Hi guys, it's Barry with a really exciting announcement for you.
As listeners of the show will know, one of the reasons that this exists in the first place
is to embody and promote honest, frank conversations and good faith debates,
both of which feel increasingly rare in our polarized country.
That is why I'm so excited to announce that the Free Press, along with FIRE,
the nation's leading defender of free speech rights, are hosting a live debate
on a very sexy and contentious subject on Wednesday, September 13th at 7 p.m.
at the historic Ace Theatre in downtown Los Angeles.
The proposition? The sexual revolution has failed.
Arguing for the proposition is co-host of the podcast Redscare,
Anacachian, and author of the case against the sexual revolution, Louise Perry.
They're going to be facing off against musician and producer Grimes,
and writer and co-host of the podcast A Special Place in Hell, Sarah Hader.
I'm going to be the moderator and I couldn't be more excited.
This is going to be an amazing night.
It's a chance to meet other people in the real world
who also like thinking for themselves and who listen to this show.
You can get your tickets now by going to thefp.com backslash debates.
Again, that's thefp.com slash debates.
I can't wait to meet some of you guys in person.
And now, here's the show.
I'm Barry Weiss and this is Honestly.
Earlier this month, Britain's National Health Service made major news
when it announced that it was banning the use of puberty blockers for children
outside of a tightly regulated clinical research program.
The decision was made after an independent review found that there were
quote, significant uncertainties surrounding the long-term effects of these drugs,
which had previously been touted as totally reversible.
That announcement followed another major decision on the same subject by the NHS.
This one was made last year.
So the Tavistock Gender Identity Clinic in London is due to close in the next few weeks.
It was the NHS's only such facility for children and young people.
And the decision to shut the clinic follows an independent review into gender identity.
And that was to close the UK's only centre for treating children with gender dysphoria,
the Tavistock's gender service for children.
The NHS found that the care being provided at Tavistock,
which had been operating for nearly 35 years, was quote,
not safe or viable as a long-term option for the care of young people with gender-related distress.
Suffice it to say that both announcements were a stunning reversal for the UK
after years of medical professionals marching in lockstep
on the thorny question of how to treat children with gender dysphoria.
These decisions bring the UK in sync with European countries like Sweden and Norway,
which have made very similar policy decisions when it comes to gender care for children.

But all of those countries are light years away from what is happening here in the United States when it comes to this issue.
A gender-affirming bill was passed during the California Senate Judiciary Committee meeting today.
This bill would classify parents in custody battles as abusive
if they refused to affirm their child's gender identity.
My guest today, Hannah Barnes, has been reporting on this topic for years.
Indeed, it was her reporting that catalyzed many of these new changes.
And she's here today to explain why what happened in the UK happened
and why the US is so out of step with one of our strongest allies.
Hannah is an award-winning investigations producer at Newsnight.
That's one of the BBC's flagship news programs.
And her new book, Time to Think, follows the story from Tavistock's inception to its close.
It explains how a clinic can open its doors to thousands of young patients
at their most vulnerable, how it can operate for 35 years without oversight or regulation,
and how, in the words of some of the clinic's own staff, this medical scandal happened.
A quick note that I spoke to Hannah before the NHS decision to ban puberty blockers was announced.
We'll be right back.
Hi, honestly, listeners. I'm here to tell you about an alternative investing platform called Masterworks. I know investing in finance can be overwhelming, especially given our economic climate. But there's one thing that will never go in the red, and that is a painting from Picasso's Blue Period. Masterworks is an exclusive community that invests in blue chip art.
They buy a piece of art, and then they file that work with the SEC. It's almost like filing for an IPO. You buy a share representing an investment in the art. Then Masterworks holds the piece for three to 10 years, and then when they sell it, you get a prorated portion of the profit's minus fees. Masterworks has sold $45 million worth of art to date from artists like Andy Warhol, Banksy, and Monet. Over 700,000 investors are using Masterworks to get in on the art market.
So go to masterworks.com slash honestly for priority access. That's masterworks.com slash honestly. You can also find important regulation A disclosures at masterworks.com slash cd.
Hannah Barnes, welcome to Honestly. Thank you so much for having me.
Hannah, you've had a really long career at the BBC. You're an award-winning producer for their flagship news and current affairs program, Newsnight, sort of like 60 minutes in terms of prestige here in the US. And for the past decade and a half, you've been reporting and editing some of the BBC's most respected documentaries and shows. But for whatever reason, you decided to
step into the most controversial topic in the world. Definitely in the US, I would say right now.
Why did you decide to do that? Well, I didn't realize at the time it was the most controversial topic in the world. It would be safe to say. I think I stepped into it just because I thought there's something going on here. And it's the job of journalists to shine a light on something that's important, but we're not hearing much about. This was about children receiving off-label drugs, doing something really quite important and major to their bodies potentially. And for some, that would obviously be the right path. But what was going on at the time we started looking at it was 10 clinicians, which was a sizable proportion, probably about a quarter

