Aide-Mémoire

Advice on National Health Service decision to limit availability of puberty blockers

Date due to MO:	5 April 2024	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	H2024038057
To:	Hon Minister Matt Doocey, Associate Minister of Health		
Consulted:	Health New Zealand: ☐ Māori Health Authority: ☐		

Contact for telephone discussion

Name	Position	Telephone
Dr Joe Bourne	Chief Medical Officer, Office of the Chief Clinical Officers | Ngā Āpiha Hauora	s 9(2)(a)
Robyn Shearer	Deputy Director-General, Clinical Community and Mental Health | Te Pou Whakakaha	s 9(2)(a)

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Date due:	5 April 2024
To:	Hon Minister Matt Doocey, Associate Minister of Health
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Purpose: This report responds to your request for further information and advice on National Health Service (NHS) decision to limit availability of puberty blockers. It also provides you with information on the Ministry of Health's (the Ministry) intent to publish the recently conducted evidence brief on the use of puberty blockers in due course.

Comment: This Aide-Mémoire discloses all relevant information.

Dr Joe Bourne
Chief Medical Officer | Ngā Āpiha Hauora
Clinical, Community and Mental Health Directorate | Te Pou Whakakaha

Puberty blockers

Context

The use of puberty blockers – Ministry of Health conducted evidence brief

1. Puberty blockers are a class of drug, such as gonadotrophin hormone analogues (GnRHa) which suppress the development of puberty. Some examples of GnRHa are goserelin and leuprorelin.

2. In recent years, the use of GnRHa in New Zealand has increased significantly. While the clinical indication for which medicine is prescribed is not captured in the available data, it is believed that there is an increased use in children and adolescents with gender dysphoria (i.e., as puberty blockers).

3. There are strong and varied views on the appropriateness and/or safety of the use of puberty blockers in adolescents with gender dysphoria. These views are varied across health professionals, rainbow communities and the general public.

4. To inform the Ministry's approach and position on the use of puberty blockers, an evidence brief was commissioned to examine the latest scientific evidence regarding the impact of puberty blockers on clinical and mental health and wellbeing outcomes in adolescents with gender dysphoria. The evidence brief takes into account international and national literature, published up until 30 September 2023.

5. The evidence brief is now complete and will be published in early April 2024.

6. On 20 March 2024, Ministry officials provided the Director-General of Health (DG), Dr Diana Sarfati with a memo (Appendix One) outlining the options and next steps following the evidence brief. This memo was signed and accepted by the DG on 21 March 2024.

7. This memo and the Ministry's plan to publish the review was discussed between Dr Joe Bourne and yourself, 25 March 2024.

8. The New Zealand evidence brief gives opportunity to further explore developing measures that monitor puberty blocker prescribing and gender affirming service delivery. Alongside ensuring that young people with gender incongruence and dysphoria can access quality services, the Ministry will consider research options to better understand the benefits and risks of puberty blockers.

NHS decision to limit availability of puberty blockers

9. You have requested information of the NHS's recently announced decision to limit the availability of puberty blockers.

10. In Autumn 2020, NHS England and NHS Improvement commissioned an Independent Review of Gender Identity Services for Children and Young People by past president of the Royal College of Paediatrics and Child Health Hilary Cass (the Cass Review)[1]. Puberty blockers were one aspect of the review, and an interim report was published in February 2022.

[1] https://cass.independent-review.uk/

11. In response to the Cass review interim report, in June 2023 NHS England published interim service specifications[2] for specialist gender incongruence services for children and young people. The service specification stated that puberty blockers could only be prescribed to children and young people within a clinical trial.

12. In March 2024, the NHS formalised their position into clinical commissioning policy[3] and publicly announced that they require puberty blockers to be prescribed through a clinical trial process, after a review found there was 'not enough evidence' that puberty blockers are safe or effective. The NHS is not stopping access, rather implementing organised processes around access to gain better understanding about clinical outcomes.

