Open Letter to Wes Streeting, Secretary of State

24 November 2025

Dear Mr Streeting,

We are writing to request that you immediately halt the Pathway puberty blocker trial that has now received ethical approval to proceed. Our experiences in mental health work over 5 decades means we feel it is imperative to talk to you directly about our concerns.

We write as the clinicians who originally raised concerns about the Tavistock's Gender Identity Development Service (GIDS) in 2004. Susan Evans worked in the GIDS and whistle blew over the practices at the clinic. She was an original claimant in the judicial review alongside 'Mother A' and Keira Bell in 2019, which importantly challenged whether children could give informed consent to puberty blockers [2]. Marcus Evans is a Psychoanalyst and a former governor of the Tavistock who resigned from the Board over the concerns raised again by staff and parents, that were about to be overlooked. Between us, we have many decades of clinical experience assessing and treating children, young people, and their families [3]. The subsequent events of the Judicial Review have confirmed that our concerns were well-founded, and the Cass Review has vindicated the warnings raised years ago [4].

The history of gender identity services exposes systemic failures in clinical ethics and governance: no long-term follow-up, failure to challenge questionable practices, ideological capture. The Tavistock GIDS commenced a study on children which began an irreversible medical process with uncertain outcomes. After the first study application had been rejected (and the seemingly questionable conflict of interest of UCL and Dr Russell Viner's involvement in the second application process [1]), the study was given approval by the Health Research Authority (HRA). The HRA subsequently lacked any rigour in their oversight and allowed GIDS to not only continue recruiting to the study without answering the HRA's requests for the required interim reporting but also allowed GIDS to extend and lower the subject age group to children at Tanner Stage 2, which meant a child of 10 years old could be included. You will therefore understand our doubts about the claims of the Pathway study to be rigorous when it is yet again under the auspices of the careless HRA. We have just learned that recruitment may commence in January 2026, which heightens the urgency of our concerns.

Dr Cass's thorough review clearly shows that there is little solid evidence supporting the use of puberty blockers in children with gender dysphoria [4]. She pointed out the poor quality of existing studies, the absence of long-term follow-up data, and the failure to see these young people as complete individuals. Her report called for utmost caution and strict research standards, given the risk of irreversible harm. Despite having the authority to do so, the Cass Review was actively prevented from longer term follow-up on the now mostly adult participants of the GIDS study. This could give us so much important information but it has been willfully obstructed and then left untouched.

Although we reject the necessity of conducting this new research before the prior cohort have been assessed, the fact that the PB trial aims to evaluate after only two years clearly demonstrates that those who designed it do not understand the nature of the clinical issue. This is not a condition where outcomes can be assessed quickly. The effects of medical interventions, such as sterility, impaired sexual function, lifelong dependence on medical care, and the psychological impact of irreversible physical changes, will only become fully apparent when these young people reach their adult years. As they age, their peers might be building families, and the reality of permanent losses and potential sterility becomes undeniable. The question of whether they would have learned to accept their bodies through psychological support becomes unanswerable. A two-year follow-up cannot in any meaningful way capture these outcomes; it can only assess short-term relief from distress, which is expected when a developmental process that young people find threatening is interrupted. This is not the "careful, clinical research" Dr Cass called for; it is research aimed at answering the wrong question at the wrong time. Any reported 'improvement' will be because the child has been enabled to avoid the physical and psychological conflicts of adolescence and ordinary human development, but where will this leave them?

Poorly designed research that fails to answer the right questions is worse than no research; it offers false reassurance and produces misleading data that may be used to justify harmful practices. Your government talks of wishing to improve resilience in the younger generation, but this treatment protocol is in effect promoting something that undermines the child's ability to develop and learn about their psychological resources.

Beyond the trial's inadequate timeframe, there is a core ethical issue that renders valid informed consent impossible. Many of the young people we have assessed showed little interest in their sexual life, and some even expressed strong disgust at the idea, and these reactions are often rooted in deep anxieties about sexual function and intimacy. This results in an unavoidable paradox: how can young people consent to treatments that are likely to impair or eliminate sexual function when their current rejection of sexuality is itself a symptom of the psychological difficulties they face?