of staff at the Gender Identity Development Service, or JIDS as I call it, but a gender clinic essentially for children. A quarter of them had expressed some really quite serious concerns at this point. And really, the British media weren't giving it the attention it deserved. And I went into it thinking, I don't know if what they're saying is true, but it's really worth looking at because that's the kind of thing we should be doing as journalists. So you spent the past four or so years reporting on the Tavistock Gender Identity Development Service. I'm just going to call it the gender clinic if that's okay. Sure. Which is the UK's only clinic for treating children with gender dysphoria, or at least it will be until it closes next year. Is that right?
It's England and Wales is only one. There is one in Scotland as well, but it's much, much smaller. So yes, for a time, it was the only one in the whole of the UK. And at the moment, it's the only one in England and Wales. Okay, so let's start from the beginning. Let's start from when this clinic opens its doors in 1989. What was the centre's mission and purpose? And how many children in England and Wales was it serving back then? So it was serving a tiny number. You could count them on one hand, two, three, four, five, you know, and it stayed like that for quite a long time. And the clue for what it was trying to achieve really wasn't its name. So it was called a development service. So it was never trying to change a young person's identity. It was about trying to help them manage the distress they might be feeling, to understand why they might be feeling the way they do, to reduce stigma, and to give them, you know, what we might call now a safe space, I suppose, to talk about what was going on. Because back then, there were so few. And actually, when the child and adolescent psychiatrist, Domenico de Caeli, opened his clinic, he recognised that this was a rare, but very serious condition that he had spotted in some young people. And he felt that they needed this dedicated service. So it was very largely therapeutic. Sometime in the 90s, what we refer to as puberty blockers were available, but only from the age of 16. So you'd pretty much gone through puberty by then, mostly. And there were pretty strict conditions about it, but it was very cautious for quite a long time. So it was largely therapeutic. And it stayed that way for at least the first decade, really.
So in the early days of the clinic, it's safe to say that the interventions that were happening, like if I was a child and I walked in and said, I feel like I'm in the wrong body, that the course of treatment would be therapeutic, not the kind of medical interventions that we'll get to later in the conversation. Yeah, it was largely talking therapies.
Exactly that. And what were those therapies? Give me a sense of what that would kind of look like. Well, in those early days, I speak to someone in the book called Ellie, who's probably about 40 now, actually. So she was 11 when she went. And she describes it as really just the first time that someone could understand what she was going through. I mean, she presented as male. She didn't think she was a boy, but she presented as male, had very short cropped hair, certainly some of her extracurricular activities. People thought she was a boy and she didn't correct them because she didn't want to have an argument and refused to wear anything remotely feminine in terms of clothing,
things like that. And she describes it as just amazingly helpful, just someone to listen to say, why is it you don't feel like a girl? And Ellie would say, well, you know, my legs aren't girls' legs. And Domenico de Chaeli actually was who she was talking to. And he said, well, there are different kinds of girls' legs. You know what, there's not one kind of girls' legs. And she said, oh, but you know, my sister is much more feminine. He said, but you know, and he was

actually really honest about what the pathway might look like if she continued to feel and present as male. But that was such a long way off at that point, you know, five years hence. And he said, look, you can stay here and we can continue to talk or you can go away for a bit. But this is what the pathway will be if that's what you want further down the line. And she found that amazingly
helpful. And so did her parents because this was kind of the early 90s, 1994. They'd never met anyone like that before. And she didn't know anyone who else had had those feelings. So it was really about making her feel that she wasn't weird and that it was okay to not present in, you know, whatever this means, typically feminine way. And it's fine. So the clinic opens in 1989. At first, it's seeing a handful of patients, very small in number, England and Wales, young children who are experiencing gender dysphoria, they're getting talk therapy.
When did that start to change? When did the clinic start introducing medical interventions? And what were those medical interventions?
So it's a huge source of frustration that I cannot pinpoint a single year where they started using blockers. But certainly at some point in the 1990s, puberty blockers became available. But as I say, only from the age of 16. And Domenico de Caeli actually helped write some guidelines for this written by the Royal College of Psychiatrists here in the UK.
And they were very, very cautious. It said, you know, basically a young person has to have completed puberty, it has to be prolonged, persistent distress, they have to have had significant amounts of therapy. And it was a really fascinating document because it acknowledged, even 25 years ago, that adolescence was this really critical time in a young person's development. And it said, if you interrupt that process of puberty, it can affect your bones, there's a risk of osteoporosis, it can affect your brain development, they didn't know how or why, but they just knew what they knew about young people. And they said, look, we have to be really careful about this condition in young people when compared to adults, because you can't assume that
strength of feeling means permanence of that feeling. So it might be that those young people, even though they feel it so strongly at that moment in time, it doesn't necessarily mean that they will feel that way forever. So at some point in the 1990s, certainly by 1998, there were blockers. But because it was so late with many of the referrals, there was a lot of time before that, that you could have this more in-depth talking really, whether regular counseling, psychotherapy, whatever. Let's take a brief tangent to talk about puberty blockers for a minute. And it's hard because I don't want to get too far in the weeds, but it's a word that's come up already a few times in this conversation. And it's a word that I think people are hearing a lot these days. It's sort of like at the center of this debate. But I'm not sure a lot of people really know what these medications actually are and how they work. So talk us, Hannah, just through the basics. What are puberty blockers and how do they work? How do they stop puberty? So they're used for loads of things. They're licensed predominantly to treat prostate cancer, actually. They've been used to chemically castrate sex offenders. They're using fertility treatment to treat endometriosis, loads and loads of things. They're not licensed to treat gender dysphoria or gender-related distress. In children, they're only licensed to treat precocious puberty. So that's when a young person starts really early. And it's just to let them catch up a bit because it can be quite distressing. And what they do is they act on the

pituitary gland of the brain and they switch off your sex hormones. So in females, that would be estrogen, in males, testosterone. And so the reason they've been colloquially called puberty blockers is that's exactly what they do. They turn off the sex hormones. And so if you're female, it switches that off. Your breasts will stop growing. You won't have your periods. With males, it will stop the development of an Adam's apple, the broadening of the shoulders, facial hair, etc. And I guess the reason that people have become more worried about their use when used to help gender-questioning young people is that they act in quite a different way when they're used in this setting than when they're used in precocious puberty. But in precocious puberty, a child is quite a lot younger, so they might be seven or eight. And typically, they won't be on them for that long. They stop and then they go through puberty. In young people with gender difficulties, typically what happens is they'll be a little bit older, certainly here in the UK, maybe 12, 13, 14, 15, the key period of adolescence where all this other stuff is going on in your body and in your identity or sexuality or cognitive development. And you may stay on them
for years and then you tend to then progress onto hormones, either testosterone or estrogen. So your body never goes through its natural puberty. So it's quite different.
If puberty blockers are considered sort of the first step toward medically transitioning, what percentage of adolescence go on to that next step, the cross-sex hormones that you just referenced? The data are really poor at every aspect of this area of healthcare. But from the data that we have, it's in excess of 95% of those who start blockers will go on to hormones.
For a long time, the sort of conventional wisdom that you would read in the press is that puberty blockers are fully reversible. Based on your reporting, do you agree with that? And if not, what are the side effects, short term and long term, of this medication on bodies as well as brains?
So strictly speaking, physically, they are fully reversible in that if you took them for a short period of time and stopped, your natural sex hormones would kick back in. But in the UK, so our national health service, and I know that's a very, very different system to what you have there with insurance, but we have a national health service and it's free for us. And they have said that actually little is known about the long term side effects of puberty blockers. We don't know what impact blocking puberty has on bone development, on brain development, and all other kinds of things. And it's not a straightforward, are they reversible? Are they not? We don't know. I've spoken to a young person for the book who I've called Jacob.
Now, he's a trans man, he's approaching 20 now. He was on puberty blockers for four years. And then
he stopped and he hasn't gone on to testosterone, but he still identifies as trans.
Now, it took two years from stopping. He was on between the ages of 12 and 16 for his periods to start. And even now, they're not regular. So are they reversible? Honest answer? We don't know. Gender clinicians don't know and they're not collecting the data.
Among the things we don't know, you mentioned that the very, very high statistic higher than I would have even thought that 95% of teenagers that are on puberty blockers go on to take cross-sex hormones. Why is that? It depends who you ask. So the Tavistock's gids, the gender clinic at the Tavistock, would say, well, that's not surprising because our assessments are really good. And we make sure that only those who are most likely to persist in their trans identification and become trans adults, they're the ones that we select and refer on for puberty blockers. So

