Some respondents also felt, given its technical nature and the difficulties in providing meaningful and useful insight, that it was an inappropriate question to pose to the general public, and a waste of taxpayers' money.

Question 3 – Are there any changes or additions you think need to be made to this policy?

In total, 3,333 respondents provided qualitative responses to this question, with 2,724 (81.7%) coming from Group A respondents and 172 (5.2%) from Group B.

As before, not all responses provided information addressing the interim clinical policy, hence the total of the number of respondents adds up to less than the total who provided an answer to the question.

Summary of themes raised by Group A respondents (n=2,613)

Group A respondents said...	Number
The policy should be scrapped and rewritten	1248
The requirement to participate in a research trial is unethical	715
The policy does not address certain risks of harm it may cause to transgender youth	707
The policy should be informed by the lived experiences of transgender people	507
Late/early onset dysphoria are undefined so should not be included in the policy	288
The research trial is poorly designed and will not provide the desired results	120
Transgender healthcare should be available everywhere, not only in specialist clinics	95
The risks of not using PSH should be discussed in the policy	44
The policy should remove harmful terminology that pathologises transgender people	25
It should provide evidence that psychological approaches alone are an effective treatment	12
The requirement for those currently using PSH to desist is misguided	5

The policy should be scrapped and rewritten

Almost half of Group A respondents who submitted an answer to this question opined that the proposed interim clinical policy should not be subject to adjustments but should be stopped, scrapped, and rewritten anew. It was again stated that the underpinning evidence review from NICE was unsoundly selective and unscientific, omitting crucial studies that could have informed a comprehensive understanding of the most successful and beneficial ways to treat gender dysphoric

children and young people, and that these flaws would lead to the arbitrary denial of necessary and harm-preventing treatment for participants.

As in answers to Question 1, Group A respondents put forward what they considered good quality studies that they felt had been unjustly excluded from NICE's review – particularly those excluded due to their inclusion of psychological support, viewed as an inherently essential aspect of treatment that should not be treated as a separate variable.

The proposed interim clinical policy was also criticised for not treating intervention and non-intervention on an equal footing and appearing to wrongly prefer non-intervention and the cessation of services for a hormone treatment that is easily accessible to non-transgender children, such as those with precocious puberty. This was seen as revealing an inherently biased stance, potentially motivated by anti-transgender political considerations, that has resulted in a selective and incomplete evidence review, an underinformed policy-making process, and an inadequate and potentially harmful outcome for gender dysphoric children and young people.

The requirement to participate in a research trial in order to receive treatment is unethical

Many Group A respondents felt that the policy should be changed to remove the insistence on enrolment in a research trial as a prerequisite for accessing treatment. This insistence was seen as coercive and as going against the principles of voluntary participation. In addition, the introduction of the novel diagnostic categories 'early onset gender dysphoria' and 'late onset gender dysphoria' were again noted as being undefined by both NHS England and NICE, while also deviating from established international best practices outlined in WPATH's standards of care. The absence of a solid evidence base for these diagnoses was said to make their use to restrict access to care ethically questionable.

Along with concerns expressed for the treatment and wellbeing of transgender children and young people due to these coercive measures, some Group A respondents felt that the need to conform with a certain diagnosis would lead some gender dysphoric individuals to provide inaccurate information in order to access the care they desired. This was seen as jeopardising the integrity of the research study and undermining the trust between patients and clinicians, impacting the overall quality of care.

Group A respondents believed that participation in the research trial should be free from all aspects of coercion and should align with established ethical principles of voluntary consent, and that it should be open to all who wished to take part, not just those who satisfied certain currently undefined criteria.

The policy does not address certain risks of harm it may cause to transgender youth

A large number of Group A respondents felt that the proposed restriction on providing PSH treatment had failed to adequately address the potential harm it may inflict on transgender youth. Some felt that the requirement for participation in a research trial might lead gender dysphoric children and young people to resort to extreme measures, such as attempting to stunt their own puberty through diet and lifestyle changes, or that they would be much more likely to seek access to unregulated hormone blockers, raising issues for the safety and well-being of those seeking such alternatives.