Young people cannot genuinely consent to losing something they claim not to be interested in, particularly when that claim may be a defensive reaction to overwhelming anxiety rather than a stable part of their identity. Similarly, parents cannot be asked to consent, on behalf of their child, to permanent consequences that will only be understood years later, when their child's psychological development and relationship to sexuality have matured. This study asks parents, when faced with the intense pressure of a distressed child, to support them and give consent and then face the consequences, perhaps for the rest of the child’s adult life. This is particularly destructive for the family, if the child later asks why nobody protected them in their childhood against medicalization, something which detransitioners have frequently expressed. The child’s absence of desire for something, or lack of expression, does not constitute a capacity for informed consent to its permanent loss, especially when that absence might itself be a sign of underlying issues. The requirement for parents’ consent for treatment provides a gateway for societal and cultural prejudices to

enter the process, as well as placing them under a huge future burden for their child's wellbeing.

This is not merely a matter of research ethics; it strikes at the core of whether valid consent is even achievable in these circumstances. A study cannot claim proper informed consent when participants are fundamentally unable to understand what they are agreeing to, not solely because of their age, but due to their psychological state which prevents them from comprehending what they might be giving up. Any ethics committee approving this research without confronting this paradox has failed in its most fundamental duty.

Dr. Cass documented the systematic silencing of debate on this issue [5]. For years, clinicians who expressed concerns were silenced or faced professional repercussions, and this suppression of legitimate concerns directly contributed to the failures. Yet, this study has now been designed without consultation with the clinicians who initially raised the alarm. This pattern of excluding critical voices continues. If this research genuinely aimed to uncover the truth about puberty blockers, it would actively seek input from those with the deepest concerns and extensive experience. The lack of such consultation raises fundamental questions about whether the design process has included the full range of perspectives necessary for robust research. Mr Streeting, we want you to be fully aware of how few of us with this level of knowledge and experience have been asked to contribute or comment. It is a repeat of what the Cass Review described.

This trial increasingly alienates the UK from recent shifts elsewhere. Sweden, Finland, and Norway have all undertaken systematic reviews of the evidence and embraced markedly more cautious and restrictive policies on medical interventions for gender-distressed youth, based on similar evidence and research outcomes to Cass [6]. These policy shifts were driven by conclusions that the evidence did not support routine medical intervention and that there was significant evidence of potential harm.

Psychiatry and psychology have a history of making incorrect diagnoses and treatments that are later recognized as harmful. We know that even well-meaning clinicians, using the best available knowledge, can unintentionally develop harmful systems. This history calls for appropriate humility about our understanding.

Gender services have faced considerable pressure in a highly politicised environment. A recurring issue has been their tendency to treat symptoms separately from the individual and their history or to view and manage different factors as if they could be considered independently from gender dysphoria. This fragmented approach to clinical work conflicts with the need to see the person as a whole and within a social context. GIDS also began interpreting patients' certainty as a positive sign, even though clinical experience shows us that doubt and anxiety can be appropriate and healthy responses. The failure to assess the entire person, including trauma, mental health issues, autism, sexual orientation and developmental challenges, contributed to the failures documented by Dr Cass [4]. Ideological capture in health services and organizations has been detrimental in allowing the necessary discussion and exploration that is essential in good mental health care.

The entire history of this clinical presentation relates to young people's experience of distress caused by their developing circumstances, as they feel trapped in a body they wish to escape from. They seek tangible physical solutions for psychological distress because they desire powerful interventions that will alter their bodies. Consequently, these young people place immense pressure on parents and clinicians to provide concrete solutions.

Clinicians in mental health have a long history of providing concrete interventions to relieve distress, partly to help the patient but also to ease the anxiety of clinicians and parents when accused that they are not doing enough. Sometimes patients put clinicians under immense pressure to accept that there is a tangible physical solution to what is essentially a psychological problem. Typically, in psychiatry, we empathise with the difficulty and the feeling that the patient cannot cope, before analysing what the symptom and the pressure to act signify. We do not promise that all problems will be solved through concrete interventions, just as we do not agree with an anorexic patient that they do not need to eat. Unless clinicians recognize the pressures, they face to act, rather than to think, they are likely to take hasty, interventionist action.