that's not surprising that it's so high. Right. The difficulty with some of those arguments is that having spoken to dozens of frontline clinicians who worked there and the young people themselves, some of whom are very happy, others who are not, they say, actually, you know what, my assessment wasn't thorough. And you know what, I didn't assess some of those kids very well at all
and we didn't always choose those who had had this lifelong gender dysphoria. In fact, some of them,
it was really recent and they had loads of other problems going on in their lives.
And so they would say, well, perhaps there's something about going on the blocker that in some way locks in the identity. You know, perhaps not going through puberty and all those other things that are going on at that time and all the rush of hormones and developing and having crushes and what have you, perhaps that in some way cements the trans identity. Now, we don't know
whether that's the case because there are no decent controlled studies. So that's a hypothesis. But so is the idea that puberty blockers give time to think because there isn't really evidence of that either given that everybody stays on them. So it's a hypothesis and that was always the fear that the British clinicians had. And it's very well documented that if we lower the age at which we give puberty blockers, might we be locking in an identity that actually would have resolved had we left them alone. And that's not to say that it's a bad thing to be trans in any way at all. It's saying what might be bad is medicalizing someone that didn't need to be.
Those who make the argument in favor of giving puberty blockers to kids at younger ages, kids who are expressing discomfort or despair uncertainty about their identities is that if they are indeed trans, putting them on this blocker gives them the best possible chance of living a normal life. And by that, I mean like a life in which they can pass as the opposite gender when they're older. And that will also result in less complicated surgeries and hormonal treatments, arguably, and that sort of like everything will be easier when it comes to transition. I wonder how you grapple with that argument. It is absolutely an argument. And it's valid. So I don't have any truck with that argument. I mean, that's true. And particularly for males, a male that persists and transitions to a trans woman, of course, it will be beneficial not to go through full male puberty. No one can really argue with that.
What clinicians have told me is that they found in their clinical experience of working with thousands of children, not just a few thousands, they just said you cannot predict which are going to benefit from the treatment and who won't. Of course, some people will benefit. And like you say, for those for whom are going to live happy lives as trans adults, blocking puberty is really important and it won't be for others. And it's really hard. It's a balance of risks. Now that we sort of have an understanding of puberty blockers and some of the issues surrounding them, let's go back to Tavistock and what was going on in Tavistock with regard to these drugs. In your book, you report that in 2000, there was this internal audit done of about 150 patients at the Tavistock Gender Clinic. And what that audit found is that the vast majority of the clinic's patients were dealing with lots of other issues on top of their gender dysphoria, whether that was anxiety or depression, maybe abuse in the home and eating disorder. And then there was this additional internal report done in 2005 by the medical director of Tavistock. And what it found was pretty alarming. It found that no one was collecting

data on the patients and that there was a lot of internal confusion and conflict within the clinic about the very treatments they were providing. In short, that providers at Tavistock could not agree on the following. Were they treating children distressed because they were trans or children who identified as trans because they were distressed or was it a combination of both? The medical director also said this of puberty blockers. And this is a quote. He says, they are relatively untested and unresearched. And that was in 2005. Tell me about both of these findings, the findings of the audit and the report and what changes were made at the gender clinic following these things coming to light. The audit was meant to be the start of a more rigorous, I guess, scientific approach to helping this group of vulnerable young people. It had been going for 11 years by that point. And the Tavistock said to Dr DeCeeley, look, we need to know a bit more about these young people because if we know more about them, we can help them better. The better you know your patients and what's going on for them, the more you can cater care. So David Friedman, a social sciences researcher, undertook this audit with a couple of other people. And the idea was that they would use that and then continue. So at that point, they had a complete data set almost. I mean, they didn't look at the open cases, but there weren't many, like a dozen, couple of dozen. And they didn't do that. And when I spoke to David Friedman for the book, I said, your data audit was the last as well. And he recently spoke to the British press and just how, well, both shocked and really quite disgusted he was about that, because the intention was that they always would continue that work. And they had it all set up. So I don't know why they didn't. So that came about because Sue Evans, who I guess was the first whistleblower, I guess, from 2005, said, even then, young people were being referred too quickly, she felt, for physical interventions, for puberty blockers, for appointments. And there really was an adequate exploration in some of these cases, she felt was very superficial.