Next steps

13. The Ministry is undertaking further work to develop an interim position statement relating to the use of puberty blockers and a communications plan to support publication of the evidence brief. In the coming weeks, the Ministry will provide your office with this information ahead of the publication date, once approved by the Director-General of Health.

ENDS.

[2] NHS England » Interim service specification for specialist gender incongruence services for children and young people

[3] https://www.england.nhs.uk/wp-content/uploads/2024/03/clinical-commissioning-policy-prescribing-of-gender-affirming-hormones.pdf

Appendix One: Memo to Director-General of Health

Options and next steps following the evidence brief on puberty blockers

Date:	20 March 2024
To:	Dr Diana Sarfati, Director-General of Health | Te Tumu Whakarae mō te Hauora
Copy to:	Robyn Shearer, Deputy Director-General, Clinical Community and Mental Health | Te Pou Whakakaha Dean Rutherford, Deputy Director-General, Evidence, Research and Innovation | Te Pou Whakamārama
From:	Joe Bourne, Chief Medical Officer, Office of the Chief Clinical Officers | Ngā Āpiha Hauora
For your:	Information and action

Purpose of report

1. This memo outlines potential next steps following the completion of the evidence brief on the impact of puberty blockers on clinical and mental health and wellbeing outcomes in gender-dysphoric[1] adolescents.

Context

2. Puberty blockers are a class of drug, such as gonadotrophin hormone analogues (GnRHa) which suppress the development of puberty. Some examples of GnRHa are goserelin and leuprorelin.
3. In recent years the use of puberty blockers has increased significantly. While the clinical indication for which medicine is prescribed is not captured, it is believed that it is linked to increasing use of puberty blockers in children and adolescents with gender dysphoria.
4. There are strong and varied views on the appropriateness and safety of the use of puberty blockers in adolescents with gender dysphoria. These views are varied across health systems, health professionals, rainbow communities and the general public.
5. Recently, there has also been changing advice and positions internationally on the use of puberty blockers in children and adolescents with gender dysphoria. For example, NHS

[1] Gender dysphoria is when a person with gender incongruence (a marked and persistent experience of an incompatibility between that person's gender identity and the gender expected of them based on their birth-assigned sex) experiences significant psychological distress (such as depression or anxiety) or functional impairment associated with the gender incongruence.

England published a clinical policy in March 2024[2] taking the position that puberty blockers are not available as a routine treatment option for treatment of children and young people with gender dysphoria and will only be accessible when used as part of a clinical trial. Whilst this position has been in practice for a while it has only recently been formalised in policy.

What we know about current settings, use, and prescribing rates of puberty blockers in New Zealand

6. Puberty is the time of sexual maturation and development and may be associated with gender incongruence or dysphoria experienced by some young people. Where a young person seeks to pause puberty progression, puberty blockers may be prescribed by a clinician.

7. The relevant medicines prescribed by clinicians for use as puberty blockers include:

    a. goserelin – this is approved for use for prostate cancer, endometriosis, and uterine fibroids.

    b. leuprorelin – this is approved for use for prostate cancer, uterine fibroids, endometriosis, central precocious puberty, and breast cancer.

8. Section 25 of the Medicines Act 1981 (the Medicines Act) allows approved medicines to be used outside their approved use when prescribed by an authorised prescriber[3] - also referred to as 'off-label' use. This is the mechanism under which puberty blockers are prescribed for gender dysphoria.

9. When prescribing under Section 25, the prescriber has a responsibility to inform the person that it is being prescribed off-label. This includes discussing with the person evidence to support the use and any potential safety concerns including an assessment of the expected risks, side effects, benefits, and costs. These obligations and duties are set out under the Code of Health and Disability Services Consumers' Rights.

10. For these medicines to become approved for use as puberty blockers, the supplier or company would need to put in a submission to Medsafe containing evidence that the benefits outweigh the risks. The current lack of evidence on both benefits and risks means it is unlikely that a submission would be made in the short term.