The lack of access to puberty-suppressing hormones during the research study was identified as a significant risk factor. Some respondents highlighted the potential negative impact on mental well-being, emphasising that participants might be forced into more drastic medical treatments when they are older. The concept of life-saving drugs is invoked, underlining the vital nature of puberty blockers in the journey of transgender youth.

One respondent drew attention to the interconnection with the policy on gender-affirming hormones, emphasising the need for a comprehensive understanding of how these policies align. Ceasing the use of puberty blockers before removing them as a prerequisite for gender-affirming hormones is deemed detrimental, particularly for individuals for whom physical transition is a primary objective.

Concerns were also raised about the terms ‘late onset’ and ‘early onset’ dysphoria, pointing out their undefined nature and the potential assumption of concepts like rapid onset gender dysphoria without sufficient evidence review. The perceived coerciveness of the policy, tying access to puberty blockers to research participation, is considered a critical ethical concern, especially when there is no alternative access to these crucial treatments.

In summary, the policy's failure to address the risk of harm to transgender youth, both in terms of driving them towards unregulated sources and negatively impacting mental well-being, is a significant concern. The potential for more drastic medical treatments later in life and the interconnectedness with the policy on gender-affirming hormones underscore the necessity for a more comprehensive and nuanced approach to safeguard the health and well-being of transgender youth.

The policy should be informed by the lived experiences of transgender people and experts

Many Group A respondents pointed to what appeared to be a lack of input from an engagement with transgender people, highlighting that the draft policy had gathered evidence and information from only "six individuals or carers/family members", with no indication of how many of these six individuals were transgender adults or gender dysphoric children and young people. Respondents said that this number should have been much higher, and that it should have included insights and real life opinions from both those who had used PSH and those who hadn't, as well as those who could provide feedback on the long-term outcomes of both. Clearly, it was stated, with such a small number having been consulted there was no real chance that anything approaching a well-rounded picture looking at PSH treatment and gender dysphoria could have been obtained.

Group A respondents also said that, in conjunction with transgender people themselves, the interim clinical policy should have been shaped by experienced experts in the field – but with only 13 unnamed organisations and four anonymous clinicians/academics consulted, with no indication of their level of expertise, qualifications, viewpoints, or ideological position, it was deemed an inadequate and disappointing level of engagement, and a missed opportunity to shape a truly beneficial and well-informed healthcare policy.

Late/early onset dysphoria are undefined so should not be included in the policy

As featured in responses to Question 2, many Group A respondents pointed out that the definitions of 'early onset' and 'late onset' gender dysphoria had not yet been agreed on, therefore they should not be included in the interim clinical policy. Respondents believed that the use of these terms without defined parameters raised questions about their validity and about the potential implications for treatment. Respondents felt that without clear explanations and a thorough

examination of the scientific evidence supporting them there was a risk of these terms assuming a legitimacy that they may not merit.

The research trial is poorly designed and will not provide the desired results

Some Group A respondents criticised the proposed research trial within the interim clinical policy for what they saw as its poor study design, noting the absence of a control group which they believed made it ethically challenging and unlikely to yield the desired evidence or results. Respondents said that a much more robust research protocol should be designed, involving a longitudinal approach and a control group. This requirement, however, was felt to lead to the ethical dilemma of clinicians needing to randomly assign some transgender children to receiving no puberty-blocking treatment, allowing them to undergo natural puberty – a scenario deemed unlikely to gain approval from ethics committees or acceptance among practising gender clinicians. This dilemma seemed to indicate that the implementation of randomised control trials was impossible, therefore the suggestion was put forward that a cohort study following transgender young people treated with puberty blockers might be a more viable option.

Transgender healthcare should be available everywhere, not only in specialist clinics

Some Group A respondents believed there was a need to desegregate transgender healthcare and make it universally accessible rather than confined to specialist gender clinics. Respondents believed that the current approach led to prolonged waiting times and placed undue burdens on transgender individuals. Reference was also made to historical ambiguity regarding whether endocrinologists or psychiatrists would oversee gender dysphoric patients, and the suggestion was made to abandon a model that requires strict psychological testing and monitoring in order to access PSH and other hormonal and medical treatments.