In the short term, anxious young people who have developed a trans identity as a psychological defence against the anxieties linked to adolescent development will understandably want to halt the progress of the rapidly developing secondary sex characteristics. In our experience, these young individuals feel threatened by the loss of control caused by these developmental changes and wish to stop the process. Puberty blockers act as a physiological aid to a psychological defense -but is that good for the person in the longer term?

However, conflicts over changing identity are part of the developmental process. Anxieties such as who will love you, whom you will love, what or who you will become, and whether you can find your place are all essential to adolescent identity development. This is an ongoing process that usually stabilises in our late twenties. Importantly, existing evidence shows that a significant majority of young people with gender dysphoria desist if they remain supported but hormonally untreated, with some studies indicating rates as high as 85 percent [7]. This improvement in symptoms usually occurs over several years. The proposed two-year assessment period might offer you a short term answer that the child feels improved, but it cannot adequately reflect the potential damage of interfering with the natural developmental trajectory of the majority of these children. This risks harming over 80% of children with puberty blockers, who would eventually be able to live without any medical intervention and even feel happy in their natural bodies.

The puberty blocker trial has a fundamental flaw in what it intends to discover. Young people experiencing intense distress about pubertal changes will understandably feel great relief when offered a way to halt them, and this relief may seem like successful treatment. However, the trial overlooks how the very prospect of medical intervention affects their mental state during assessment, and it fails to consider what this communicates: that their distress is unbearable instead of something they might be supported to work through.

Many of these young people already struggle with their identity and experience a sense of not fitting in with most of their peers. Keeping them in developmental stasis for two years while their peer group matures around them does not provide a neutral pause; it further isolates them from a normal developmental path. While their friends face the social and psychological challenges of puberty, forming new relationships and shaping their adult identities, these young people remain frozen at an earlier stage. This divergence from their peers may worsen their difficulties rather than help, reinforcing their feeling that they cannot manage what their peers are handling, at the very moment when connecting with peers matters most.

The fact that most young people starting blockers progress to cross-sex hormones suggests these medications may create a pathway rather than offer a pause for reflection [8]. (Perhaps the 'Pathway' team knew this when they named their new service?).

There is also a worrying pattern that could impact recruitment. The Cass Review documented how social media has provided young people with frameworks for understanding and expressing their distress in ways that fit treatment pathways [11]. When young people are suffering and view medical intervention as their only hope, they will naturally present themselves in ways that seek that help, not through manipulation, but out of a genuine need for relief.

This presents a significant research challenge. If trial entry depends on meeting specific criteria, recruitment might reflect learned behaviours rather than the genuine diversity of this population. Without assessment methods that look beyond superficial appearances and answers, to understand the full complexity of each young person's difficulties, we cannot accurately identify who we are studying. There is no accurate assessment tool to predict which children will persist with a transgender identity, and neither the professionals, nor the children will know in the moment. The underlying psychological issues manifesting as gender distress may remain unaddressed and unexplored, and although the Pathways study claims it will be doing careful assessment prior to entry to the puberty blocker trial, the very fact the trial exists, waiting as a goal on the horizon within the service, will alter almost everyone's ability to resist the belief that the puberty blockers will provide relief to them all.

The documented physical harms of this approach are potentially severe and cannot be ignored. In brief, these include decreased bone density with lifelong risks of osteoporosis and fractures [9], impaired sexual function and possibly sterility, and effects on brain development during a critical period of maturation [10].

The psychological effects are equally troubling. Young people who might have found alternative ways to understand and manage their distress are instead led to believe that their bodies require medical correction. Many leave childhood as lifelong medical patients, reliant on ongoing hormone treatment, surgically altered, with their futures determined by permanent medical intervention rather than psychological growth.

The rising number of young people detransitioning underscores these harms, although the number is not accurately recorded anywhere. Keira Bell's case is revealing: a young woman with significant unresolved childhood trauma was swiftly guided toward medical treatment at Tavistock GIDS [2]. Her underlying issues remained unaddressed, while she underwent irreversible physical changes. Her experience demonstrates how the rush to affirm and medically intervene can mean that the true sources of a young person's distress are never fully explored or treated.

From our experience, parents and clinicians face considerable pressure to accept a physical solution for a psychological problem. This pressure partly arises from the high level of internal persecution experienced by these children and young adults, which is then transferred to parents and clinicians. Continuing with this trial despite already documented harm, without properly addressing it in the design, suggests that the evidence of harm has not been given serious consideration.