Data show increased prescription of medicines used as puberty blockers

11. We reviewed prescribing data[4] on the incidence/first time prescription for an individual of the two medicines primarily used as puberty blockers in New Zealand. Incidence was selected to show the number of people being started on puberty blockers - to reflect the rate of increase, rather than absolute and cumulative numbers of all people receiving prescriptions (prevalence). It is important to note that the clinical indication for which medicine is prescribed is not captured in these data however, there is no reason to believe

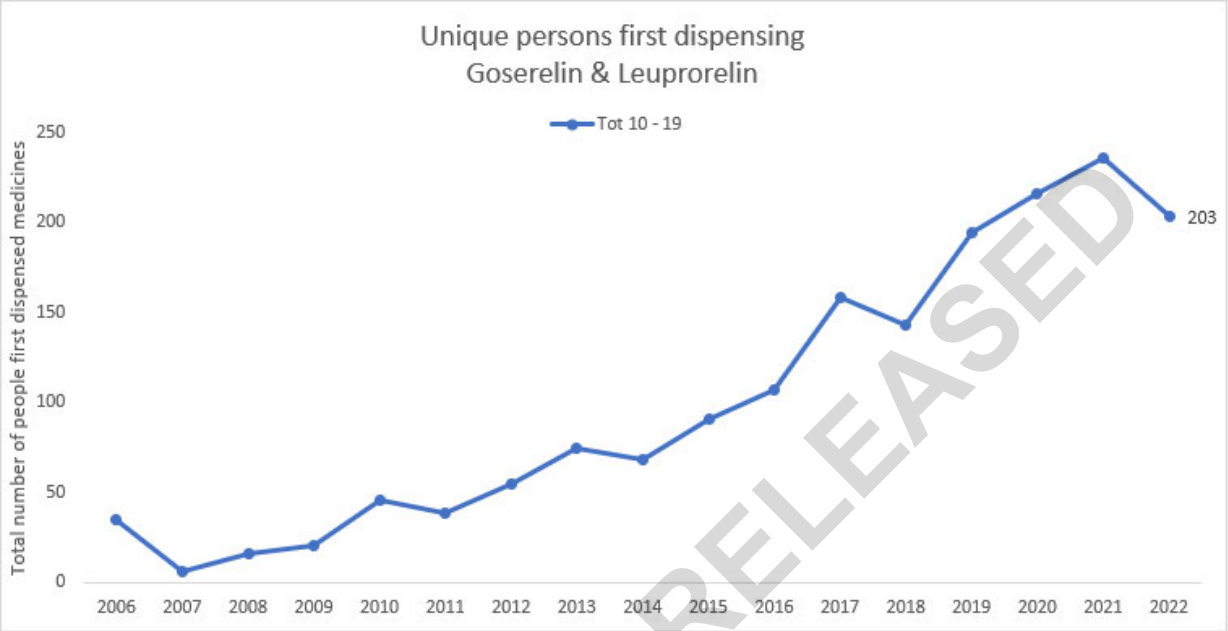
[2] clinical-commissioning-policy-gender-affirming-hormones-v2.docx (live.com)

[3] An authorised prescriber is anyone with prescribing rights as authorised by the Health Practitioners Competence Assurance Act 2003 and includes nurse practitioners, optometrists, dentists, registered midwives, and designated prescribers. The authorised prescriber must always be working within their scope of practice.

[4] From Health New Zealand Pharmaceutical Collection. Data is provisional and has not undergone full quality assurance. The Pharmaceutical Collection is a live dataset, whilst the Pharmaceutical Data Web Tool is a static extract. Comparing the two extracts may result in different figures. There are limitations in interpreting this data.

that prescribing for other indications/conditions would have increased during the period covered.