Advocates for desegregating transgender healthcare contended that it would save on costs, significantly reduce waiting times, and prevent the abuses of power and invasive medical practices previously observed in certain specialist clinics. Some believed that the segregation of healthcare represented a dehumanising approach of NHS England to transgender individuals, stating that treating gender dysphoric children and young people on par with other patients would make a statement that recognised their fundamental right to bodily autonomy and the ability to make decisions about their medical procedures and bodily changes. The disparity in access to hormone

treatments for gender dysphoric individuals compared to other medical interventions was also cited, advocating for a system where competent doctors can monitor treatments their patients have consented to without the need for specialist oversight.

The risks of not using PSH should be discussed in the policy

Some respondents felt that the interim clinical policy should have included evidence, and literature, as well as measures centred around the risks of gender dysphoric young people not being treated with PSH. This suggestion was underpinned by the belief the benefits of taking PSH were well studied and evidenced and that they clearly outweighed any potential risks.

Group A respondents also expressed a need for a more comprehensive consideration of the social context and epidemiological trends related to transgender identities and transgender healthcare, arguing that the unique nature of the treatment's connection to a social issue required clear navigation and recognition within the policy.

There was also criticism of the insufficient explanation of the metrics used to establish how the benefits and risks of PSH treatment had been weighed and measured, and of how the conclusion to limit PSH treatment had been so conclusively arrived at when, to Group A respondents, the benefits of PSH very clearly outweighed the potential risks.

The policy should remove harmful terminology that pathologises transgender people

Some respondents felt that the policy conspicuously avoided the use of terms such as 'transgender' and 'gender dysphoria' in favour of the clinical term 'gender incongruence.' This was interpreted by some as a pathologising of transgenderism and gender diversity, betraying an ideology which suggested transgender existence is an abnormality that requires correction. In the broader societal context, where anti-transgender bigotry is seen as being on the rise, respondents emphasised the importance of language and terminology in shaping the narrative around transgender issues, advocating for a more affirming and inclusive use of language in the policy.

The policy should give evidence that psychological approaches alone are an effective treatment

A small number of Group A respondents highlighted concerns about the perceived lack of good quality evidence supporting the effectiveness of psychological approaches as a standalone treatment in the proposed policy, stressing the need for psychological treatments to be held to the same standard of evidence as those applied to PSH and other gender-affirming interventions.

The requirement for those currently using PSH to desist is misguided

Some Group A respondents believed that the requirement for individuals already receiving PSH treatment privately to discontinue the treatment for baseline testing was misguided and could potentially cause them harm or that they would face challenges when seeking to resume treatment, to the extent that they may not be approved to use them again. This requirement was viewed as being detrimental to both the patient and to the integrity of the research study. Furthermore, it was believed that for young people who had already been using PSH, any baseline reading obtained would not represent their true baseline. Respondents therefore proposed that it would be more effective, efficient and all-round beneficial to have patients provide baseline results from their previous private providers.

Summary of themes raised by Group B respondents (n=162)

Group B respondents said...	Number
The definition of 'gender incongruence' should align with that in the ICD-11	94
The research trial is unethical and violates the 1964 Declaration of Helsinki	90
There should be no exceptional cases outside of the trial	83
Safeguarding policies should be clearly set out and described in full	82
The policy should address how modern culture has influenced gender dysphoric CYP	55
The policy should make support available for detransitioners and CYP harmed by PSH	53
The research trial should be a Clinical Trial of an Investigational Medicinal Product	42
Patients and their families should be educated on the risks of using PSH	39
The language used in the policy should be scientifically and medically accurate	38
The policy should address private or overseas prescribers	23

Research participants must be carefully screened	6

The definition of 'gender incongruence' should align with that in the ICD-11

A significant proportion of Group B respondents who provided an answer to the question believed there was a greater opportunity for consistency and clarity in the definition of 'gender incongruence' within the interim clinical policy, suggesting that the definition should align with the diagnostic framework of the interim service specification and adopt the ICD-11 definition. Respondents argued that the current policy's definition, which refers to 'gender dysphoria/incongruence' as a condition related to discomfort or distress due to a misalignment between gender identity and natal sex is inappropriate and inaccurate.