And you get this report, which is really, really thorough, but no one actually knew what this report said until 2020, when I received it after the TAVSTOP was forced to give it to me under the Freedom of Information Act, but they had resisted quite vigorously. And it's really striking because the recommendations are really, really sensible. And what Dr David Taylor, who was the medical director, he said, look, if we're going to do this, we need to do it properly. And we want to be the best in the world. We need to conduct proper research. So how are these young people using the blocker? Are they using it as time to think? Or what else is going on? Who are the people that we're seeing? And he said, look, I'm not saying we shouldn't use them, but they should be a last resort. He doesn't use that phrase, but he says, therapy should come first. And actually, really importantly, this is the start of significant pressure being put on clinicians to refer for puberty blockers. And he said, as a mental health trust, we have to support our staff in being able to say no. If they don't think it's appropriate, they must be able to say no and be supported in doing that. And he suggested that they do regular audits. They do retrospective audits of both, really importantly, both those who went onto the blocker and those who didn't, because you can learn from everyone. And none of that happened. So the second part of your question, how were they used? They were ignored. Let's talk about that pressure. You write really clearly in your book that there was sort of mounting pressure on the people at the clinic to prescribe this very significant, and according to the head of Tavistock, untested and unresearched drug. Where was that pressure coming from? What was

happening
in the culture that the people at the clinic felt that pressure, including Sue Evans, who you referenced? It came from loads of places. So it came from charities, groups that support trans families. But it would be a mistake to say, oh, it was all kind of lobbying. It really wasn't. There's loads of pressure also coming from within this area of healthcare, which at that point was tiny. So it was coming from colleagues in the Netherlands that had pioneered this approach, I suppose, the medical approach. It was coming from some colleagues in the US. You had clinicians in Boston that were practicing at that time. It came from professionals working in adult gender identity clinics who said, we see the aftermath of people who haven't been able to have this treatment. And it's really distressing. And they would have loved this because now they are dealing with a body that has gone through the puberty that they didn't want to and they don't identify with. So there was pressure from them. And there was also pressure from endocrinologists and ethicists who said, look, this treatment is there now, the Dutch are doing it. It seemed at that point that it might be really helpful for a very selected group of people. It's actually not ethical to withhold that treatment if we think it's something that could help. And actually young people have agency. They should be allowed to make this decision along with their families. So there was lots of pressure. So just to contextualize what's happening in 2005, this is happening at the Tavistock Gender Clinic. They're feeling this pressure to give out the block or more.
Is this also happening at gender clinics in the US and in other parts of the world?
Is the UK sort of in step with other Western nations or is it catching up to the Dutch and others?
So the Dutch were definitely first. And the UK up to this point had actually been relatively pioneering itself. So the lead endocrinologist at the time sort of explained to me that actually using a blocker in puberty was quite pioneering. This is when they were doing it at 16 because in the United States, apparently another way of blocking puberty is to give huge doses of opposite sex hormones. So if you were a female, one way of blocking your puberty, you probably wouldn't do it would be to give huge doses of testosterone. But we didn't do that. So it was quite advanced. I think by the time we get to 2005, you have an endocrinologist called Norman Spack. He was treating a handful of British children because the blocker wasn't available at those younger ages here. So he was doing that. And I think possibly Belgium, but it was the Dutch that who were pioneers. I mean, the UK was much earlier than many others, but it was behind I suppose at that point. It felt like within the span of a few years, the standard of care for gender dysphoria for minors completely flipped. Right. And I guess like looking back at it, and especially given your research in this book, how do you understand how almost what feels like this a little hyperbolic, but it felt like almost everyone all at once decided that despite very little research, despite very little data and despite very little evidence, puberty blockers were now going to be the gold standard. Like was there a tipping point or was it just a kind of group think, or was it leading doctors in different places, simply all falling on the same side of the argument? How do you make sense of it?
I can't identify a particular tipping point that would explain it globally. I mean, I know that Russell Weiner, who was this lead endocrinologist, he said to me that there was a conference here in 2008. And that was absolutely the tipping point for British gender clinicians, because the pressure had got so great that even their peers were saying, look, maybe we should do this, but do it sensibly. I think in part this is a story of well-intentioned people making mistakes.

And it's interesting, you say a gold standard, and it's quite striking that this was viewed as the gold standard. So what the Dutch were doing, which was blocking puberty at that stage from the age of 12, and then hormones at 16 followed by surgery, that was seen as a gold standard. But the evidence base for that was always very small and quite weak. So how it became to be seen as a gold standard, I don't know. But what happened here was the Tavistock had been really quite cautious. And those concerns that they had about bones, about potentially locking in an identity that might have changed, they didn't go away. But they had all this pressure and they said, look, if we're going to do this, we need to do it properly. So we're going to do a research study, which was absolutely the right thing to do. They said the Dutch data looks promising, but there isn't much of it, and you can't just go on that. So we need to collect some data ourselves. So they set out to do this study in 2011, but it's no control group like all the other studies in this field. And instead of waiting for some robust and proper data to come back, they just roll out the early blocking of puberty as policy from 2014. And they really didn't have any data at that point to support that decision. And they've really been quite open in the past saying, we just think young people can benefit from this. There wasn't really anything to support. It was a feeling, I guess. And they were quite open with parliament here, with our politicians that they were referring young people for puberty blockers who absolutely did not fit the profile of the Dutch studies, which pioneered the approach, the completely different young people, but they felt why deny it to them. So the two things that are starting to change a lot in the early 2010s are that puberty blockers are now becoming the sort of standard of care. They're being prescribed at ages as young as 12, as opposed to older. They're being prescribed for longer. The other thing that started to change around 2015, and you'll correct me if I'm wrong, is that the Tavistock Gender Clinic started to see a very, very sharp rise in the number of referrals. They doubled. And if you look at the graph that you have in the book, it's just unbelievably stark. You sort of have this steady level of a very few referrals for about 20 years, then it begins to slowly rise about 50% starting in 2009. And then it's like a hockey stick. It goes straight up, the kind of thing like venture capitalists want to see when they're investing in a company. So here's what you write in your book about this time. Caseloads were absolutely exploding. And a single clinician might have 100 families on their individual caseload. To put that into some context, that would compare to around 20 to 30 in any other
regular national health service setting. So essentially, Tavistock went from serving 90 children a year to over 2,500 children. And this is in the span of a decade.
What was going on? What accounted for this hockey stick and growth, and who were these new patients? The first part of your question is the $64 million question, isn't it? Why? But in terms of who were the patients, I'll do the second bit first. The numbers hadn't just exponentially increased, like you say, like that classic hockey stick graph. The demographics had completely shifted as well. So they went from predominantly birth-registered males assigned at birth, whichever phrase someone wants to use. Let's say boys in shorthand who had gender dysphoria or gender incongruence from early childhood that had stayed and then got worse with the onset of puberty. It used to be about two-thirds male, third female. So there were always were girls. And around sort of 2011, there was parity. So we had about 50-50. By 2015, there was a complete reversal. So we had two-thirds girls, one-third male, but the girls were a completely different