12. As illustrated below, over the last 15 years, there has been an overall increase in the number of young people aged 10-19 years being commenced on medicines that can be used as puberty blockers[5]. There has been an increase from less than 40 per year from 2007-09 to over 200 per year across 2021-22.



13. This represents a five-fold increase in the number of people being commenced on puberty blockers. As a proportion of the total New Zealand population aged 10-19 years (approximately 655,000 people in 2022), the number of young people receiving first time prescriptions in 2022 equates to less than one in 3,000 young people (an increase from approximately 0.006% in 2006 to 0.03% in 2022).

14. To consider variables such as duration of treatment, geographic distribution and number of prescribers, further analysis is required.

An evidence brief was commissioned to examine the latest evidence

15. To inform the Ministry's approach and position, an evidence brief was commissioned to examine the latest scientific evidence regarding the impact of puberty blockers on clinical and mental health and wellbeing outcomes in adolescents with gender dysphoria.

16. The scope of the evidence brief:

    a. was limited to individuals aged 13-18 years of age

    b. captured evidence up to 30 September 2023

    c. sets out the current evidence base that exists but does not provide recommendations about the future use of puberty block

[5] This is administrative data and is limited to pharmacy script records. This data only counts someone's first ever dispensing and the year it happened and only goes back to 2006. Due to the way this is being counted there is a noticeable higher amount of first dispensings in 2006 than later years because people were already on a puberty blocker.

d. evidence looking at transition to cross-sex hormones or gender-affirming surgery was out of scope.

Summary of the evidence brief findings

17. Overall, the quality of the evidence was low, with studies presenting a high risk of bias and significant limitations. For example, no New Zealand-based studies met the inclusion criteria; all evidence is drawn primarily from longitudinal or cross-sectional studies that use population-based reference standards; the included studies involved individuals across a wide age-range and at different pubertal stages; and there is very little evidence on indigenous adolescents, adolescents living in low socio-economic conditions or those who do not have parental/guardian support.

18. There is some evidence, that for young people taking puberty blockers, their bone mineral density is lower than what is expected for the individual's age or stage of pubertal development, when compared to a control group.

19. The evidence on mental health and wellbeing outcomes is of poor quality with a low response rate across the outcomes of depression, anxiety, and suicidal ideation for young people treated with puberty blockers. The outcomes constitute a combination of self-reported and clinically diagnosed conditions. Measures of outcomes were also varied. For example, results on suicidality were an aggregation of non-suicidal self-injury and suicidal ideation. Thus, any interpretation on positive or negative impact of puberty blockers on mental health and wellbeing outcomes should be made with caution, and within the context of an individual's wider social circumstances.

20. The evidence brief also includes a stocktake of legislative or governance changes relating to puberty blockers. It notes that prescription of puberty blockers is a complex issue and that some jurisdictions have recently made changes to prescribing practices and regulatory oversight. These changes range from targeted mental health and wellbeing support as the first intervention; prescribing puberty blockers as part of a clinical trial; to a complete ban. New Zealand does not have any specific legislation related to puberty blockers.

21. The evidence brief is complete and awaiting publication.

22. There remains a high level of interest in the evidence brief from health professionals, rainbow organisations and stakeholders, and the media.

23. A communications plan is being developed to support the public release of the evidence brief, currently intended for release in March 2024. The communications plan will reflect next steps once you have confirmed them.

Considering the evidence brief in the wider context

24. Overall, the evidence brief identifies that there is a lack of conclusive evidence on the safety and impacts (or otherwise) of the use of puberty blockers in adolescents.

25. We acknowledge that there are strong and varied opinions and positions in this space, and a balance needs to be struck between reducing potential psychological and physiological harm.

26. Consideration needs to be given as to how to balance the need to have better evidence regarding the risks of puberty blockers whilst still maintaining the trust of those experiencing gender incongruence who may benefit from gender affirming services.

27. Issues of informed decision making are sometimes raised, particularly among young people in early adolescence, who are seeking access to puberty blockers. With puberty being a time of sexual maturation and development, experiences of gender incongruence in young people can overlap with neurodiversity and mental health needs.