The research trial is unethical and violates the 1964 Declaration of Helsinki

Some Group B respondents felt that the ethical aspects of the proposed research trial outlined in the interim clinical policy violated the 1964 Declaration of Helsinki by not adequately ensuring the safety and well-being of participants in the pursuit and development of medical knowledge and treatments, pointing to the Declaration's 8th principle which emphasises that the primary purpose of medical research should not take precedence over the rights and interests of individual research subjects. Group B respondents therefore requested an explanation of how the trial aligns with ethical principles to safeguard the rights and interests of the participating individuals and a clear rationale for using children as research subjects beyond advancing medical knowledge.

There should be no exceptional cases outside of the research trial

Some Group B respondents raised concerns regarding the possibility of 'exceptional cases' being able to receive treatment, as stated in the interim clinical policy. This was felt to open the door for subjective interpretation and potential loopholes, leading to individuals or families perceiving and/or presenting their circumstances as exceptional and thus seeking access to PSH.

Group B respondents believed that statistics indicate that around 80% of children outgrow gender dysphoria if not affirmed, but that individuals using PSH often proceed to cross-sex hormones. This led some to fear that some children who might naturally outgrow their condition could be classified

as an exceptional case which, in turn, could lead to a lifelong dependence on medical interventions and the potential induction of hormone imbalances.

Respondents therefore suggested that there should be no provision for exceptional cases outside of the research trial setting.

The concern extends to the idea that the concept of 'exceptional cases' could be misused or misinterpreted.

Safeguarding policies should be clearly set out and described in full

Group B respondents highlighted the imperative for clear and comprehensive safeguarding policies within the interim clinical policy, especially considering the profound and irreversible nature of some of the decisions involved, such as those concerning the body, sexual functionality, and fertility. In addition, there were calls for careful examination of parental consent, urging restrictions on the rights of parents, with a particular concern raised about the potential for Munchausen by Proxy.

Respondents suggested clear and exhaustive safeguarding policies that recognised the vulnerabilities of children and young people who have limited life experience and understanding of their sex and sexuality in making life-altering choices.

The policy should address how modern culture has influenced the rise of gender dysphoria

Group B respondents felt that the interim clinical policy should acknowledge and address the influences of modern culture, including the impact of social media, social contagion, and parental influence on gender dysphoric children and young people. These influences were seen to form a critical aspect of the discourse and that the policy should include an exploration of how cultural shifts had contributed to the recent rise in the numbers of gender dysphoric children. The argument was centred on the premise that it is increasingly uncommon for a child to arrive at the clinic without some degree of influence or affirmation related to gender dysphoria. Any policy, therefore, should include and use evidence that has scrutinised and accounted for these cultural dynamics when addressing the needs of gender dysphoric children and young people.

The policy should make support available for detransitioners and those harmed by PSH

Some Group B respondents believed that the interim clinical policy should include comprehensive support mechanisms for detransitioners and individuals who have experienced harm from puberty blockers, implementing a framework that acknowledges and addresses the potential harms and challenges faced by individuals in their journey. Respondents believed that currently there was a gap in available services and a dearth of assistance for detransitioners, and that the interim clinical policy had an opportunity to address this and provide a more comprehensive and supportive healthcare approach for those who had been harmed by PSH and gender transition.

In addition, respondents proposed that gender services be augmented by resources within Child and Adolescent Mental Health Services (CAMHS) to provide comprehensive psychiatric assessment and psychosocial support. The concern expressed was that, by exclusively viewing issues through a "gender lens" some children may be deprived of broader psychiatric evaluation and mainstream CAMHS assistance.

The research trial should be a Clinical Trial of an Investigational Medicinal Product

Some Group B respondents stated that the proposed research trial should be classified as a Clinical Trial of an Investigational Medicinal Product (CTIMP) as it pertains to studies evaluating the safety or efficacy of a drug and involves specific requirements and regulations to ensure the welfare of participants. This viewpoint aligned with an overarching demand for stringent regulatory measures designed to ensure that the trial meets the required ethical and safety standards and to safeguard the well-being of the participants, particularly considering the unique vulnerabilities associated with children involved in clinical trials.