presentation. So these were not people who had this lifelong sense of mismatch between their sex and their identified gender. That had only started in adolescence. And also, so many of these girls, and the boys actually, had loads of other difficulties that they were contending with at the same time. Depression, anxiety, eating disorders, traumatic childhood. Some had been sexually abused. Some had suffered physical abuse or they'd witnessed it in the home, indulging in risky sexual behavior, all sorts of things. So while it was always the case, the caseload was complicated to be fair, because we've mentioned there was an audit back in 2000. But now you had a complicated caseload, very different presentation, but thousands of them, and the clinic didn't know what to do. So let's talk a little bit about the why, because this is, as you said, the $200 million question.

There are broadly two arguments that I think are plausible when people are trying to explain that hockey stick curve. Here's one side of the argument, what I call the social contagion argument. And it's in the same way that we see groups of young teenage girls doing lots of things at the same time, having eating disorders together, cutting together, sometimes in the age of TikTok, diagnosing themselves with Tourette's together, that it is a phenomenon that is historically documented that among girls of this age, they do things sort of as a hive. And that social contagion, which maybe in my generation looked like anorexia or bulimia as a group, now that's moved on to gender dysphoria. The other side of the argument says, look, when the social stigma falls away, it would only make sense that more people would sort of be transgender. An argument that a lot of trans activists like to make is they compare it to sort of left-handedness, that once the sort of social stigma around left-handedness fell in the early 1900s, by 1950, you have 12% of people identifying as left-handed. So I guess I want to ask you what you make of these two arguments. I think it's both and. So I think it's too simplistic to pick one or the other, and I think there are others that you can add to those two. And I think it will be different things for different young people. What are the ones you would add? I'm just curious.

Internalized homophobia. Yes. Which this is one of the things that has shocked me the most about this story. I mean, I'm 41. I've got loads of gay friends. I grew up in cities. I've spent most of my life in cities. I just didn't think that that was a thing anymore, like that young people would feel ashamed to be gay. But they do. They do. And I've spoken to them. And it came up pretty much with every single clinician I spoke to. Those who are supportive of gids and those that were critical. So I think particularly for the girls, and this again is what, you know, it's not Hannah Barnes' hypothesis. It's from the experience of people I've spoken to. But it's hard being a teenage girl at the moment. They live in a hyper-sexualized world. Pornification. It's scary for some girls. It's really intimidating. And it's not nice going through puberty. And I've spoken to young people who would say this themselves. It's a way of identifying out of being feminine. It's a way of understanding why you feel different if you don't fit that stereotype, I suppose. I think for some people who are struggling with their mental health, again, it's a way of understanding why you might be really unhappy. Because for a while, even for those for whom transition hasn't worked, for a while, it did really help. It did really help with their mental health. And then go through this period of euphoria because it's like, that's it. That's the thing. That's why I'm really not feeling very well. And I have spoken to some young people for whom that totally fits, that they had felt that way, that something wasn't right. They didn't feel comfortable with themselves

for as long as they can remember. And when they had the words for it, they went, that's me. I'm trans. And they're now, they're happily transitioned and have been for a long time. So I think that does describe it for some people. And I think peer group pressure, not even pressure, but as you say, the influence of peers is definitely a factor as well. And I've spoken to people on there in the book who'd say, my whole group of friends were either trans or non-binary. And it was trendy. So I think it's all of these things. I think it's really complicated.
So by 2015, you have this clinic that's no longer catering to a handful of kids. It was seeing thousands of kids every year. And as we've talked about, it had done this internal audit, it had done this report. By this time, multiple nurses, clinicians, therapists has sort of begun to raise concerns, some of them quietly, some of them in public about the lack of data collection, about the fast-track nature of the care. And yet, Cavistock continued to prescribe things like puberty blockers as policy anyway. So in other words, like, and tell me if I'm overstating this, the gender clinic was prescribing medication to children without understanding whether or not that medication had side effects, without understanding whether that medication was effective in the long-term view, without understanding whether the mental health of their patients was resolved or ongoing. It seems to me from your book that Cavistock understood almost nothing about the thousands of kids that they were treating and perhaps sort of altering, let's say, in some permanent or semi-permanent way, putting the sort of like lightning-rod nature of this topic to the side. Make this about anything else, right? If I just described those circumstances to you, you would probably say it's just a person listening, that sounds like negligence. How do you understand how the clinic continued to practice in this way with children as the patients? And maybe is negligence too strong a word, Hannah?
I think certainly some of the people who have been harmed might use that word.
For sure. I think we won't get the true scale of it for quite some time. But what we do know is that certainly some young people have been harmed and, you know, some have been helped as well. And when you say harmed, what do you mean by it? Well, some young people have gone through that service and say that their assessment prior to either a referral for puberty blockers or a referral to adult services, in fact, was grossly inadequate. The obvious things in their lives went unexplored, that it was too simplistic. And they've gone on to medically transition and some have had surgery and they regret that now. And they re-identify as their birth sex. And some of them are quite angry. Some of them have medically transitioned and stay that way and surgically transitioned. And they're really, really unhappy. And they can't go back because if you've had full sex reassignment surgery, if you've had in the language of the trans community, top surgery and bottom surgery, then even if you regret that, what can you do? Society will never perceive you as your birth sex. So, you know, now I'm not saying those numbers are huge, but there are people who've gone through jids, who fit those categories. And there are people who are trans, who are unhappy with the treatment they received, who potentially have been harmed, like the person who was on the blocker for four years, while on the blocker broke four bones, had a terrible time. And now, approaching 20, feels that they're developmentally and emotionally behind their friends. They've not had their first kiss. They've never felt sexually attracted to anybody. So, there are people left wondering, has this done me permanent damage? So, I think it is fair to say some young people have been harmed by this. But I will add that some people have been helped as well. So, it's not black and