28. It is noted that any medical treatment has benefits and risks which need to be discussed with the patient/their care givers to ensure an informed decision is made. Given this, any individual (and their whānau) considering puberty blockers needs to be aware of areas in which evidence is limited to inform their decision making and weigh up currently unknown potential risks against potential benefit, alongside other treatment options.

29. Consent to medical treatment can be given by legal minors of, or over, the age of 16 years and is detailed in Section 36 of the Care of Children Act 2004. The Care of Children Act 2004 also outlines the referral process to the Family Court for rulings when there is disagreement between parties. Under common law, Gillick competence is used to establish if an adolescent under 16 years is capable of giving consent to medical treatment.

30. Guidelines for gender-affirming care have been published in New Zealand[6]. These guidelines set out the key considerations for health teams, including the prescribing of puberty blockers. There are also existing New Zealand guidelines to support gender-affirming hormone therapy for adults in primary care[7].

There are opportunities to improve access to broader gender-affirming health care

Work already underway

31. Budget 2022 allocated $2.184 million over 4 years to improve access to gender-affirming primary care for transgender and non-binary people. Work currently underway as a result includes

    a. updating existing guidelines, which include advice regarding the use of puberty blockers, to provide clinicians and community members with information on gender-affirming care

    b. developing training programmes for the primary and community care workforce

    c. funding community-driven models of care to deliver gender-affirming healthcare.

32. Internationally, the World Health Organization is also in the process of developing a guideline on the health of transgender and gender-diverse people, this is specifically for adults and is likely to be ready by 2026.

Potential additional activities

33. Publication of the evidence brief presents us with an opportunity to review the settings relating to the use of puberty blockers as part of treatment for adolescents presenting with gender dysphoria.

    Options include:

[6] content (waikato.ac.nz)

[7] Primary-Care-GAHT-Guidelines_Final_Web.pdf (genderminorities.com)

a. requesting Health New Zealand explore establishing a clinical governance and quality assurance framework for gender-affirming services.

b. further New Zealand research to better understand the long-term outcomes of puberty blockers.

c. exploring options for introducing additional requirements, criteria, or conditions on the use of puberty blockers.

34. These options are not mutually exclusive.

Request Health New Zealand consider establishing a national clinical governance framework and quality assurance framework

35. This work could include taking a multidisciplinary, community partnership approach to overseeing the system of care from a national perspective and putting in place clinical governance or national-level support. For example, it could involve Health New Zealand establishing a clinical network to support the delivery and quality of gender-affirming care.

36. Implementation would sit within Health New Zealand and decisions to progress this work would rest with them. The Ministry could have a role in monitoring at a national level.

Further research to understand the long-term outcomes of puberty blockers

37. Given the lack of good quality evidence, the Ministry could commission New Zealand research that looks at longer term outcomes for all individuals prescribed puberty blockers. This could be funded and commissioned directly by the Ministry through its Research & Evaluation fund.

38. Further research would be useful to generate New Zealand data on the following topics:

a. epidemiology - incidence of puberty blockers prescription including but not limited to age and ethnicity; trend of prescribing; rate of transition to cross-sex hormones and subsequently to gender-affirming surgery; and the rate of detransition.

b. determine the long-term impacts on clinical outcomes of puberty blockers in gender-dysphoric individuals, including but not limited to adolescents

c. determine the long-term impacts on mental health and wellbeing outcomes, including established developmental review, for all gender-dysphoric individuals.

d. access to services - type, timeliness, quality, experience

e. Whānau/guardian experience/impacts.

Explore options for putting additional requirements, criteria or conditions on the use of puberty blockers

39. In the absence of any changes to current settings, puberty blockers will continue to be available through prescribing clinicians under Section 25 of the Medicines Act.