Patients and their families should be educated on the risks of using PSH

Group B respondents believed that the interim clinical policy should include comprehensive education for patients and their families regarding the realities of using PSH. Respondents called for transparency and honesty in conveying the risks, side effects, and nuanced experiences associated with PSH, encouraging NHS England to move beyond an idealised notion of the effects a child might anticipate from PSH treatment and ensuring that both parents and children are fully informed about the likely outcomes, differentiating between reversible and irreversible effects.

In addition, respondents felt that the interim clinical policy should incorporate the experiences of detransitioners, believing that acknowledging and sharing detransition narratives would provide valuable insights into the potential challenges and consequences of gender transition interventions. Such a holistic approach to education was seen as furnishing patients and their families with a well-rounded understanding, fostering informed decision-making and mitigating the potential for misconceptions or unrealistic expectations.

The language used in the policy should be scientifically and medically accurate

As noted in responses to other questions, some Group B respondents felt that some of the language used in the interim clinical policy showed signs of ideological influence and was not strictly biologically or medically accurate. The policy should therefore be updated to ensure that all terms used reflect accepted scientific consensus.

The policy should address private or overseas prescribers

Some Group B respondents felt that the interim clinical policy should contain an explicit protocol or legislative framework to address the actions of private or overseas providers who prescribe PSH in order to monitor and potentially restrict access to PSH from sources outside the defined healthcare system. Such legislation or protocols would serve as a deterrent and regulatory mechanism to curtail the prescription of PSH by private or overseas entities, ensuring the safety, ethical practice, and comprehensive oversight of PSH prescriptions within England.

Research participants must be carefully screened

A small number of Group B respondents proposed that the interim clinical policy should include a protocol that sets out a meticulous screening process in order to protect vulnerable research participants. Specifically, it was suggested that individuals with low IQ or those identified as mentally ill or neurodivergent should be screened out and excluded from participating in the research trial. In addition, there were calls to assess the home situations of prospective participants as a crucial component of the screening process. This approach aimed to ensure ethical and responsible research practices, acknowledging the need for enhanced protection for certain subgroups within the participant pool.

Summary of themes raised by all respondents

All respondents said...	Number
The policy should be closely reviewed and updated following new research outcomes	46
The general public should not be consulted on medical matters	29
The policy should greater clarity	20

The policy should be closely reviewed and updated following new research outcomes

Respondents from both groups suggested that it was imperative that thorough reviews and subsequent updates should be made to the interim clinical policy in light of emerging research. It was suggested that a vigilant monitoring of new research outcomes should be a catalyst for potential adjustments to the existing policy framework, recognising the evolving landscape of medical knowledge and its implications for the well-being of individuals. Respondents believed that policies governing such critical interventions as those involving gender dysphoric children and young people should remain open to refinement based on the most current and robust research findings. This perspective would align with a commitment to the highest standards of patient care and safety.

The general public should not be consulted on medical matters

Some respondents felt that matters pertaining to medical treatment, particularly for marginalised groups, should not be subjected to public consultation, positing that decisions concerning healthcare should be exclusively informed by the insights of medical and scientific professionals, rooted in rigorous research and expertise, and not by a public who may not possess the necessary depth of knowledge to meaningfully contribute to discussions about nuanced and scientifically intricate medical treatments.

Some respondents also noted that, in times marked by politically charged moral debates, the notion that the wider public might influence decisions related to the healthcare of a marginalised group was a situation which should be approached with apprehension – if at all.

The policy should give greater clarity

Respondents from both groups felt that the interim clinical policy should be made clearer and more precise, with specific points of vagueness highlighted in the feedback. Concerns were raised about the lack of explicit details on whether psychological treatment would be inherently gender affirming, while the ambiguity surrounding the criteria for determining 'exceptional circumstances' within the context of the research trial was also flagged as an issue. Also noted was a lack of elucidation on how decisions will be made concerning individuals already undergoing treatment through alternative providers or routes.

Respondents advocated for a more transparent policy that avoids ambiguity and ensures that individuals, including those already in the treatment process, clearly understand what the policy means for them, how it will affect them, and where they stand.