white, none of it is. Going back to your summary, I think your summary was pretty accurate. So, by 2015, it really was kind of flying blind in a way. There was no robust evidence that this was a effective treatment. And actually, when actually people became concerned, there was nothing in the public domain at that point. And obviously, we've touched on the very early whistleblower, but no one knew about that until 2019-20. So, there was nothing coming out of the clinic at this point. And it wasn't really until that first proper little bit of data came back from that study that they had started in 2011, but they just rolled it out anyway, that some of the clinicians working there just went, oh, my God, what are we doing? Because this data came back and showed that every single one of the young people that had gone on the blocker who had reached 16 had also gone on to cross-sex hormones or gender-affirming hormones. And that's when people like Anna Hutchinson, who were working there at the time, said, hang on, what are the chances of everyone, and we're talking about young people here, teenagers, being given time to think and all thinking the same way. That's just not what happens. Like, we're mental health professionals, that's just not what young people do. And then they said, but also, we're giving these drugs that we thought worked in one way, and they now don't seem to be, to really complicated young people. And actually, we're starting to see that just anecdotally from our own case loads, that they don't seem to be getting better. They don't seem to be happier when they're on the puberty blocker. And in fact, sometimes their mental health and their physical health is going down. When they started getting data back, that's when the concerns came in. And I suppose up to that point, you could understand why they were doing it. I think what's more difficult to understand is why they didn't change direction when actual data came back that challenged the original assumptions.

After the break, Hal Hanna discovered that all of this was happening,
and why she decided to pursue this story despite the personal ramifications. We'll be right back.

Hal Hanna, aside from Sue Evans, that early whistleblower who actually published in the free press, that until 2019, 2020, most people didn't know any of this was going on, right? This is on the taxpayer dime, but they don't know what's going on. And then they start to know about it. And I don't think it's an exaggeration to say that in large part, that was due to you and your reporting. So I want to talk a little bit about the journalistic aspect of this story.

You've reported on a range of subjects for more than a decade, some of the most prestigious things on the BBC. And as you're looking through the documents, the internal emails, these unpublished reports, what was your light bulb moment if there was one? When did you realize that this wasn't just a few examples of treatment gone awry, that this was sort of a system-wide problem? How did you come to realize that? Where did you begin? Like, how did you crack open the story?

So this is a healthcare story. No one is questioning someone's identity, or that trans people should have anything other than happy lives free of harassment. It wasn't about identity for us ever, and the book isn't about identity. It's about our vulnerable young people being given the best and safest care possible in each and every case. So that's what it's about.

So we started looking at the evidence base and this study that we've talked about a little bit. But I think it's taken a long time to gain people's trust. And you'll know this, Barry. I mean, people have got to trust you. And when they've got their mortgages and their families and their careers on the line, like, it's not easy. They're speaking at huge risk. So that took lots of time.

But I think when I realized, hang on, there's something really quite serious here, is when I saw the transcripts of some of the interviews that took place as part of an official review of the clinic. And that review was published early in 2019. And it said, oh, look, none of these fears that you might have heard about, none of these concerns that have been raised and it's been leaked to the media, we've investigated and everything's kind of fine. There's no immediate safeguarding concerns. And then you read what a sizable number of clinicians told the person carrying out that review, who was the then medical director. And it's awful, some of it. You know, serious child protection concerns. You've got clinicians saying these are some of the most vulnerable children I've ever worked with in really desperate situations. And in some cases, they're being referred for a medical intervention after an hour, two hours. And it's quite clear from those documents just how worried they are. And it's just impossible to see those concerns as coming from a place of transphobia. It's just not credible that these are professional people who've dedicated their working lives to helping young people.

And what they were saying, actually, really, it boils down to this is not good clinical practice. This isn't how we've ever practiced in other places we've worked. And somehow, because this is a gender clinic, the same questions that we would ask normally are not welcome. In 2019, you make four films for Newsnight, as well as a radio documentary about puberty blockers, about detransition, about the internal staff concerns inside gender clinic that we've been talking about, about how patients were getting referred for various serious drugs after only one assessment. And I've watched some of those and I have to say, I cannot imagine any of those documentaries airing on, I don't know what our equivalent would be, maybe 60 minutes here in the US. And yet, you managed to successfully make and air multiple prime time pieces about this very, very sensitive subject. Were those news stories hard to pitch? Were they hard to get through? And what was the reaction in the UK to your reporting?

We had an amazingly supportive editor, a brilliant editor called Esme Ren at Newsnight, who felt that this was a really important story that wasn't getting really much attention at all in the British press. Some of the newspapers had started at that point, particularly The Times, but broadcast wise that there wasn't much going on at all. And we decided as a team, Esme, Deb and myself, that we would take an evidence-based, calm, healthcare approach to this. And that's what we did. And I don't think, we were nervous, obviously, but I don't think we didn't anticipate how controversial they'd be, I suppose. And we did come in for some stick, but we just felt it was important, so we kept going. And that's what we should be doing.

And in terms of the public, I think most people appreciated it. And they saw it as serious journalism. And we weren't out to demonise anybody, or we were grown-ups about it. I mean, obviously, we got some nasty messages on social media. I mean, Deb were probably more so than me. But, you know, on the whole, it was received really well, because I think we stuck to the evidence. And I think it's important to say what you don't know as well. But I think generally, human beings are frightened of doing that. But if you don't know, just say you don't know. And where there's uncertainty, you have to acknowledge it. And this whole field is full of uncertainty.