Over the six years since we first raised our concerns publicly, we have received weekly letters from parents who feel deeply betrayed by statutory services. They describe how the affirmation model and the prospect of this medical pathway have harmed their families and strained their relationships with their sons or daughters. They often emphasise that they are not opposed to their child's transition in adulthood but believe their child has been hurried into a medical process that conceals ongoing issues. They feel that statutory services failed in their duty to properly assess or address the complex difficulties their children faced, which often existed before the gender distress or alongside it. Many recount being sidelined, dismissed as ‘unsupportive’, ‘transphobic’ or having their legitimate parental knowledge of their child ignored, while their child's underlying trauma, mental health issues, or developmental challenges went unaddressed.. Instead, these services reinforced their child's belief that a medical solution was the answer, without undertaking the essential psychological work required.

We continue to receive similar reports from parents engaging with the new services post Cass. This suggests that those designing and delivering these services have not fully understood the complex dynamics involved. If the new services and this proposed study truly learned from the GIDS scandal, we would expect to see evidence of a markedly different approach. Instead, the same patterns are reappearing.

Summary

This proposed research risks causing iatrogenic harm to children who will bear the consequences for life. The parallels with past scandals are clear: rushing to intervene, silencing dissent, short-term assessments, failing to understand complex cases, and prioritizing patient demand over clinical judgment. We have the Cass Review as a warning, the GIDS experience to learn from, and examples from Sweden, Finland, and Norway to guide us.

1) We urge you please to immediately halt this trial before more young people suffer iatrogenic harm. Many of us involved in this area of clinical work believe the study has been developed and pushed through the ethics committee with an air of secrecy and exclusivity surrounding it. Cass warned of the dangers of activists and ideology affecting thoughtful clinical practice.

2) A properly designed research study must be set up first, one that involves carefully assessed children and/or their families, receiving high-quality psychological support without medical interventions. This would help establish the natural course of the presentation and symptoms of gender distress, when young people are properly supported. It would also allow for valuable research data to emerge over a meaningful period. Eg 10-20 years. Any such study should involve extensive consultation with experienced clinicians who have worked with this (non-medicalized) population.

3) Equally important is an immediate restart by a newly appointed team of the previously prevented Cass review follow-up on the patient cohort who received medical treatment in the PB study at Tavistock GIDS. There is huge value in learning more about the ongoing longer-term outcomes for them before we impose puberty blockers on a new cohort of children. It is in our view essential to do this first.

4) Our request number 3 should also lead to the more urgent development of the services to support patients who underwent puberty blockage (and their families). Too many people have been left without resources, to struggle with the consequences of their medical (and often surgical) treatments without any formal NHS support services. They have been seriously failed by the current system.

The stakes are too high, and the lessons from recent failures too fresh to ignore. These vulnerable young people deserve our most careful consideration, not our quickest action. We owe them the honesty to admit how much we still do not know, and the integrity to discover the facts before we intervene further.

What they need are clinicians who will invest the time to understand the whole individual, including their trauma, mental health difficulties, family circumstances, and developmental challenges, and who will support them in developing the psychological resources needed to manage the challenges of adolescence. Please don't spend more money on this shallow, harmful medical trial, instead we urge you to invest holistically in the children's futures and take care of the people already harmed.

We are here, formally recording our concerns. The evidence of risks is clear to us, but, in our opinion, these have not been properly addressed and now there is an intention to knowingly risk causing further harms before evaluating the ones that might already have occurred. Continuing without resolving these fundamental issues and risks to child health would constitute a failure of clinical governance and child safeguarding, thus repeating the very errors highlighted by the Cass Review. We do this because we wish to promote and support the safe care of children.

Yours sincerely,

Susan Evans
Psychoanalytic Psychotherapist BPC. BPF, LPPS
Retired SRN and RMN. Previously Clinical Nurse Specialist Tavistock GIDS
Senior Fellow University of East London

Marcus Evans
Psychoanalyst, Fellow, Institute of Psychoanalysis BPC
Retired Registered Mental Nurse and Previously Director of Adult and Adolescent Services, Tavistock NHS Trust

Co-Authors: Gender Dysphoria: A Therapeutic Model for Working with Children, Adolescents and Young Adults

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