TALKING POINTS FOR DOCTORS — NEW ZEALAND PUBERTY BLOCKER POLICY (2025)

1. NZ Has Halted Puberty Blockers for New Cases

Key Message: The Government has placed a moratorium on prescribing puberty blockers (GnRH analogues) to *new* patients presenting with gender dysphoria or incongruence.

Quote from Beehive:

> "New patients… can no longer be prescribed gonadotropin-releasing hormone analogues."

Clinical implication:
Doctors should not initiate puberty blockers for gender dysphoria outside a formal clinical trial. No such trial currently exists in NZ.

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2. Government Recognises Lack of Evidence

Key Message: The decision is based on clear evidence gaps identified by the Ministry of Health and international systematic reviews.

Quote:

> "There is a lack of high-quality evidence demonstrating the benefits or risks of puberty blockers for gender dysphoria or incongruence."

Clinical implication:
Doctors must communicate these evidence limitations during consultations and informed consent sessions.

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3. The 'Precautionary Principle' Now Applies

Key Message: NZ is officially adopting the same precautionary framework as the UK, Finland, Sweden, and Norway.

Quote:

> "While this uncertainty persists, the Government is taking a precautionary approach."

Clinical implication:
A cautious, exploratory, and holistic approach is now expected as the clinical standard — not automatic affirmation.

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4. Medical Care Must Follow Evidence-Based Standards

Key Message: The Beehive explicitly states that all youth treatments must be **clinically sound** and in the **best interests of the child**.

Quote:

> “We are putting in place stronger safeguards so families can have confidence that treatment is clinically sound and in the best interests of the young person.”

Clinical implication:
Doctors must revert to normal child and adolescent care standards:

- full assessment
- screening for mental health conditions
- developmental evaluation
- family context
- trauma history
- ASD/ADHD where relevant
- risk assessment
- differential diagnosis

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5. Psychological and Holistic Care Should Be First-Line

Key Message: Hormonal interventions are not the frontline treatment for gender distress.

International alignment:
This matches Cass Review recommendations, NICE findings, and Nordic guideline changes.

Clinical implication:
Offer or refer for:

- psychological therapy
- family therapy
- broader mental-health support
- support for school challenges, bullying, or social stressors
- exploration-based care, not directive care

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6. Blockers Are Only Available Within a Clinical Trial (UK Model)

Key Message: NZ is aligning with the UK, where puberty blockers are allowed **only** within a clinical research setting.

Quote:

> "Pending completion of the United Kingdom's clinical trial…"

Clinical implication:
Doctors should inform families that:

- puberty blockers are not available as routine care
- any future use will follow formal research governance
- long-term outcomes remain unknown

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7. Existing Youth May Continue Treatment — With Oversight

Key Message: Current patients will *not* be forced to stop, but their care must be carefully monitored.

Quote:

> "The new approach will not impact patients currently receiving puberty blockers…"

Clinical implication:
Doctors should:

- review ongoing treatment
- reassess risk/benefit
- ensure thorough documentation
- discuss long-term uncertainties openly
- ensure fertility and bone health monitoring is up to date

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8. Suicide-Prevention Messaging Must Be Evidence-Based

Key Message: The government decision rejects activist claims such as "puberty blockers prevent suicide."

Evidence base:
No high-quality studies show blockers reduce suicide risk.
The Cass and NICE reviews found no mental-health benefit.

Clinical implication:
Doctors should use accurate, non-coercive language when discussing risk and ensure suicide risk is managed using established mental-health interventions.

9. International Consensus Has Shifted

Key Message: NZ is following a global movement away from the gender-affirming model for minors.

Countries taking the same approach:

- United Kingdom
- Finland
- Sweden
- Norway
- Denmark (partial)
- France (urgent caution guidance)
- Australia now reviewing (post-Cass)

Clinical implication:
Doctors can confidently inform families that NZ practice now aligns with international best evidence, not activist guidance.

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10. Professional Obligations: Informed Consent Must Reflect Reality

Key Message: Doctors must ensure families are given accurate, complete information.

Informed consent should now explicitly include:

- lack of long-term evidence
- potential risks to fertility
- impact on bone density
- psychosocial factors influencing gender distress
- the possibility of desistance
- increasing awareness of detransition
- alternative treatment pathways
- the fact blockers do not “buy time”
- the fact most youth on blockers progress to cross-sex hormones (96–98%)

Clinical implication:
Clinicians can no longer rely on WPATH, PATHA or activist materials.
Primary sources and government-approved guidelines should guide discussions.