Well, you're reporting had a really big impact. It helped precipitate this very extensive review by the UK's National Health Service in February 2022. And it found that the type of care that was being provided at the Tavistock Gender Clinic wasn't safe. Here's what Dr. Cass, the author of the

report, writes in one part of the report. Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning, affirmative approach. In other words, putting people on things like blockers, and that this is at odds with the standard process of clinical assessment and diagnosis that they've been trained to undertake in all other clinical encounters. Your reporting also led directly to an inspection by the Care Quality Commission, which has published this past March, and it found that the gender clinic at Tavistock was inadequate. Tell us about these reports, the inspections, the details of what was found, and why. And this is the major thing that's happened. The National Health Service ultimately decided that they're going to close the clinic in 2024. So the first thing we had was the CQC, which is kind of our healthcare inspectorate. They go into hospitals and check their safe and care homes. In January 2021, they published that, and they rated the clinic as inadequate, and the leadership of the clinic is inadequate. It did acknowledge that the staff obviously were compassionate and they cared about the young people. No one's saying that these are bad people,
but lots of aspects of the care being provided, and just the approach they were taking were criticized. So it said in lots of cases, there was no evidence that consent had been obtained, informed consent, and even when the clinic toughened up those processes, because for a long time there wasn't a codified process for taking puberty blockers, even when they toughened it up, there was still sort of a sizeable proportion that there was no record of it. They said that risk wasn't being adequately managed, both for those on the very long waiting list for care, but also those who were already being treated at the service. They said they couldn't understand why clinical decisions had been taken. It wasn't well documented. There wasn't the expertise to deal with young people with autism who, according to the Taverstock's own figures at one point, at least, made up 35% of referrals. Well, people with autistic traits, not necessarily an autism diagnosis. It said that staff felt unable to speak up through fear of retribution.
Loads of things. It was very, very damning. It also pointed to this idea of there being a complete clinician lottery. On the one hand, you could have an assessment that consisted of two appointments, which was significant because we had reported that, but two was contrary to the guidelines, I guess, that they were meant to be running to. The inspector found it just in their small sample. It could range from two appointments to 30 or even 50. Now, the implications of that are huge for a young person and their family. One is years of talking therapy. Then, of course, you might get a referral for physical interventions at the end, but then you can feel as confident as you ever could be that you've explored and, yeah, that's going to be the right path for that particular person, or it could be two. Now, it's so massively different. It said a variety of things. Then, we got the interim report that you've mentioned from Dr. Hillary Cass,
which, again, it was quite sad reading in a way because she made exactly the same points that these members of staff had been raising for seven years, but nothing had changed, that there needed
to be different pathways, that just as there were different ways, if you like, into gender dysphoria, there had to be different ways out of it as well. She acknowledged the weakness of the evidence base.
She acknowledged the absolutely huge shift in the demographics of the young people presenting, and in fact, the largest group, these adolescent girls with often other difficulties,

were the group that we knew the least about, and that we had to plug some of these evidence gaps. She said there was no agreement on what the purpose of the blocker was. All these things were, I mean, they wouldn't put it in these words, but they were vindicated, really, all those clinicians that had spoken up for years. Then, as a consequence of that, the NHS made the decision that actually there has to be a fundamentally different model, really. There was more holistic, there had to be greater emphasis on mental health, and you needed experts in just really working with
young people. You didn't have to be a gender expert. You needed to understand adolescents and mental health and maybe autism and neurodiversity and trauma. All these things were really relevant in dealing with this cohort, I suppose. She's called for a fundamentally different model, and the NHS is closing JIDS, the Tavistock's Gender Clinic. It was meant to be shut by now, but it's not. It's going to be another year, they say. Well, March 2024 is the latest they've given. In the meantime, it's a complete mess. You've got 8,000-plus struggling young people on a waiting list with absolutely no care or support whatsoever.
When you sort of look at your reporting from a 10,000-foot view, do you think what happened at Tavistock is a unique scandal, or do you think that the real scandal is how normalized this kind of medicalized treatment among young people has become? Is the problem that kids at Tavistock didn't get the proper oversight because there were overworked clinicians and because there wasn't a
sort of systemized, consistent care? Or is the scandal that it's become a normal thing to halt children's puberty when they express gender dysphoria? I'm going to start with my BBC hat and my understated Britishness by saying, I avoid using the word scandal because I think that we don't know yet what the scale might be because we just don't have the data.
So I've said it a few times. So we know that some people have been harmed and we know that some people have been helped and we just don't know the numbers either way. But what I think is really striking is that people who worked in the clinic, who did those assessments, who made those referrals
fear that they have played a part in a huge medical scandal. So I'm just going to start with that caveat.
What I would say is that, yes, we have a different healthcare system, but the evidence base is the same wherever young people live in the world and the evidence base is weak. And no one has been able
to replicate the findings of the Dutch team that pioneered this approach. And to this day, the best studies are these two studies from the Dutch team, which purported to show that in the right group of young people, in a carefully selected group of young people, early blocking of puberty, followed by cross-sectional men's, followed by surgery, was beneficial. Now, those studies have, in the last year or two, come under much more scrutiny and those findings themselves are not strong. And yet that is the basis, really, for gender-affirming medical care in young people, in its entirety. And there have been other studies which purport to show increases in mental health in young people taking blockers, but they're all really methodologically flawed. And when they're looked at in great detail, they have found wanting. And I think it's really striking that when systematic reviews of this evidence base across the globe, taking into account all the studies that have taken place in gender clinics around the world, when systematic reviews have