40. Options for placing additional monitoring, criteria, requirements, or conditions on the use of puberty blockers would require further investigation. These could include:

a. exploring a Special Authority approach with PHARMAC which would set out specific criteria to be met before the medicines will be publicly funded, such as involvement of psychological services, appropriate consent processes, and follow-up plan.

b. establishing a registry that will allow us to monitor and collect data and information and assess the long-term outcomes of puberty blockers.

c. formalising parts of new requirements for prescription of puberty blockers in the updated guidelines into regulation made under the Medicines Act[8].

d. restricting or clarifying use other regulation or legislative change.

41. We can undertake further work to explore these options and understand the feasibility and implications, including costs, risks, and impacts. Resource would be required to explore the legislative and regulatory changes that might be needed.

We recommend proactively developing and publishing an updated position statement alongside the evidence brief

42. We recommend publishing a clear position statement from the Ministry alongside the evidence brief to provide clarity for both health professionals and the community regarding expectations for the use of puberty blockers in the immediate future.

43. We propose that the position statement could include the following key messages/themes:

- Overall, the evidence brief found limited quality evidence on either the benefits or risks (or lack thereof) of the use of puberty blockers.
- This means there is insufficient basis to say that puberty blockers are safe (or not) for use in gender dysphoria in adolescents.
- Given this, our current view is that we recommend caution on their use.
- Like all treatments it is important that individuals (and their whānau) discuss with their clinician the potential benefits and risks (including potential unknown longer-term benefits and risks) of using puberty blockers in their context. This should also include offering access to other treatment options such as psychological support.
- Some young people experiencing gender incongruence will experience distress and it is important that they are supported and able to access health care and support that meets both their psychological and physiological needs.
- The Ministry will explore developing measures that monitor puberty blocker prescribing and gender affirming service delivery. This would enable monitoring of changes over time, and identify emerging patterns in prescribing and access to inform assessment of quality and safety.

44. If you agree with the draft outline above, we will work with the Ministry's communications team to develop and finalise this further.

Next steps

45. There is a high level of interest in the evidence brief from health professionals, rainbow organisations and stakeholders, and the media.

8 Section 105 of the Medicines Act allows regulations to be developed for a range of purposes. Ministerial and Cabinet decisions would be needed to develop new regulations and they would need to go through a consultation process.

46. A communications plan is being developed to support the public release of the evidence brief, currently intended for release in March 2024. We will also share a copy of the evidence brief with Health New Zealand in advance of publishing.

47. It is suggested that you brief the Minister of Health, and the Associate Minister of Health, Minister Doocey who has delegated responsibility for rainbow health, on the status of the evidence brief, the proposed next steps, and the proposed timeline for publication.

Recommendations

It is recommended that you:

1.	**note**	that the evidence brief on puberty blockers is now complete and we intend to publish it on the Ministry of health website.	Yes/No
2.	**agree**	for Ministry officials to undertake the following proposed next steps:	
		2.1 develop a position statement which sets out Ministry expectations for the use of puberty blockers within existing settings.	Yes/No
		2.2 request that Health New Zealand investigate establishing a national clinical governance framework and quality assurance framework.	Yes/No
		2.3 consider options for further research on the outcomes of puberty blockers in New Zealand.	Yes/No
		2.4 explore the feasibility of options that put additional criteria or conditions on the use of puberty blockers, such as testing with PHARMAC the option of a Special Authority approach.	Yes/No
3.	**agree**	to brief Minister(s) on the status of the evidence brief, the next steps, and the proposed timeline for publication.	Yes/No
4.	**agree**	to publish a position statement alongside the evidence brief	Yes/No
5.	**agree**	to the draft key messages proposed for the position statement	Yes/No

Date: 20 March 2024

Dr Joe Bourne

Chief Medical Officer, Office of the Chief Clinical Officers | Ngā Āpiha Hauora

Signature _____ Date:

Dr Diana Sarfati

Director-General of Health | Te Tumu Whakarae mō te Hauora