been undertaken by national health bodies, so in Finland, in Sweden, I think in Norway, and in England, they've all found it to be wanting and of a low quality. And even WPATH, the World Professional Association for Transgender Health Care, which will be the biggest body there in the US, the one you hear about, even they acknowledge that the evidence base is weak. And actually, even they acknowledge that this pathway won't work for everyone. And even they acknowledge that, for some, there will be an influence of friendships that will shape their identity. So is what happened in the Tavistoc happening elsewhere? Absolutely. It must be because it's the same evidence base. And so, of course, there have always been in all the studies that exist in this area for the last 50 years or so, you take any group of children with gender incongruence, some will grow up into be trans adults, and some won't. And the older studies showed that the majority wouldn't, and the majority of those would be gay. But there have always been these two groups of different sizes. So to apply one method, which is arguably what happened here, and even it's not to say that everybody got put on the blocker because they didn't, but there was no other treatment given to them, then potentially there is something not each and every one of those young people is getting the best care for them. I think it's difficult to draw another conclusion. I think one of the things that's made people stand back and really give them pause is that countries across Western Europe that had been at the cutting edge of this kind of treatment, Finland, Sweden, Denmark, are now like very obviously and publicly reversing course. Finland now says that psychotherapy rather than puberty blockers and cross-sex hormones should be the first line treatment for gender dysphoric youth and that gender reassignment of minors is an experimental practice. In France, the National Academy of Medicine called for great medical caution regarding treatment of young people for gender-related distress. I think that the evidence is just almost like a snowball. I mean, it started slowly and now it's gathering speed and it's really giving people, I think, a sense of like, wow, something major went wrong here. You are a reporter. I know you don't predict the future, but what is your hypothesis for what went wrong? This area of healthcare, which is what it is, has avoided any of the normal scrutiny that one would expect, particularly when you're dealing with children and when you're dealing with a drug that's being used off-label in this way. What staff at the Tavistock Gender Clinic, and I know that Jamie Readers made this argument to you, Barry, as well, is that gender, this word somehow, it muddied the waters and the normal questions and the normal scrutiny that you would apply. That would be from healthcare commissioners here, from politicians, from society, from the media. They just weren't asked. I think that's what's gone wrong. Collectively, there's been this fear that if you question the standard of care here, that you're somehow questioning the patient population. I use that in the loosest sense of the word, not to pathologize these young people. We wouldn't do that normally. We wouldn't say, this great cancer hospital, it's applying these treatments, which haven't gone through clinical trials and don't appear to have any evidence for them working. That's not attacking people with cancer. That's attacking the system. I mean, it's really strange that any scrutiny or even asking questions is seen as hateful,

when actually the reverse is true, because if gender clinics and society and medicine can get this right, then care will be better both for those who will thrive as trans adults and those for whom it won't be the right pathway. It's going to be better for everybody. I think maybe what's gone wrong, it's not for me to say what's gone wrong in another country, especially the United States, but I think those European countries that we've mentioned, there aren't calls to ban all care. It's about giving safe care. I think some of the heat comes out of it,
if you look at it from an evidence point of view and take some of the ideology out.
Watching what's going on here in the US from where you sit, I wonder if it looks to you,
we are where you guys were maybe four or five years ago. We have whistleblowers starting to maybe not fully sound the alarm, but quietly voice their dissent. In 2021, we published this piece by Abigail Schreyer in which Dr. Erica Anderson and Dr. Marcy Bowers, two of the leading trans doctors in the US who themselves are also trans, told her that there's a lot of quote,
sloppy care. Anderson has been even more outspoken since then, saying that things have gone too far,
saying that she's concerned about the rising number of young patients. Of course, you mentioned Jamie Reed, the whistleblower from the Washu transgender clinic. Do you think that the US is headed in the same direction that Denmark and Finland have already gone, that the UK is on their way toward, and that we might soon be pivoting in the same direction? I think it's probably beyond my expertise, but I do think that article by Abigail Schreyer with Dr. Anderson and Bowers was so strong. I think what we've never had here though, I don't see sort of the US being behind the UK in some senses, because we don't have the level of partisanship politically. We obviously have separate political parties, but it's not become, from my sense, it's not the same that you have over there. And as I say, there's no push to ban health care. Of course, not for adults either. Here in the US, this feels like a very partisan issue. I don't think it actually is,
but I think it feels that way to a lot of people. And that's because there's lots of laws in lots of different states that are directly about this issue. And you see a lot of politicians that I think are capitalizing on this as a way to make a statement and distinguish themselves. Just this week, Florida Governor Ron DeSantis signed a set of bills that ban gender transition care for minors, prevent children from attending drag shows, and restrict the use of preferred pronouns in schools in Texas. The state legislature passed a bill banning gender transition for minors, becoming the largest state to ban this kind of treatment. So the other aspect of it, of course, is that there's real bigotry against transgender people, and they face violence online and in real life.
And so certainly the pushback I will say that we've gotten at the free press to some of the pieces we've published goes something like this. Why are you making such a big deal of this?
Trans people are already victims in society. They're already incredibly vulnerable. And by the way, we're talking about a tiny percentage of people. It's about roughly 1% of young people between the ages of 13 and 17 in the US identify as trans, and only a tiny percent of those people actually seek care. According to one recent study, just 5,000 American children are on puberty blockers.
So their argument is like, leave us alone. Why are you guys sort of obsessed with this issue?
And if it's objectively such a small number of children, why is this so important?
It's important because it's children, and it's the rest of their lives. And adults need to protect children. And absolutely trans people face real transphobia and bigotry, but actually the current system isn't serving trans people very well. And I think in this area of healthcare, that's what

clinicians working in the UK's clinic have said, you know, the adults need to come back into the room. Kirsty Entwistle, who worked at JIDS, said, sometimes children can want things that aren't good for them. And it's the job of adults to say no. And this is why, but no. And that's not saying no to every one of these young people, because I think it's more complicated than that.
And I think there is lots of gray, and I think there's this real desire for certainty, like banned puberty blockers, or everyone has them, and I, it's not that. But I think the welfare of children is everybody's responsibility. And, you know, the judge of a civilized society is how we protect the most vulnerable. Hannah Barnes, thank you so much for joining me.
Thanks so much for having me.
Thanks for listening. I'm not telling you anything you don't know when I say that this is a subject with a lot of heat and not a lot of light. One of the reasons I so enjoyed this conversation with Hannah Barnes was because of her frankness, her sobriety, and how thoroughly she reported on this subject without fear or favor or hesitation at all. Please share this conversation with your friends and with your family and use it to have a conversation of your own. And if you want to support Honestly, there's just one way to do it. Go to dfp.com, T-H-E-F-P, and become a subscriber today. We'll see you next time.
I invite you to check out the podcast I host called The Witch Trials of JK Rowling. Over our seven-episode series, we interview journalists, historians, transgender adults, teens, and advocates, doctors, and lawyers, and of course, author JK Rowling. You can find the show by opening the very app you're listening to this show on right now, searching The Witch Trials of JK Rowling, and hitting subscribe. Thank you.