Submitted: 03.01.2024
Accepted: 16.01.2024
Early publication date: 25.02.2025

Endokrynologia Polska
DOI: 10.5603/ep.104289
ISSN 0423–104X, e-ISSN 2299–8306
Volume/Tom 76; Number/Numer 1/2025

Framework guidelines for the process of caring for the health of adolescent transgender (T) and non-binary (NB) people experiencing gender dysphoria — the position statement of the expert panel

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Abstract

This article presents framework guidelines for the care of adolescent transgender (T) and non-binary (NB) individuals experiencing gender dysphoria (GD) and/or gender incongruence (GI). Developed by a multidisciplinary expert panel, these guidelines aim to address the complex medical, psychological, and social needs of this diverse population.

The document emphasises the importance of individualised, affirmative care that respects the autonomy, identity, and rights of adolescents. It outlines best practices for psychiatric, psychological, and sexological assessment; criteria and protocols for gender-affirming hormonal interventions (GAHI) and puberty suppression; and ethical considerations for medical decision-making. The guidelines advocate for comprehensive support systems, including family involvement and multidisciplinary team collaboration, while addressing co-occurring mental health conditions and neurodiversity.

The article also highlights global perspectives on gender-affirming care, comparing practices and policies across countries to provide a contextualised approach that aligns with international standards while addressing local legal and healthcare frameworks. The proposed care model is designed to enhance the mental and physical well-being of adolescents, reduce stigma, and improve their overall quality of life. This work serves as a vital resource for healthcare professionals, policymakers, and advocates seeking to advance equitable, effective, and compassionate care for gender-diverse youths. **(Endokrynol Pol 2025; 76 (1): 1–28)**

Key words: *guidelines; transgender; gender dysphoria; non-binary*

1. Introduction

The guidelines of the expert group[1] (hereinafter referred to as *the Guidelines*) were designed for adolescents seeking specialist help due to gender incongruence and/or persistent gender dysphoria. We do not precisely define the age of the adolescents included in the document because clinical decisions, including those on the implementation of possible medical interventions, should be based on the assessment of the advancement of puberty and cognitive and emotional development of an individual [1, 2].

Polish guidelines for children before puberty have not been published yet. However, the Recommendations of the Polish Sexological Society should be applied to adults (all individuals over 18 years of age) [3].

As a multidisciplinary team of experts on gender incongruence/dysphoria and/or mental health of adolescents, we agree on the following assumptions, constituting the subject-related and axiological bases for the Guidelines:

— gender identity perceived by a person is not a mental disorder *per se* and cannot be easily derived from one group of conditions;
— affirmation of experienced gender identity and living in accordance with it constitute an inalienable right of each individual;
— once formed, gender identity is not subject to volitional change. Similarly, gender identity cannot be formed in an arbitrary way. In addition, attempts to forcefully influence the development of gender identity in an individual are not only ineffective but are associated with negative health consequences for such an individual. Although gender identity is stable for most transgender people, changes in self-definition are a phenomenon that falls within the diversity of gender experiences. They should not be considered a sign of mental instability or a contraindication to the provision or continuation of gender-affirming care in the absence of other contraindications [4];
— persistent gender dysphoria often adopts the form of increased mental distress adversely affecting the health, social functioning, and development of the individual;
— not undertaking clinical activities is associated with some consequences, and the implementation of adequate interventions is a health-promoting approach that is lifesaving in some cases [5, 6];
— the complexity of the issues related to individuals at the developmental age excludes extreme solutions, such as access to medical interventions (e.g. gender-affirming hormonal interventions) without adequate assessment and preparation as well as arbitrary and complete denial of the inclusion of these interventions [7]. The need for individualised care is also crucial;
— we understand the affirmative model of care as an approach that combines acceptance and mindfulness. We oppose the incorrect and harmful definition of affirmative care as the thoughtless and automated issuance of diagnoses and prescriptions. We believe that accepting the identity experienced by an adolescent person, addressing them using the preferred personal forms and allowing medical (i.e. pharmacological and, to a limited extent, surgical) gender-affirming interventions under the age of 18 years preceded by a reliable diagnosis are among the elements of comprehensive care and do not contradict it;

[1]The expert group was initiated by Prof. Aneta Gawlik (Department of Pediatrics and Paediatric Endocrinology, Faculty of Medical Sciences in Katowice, Medical University of Silesia, Poland) and Associate Prof. Bartosz Grabski (Sexology Lab, Department of Psychiatry, Jagiellonian University Medical College, Krakow, Poland) in 2019. The specialists working with adolescents with gender dysphoria and gender incongruence had the opportunity to join the group at every stage of the work. The final version of the document was accepted by all the authors of the guidelines.

— increasing social and political tensions related to the care of adolescents reporting gender incongruence and the lack of consensus in the medical community should not lead to the complete denial of affirmative interventions;
— current criticism of the affirmative approach is based on low-quality studies evaluating the effectiveness of hormonal interventions in adolescents. We agree that in light of the significant increase in the number of adolescents presenting with this issue in the last 10–15 years, the need to update knowledge in this area is particularly urgent. Nevertheless, the research indicates the benefits of affirmative interventions provided that their effects are adequately monitored and their inclusion is preceded by comprehensive and individualised care;
— due to the specificity of the age group of the people to whom the Guidelines refer, many complex factors and circumstances should be considered. They shape the well-being of an adolescent and constitute a unique context for the selected course of action. We believe that such circumstances require careful and individualised management based on the cooperation of a multidisciplinary team, the immediate family (caregivers/legal guardians), and the social environment in which the person lives;
— adolescents who seek or are referred for assessment and care are diverse in terms of how they experience and express their gender identity, the severity of gender dysphoria, and the degree of certainty about their gender identity and needs;
— therefore, although these framework Guidelines also include recommendations for conducting medical interventions, we emphasise that not all adolescents who experience their gender identity incongruent with sex assigned at birth are eligible for such interventions and/or report such a need;
— clinical interventions are aimed at the long-term reduction or elimination of experienced gender incongruence and dysphoria and the improvement of social adaptation and mental health of the individual [8]. Their goal cannot be related to ethically dubious and ineffective attempts to change someone's gender identity or to force socially accepted or expected gender expression;
— professionals working with people with gender incongruence and/or dysphoria must be aware of the social context in which they provide assistance. We hope that the Guidelines will prompt a revision of potentially discriminatory and transphobic assumptions, the most blatant and harmful forms being conversion therapies and excessive and unwarranted restriction/denial of access to care;
— according to the contemporary understanding of gender incongruence, we do not consider discomfort based on gender characteristics to be a symptom necessary to provide gender-affirming care. Transgender individuals who do not experience gender dysphoria and seek gender transition due to their desire for self-actualisation or expression of their gender identity should also have access to gender-affirming interventions [1];
— although decisions about detransition (understood as actions aimed at reversing changes caused by medical interventions) are rare, the increase in the absolute number of people who want to reverse transition should be expected, considering the global increase in the number of people deciding on transition. However, the mere fact of detransition should not serve as an excuse for restricting access to care [1];
— detransition is used in many different meanings in the medical literature and public discourse as striving to reverse gender-affirming medical interventions, returning to social functioning in accordance with the sex assigned at birth, changing the perception of gender identity to the one consistent with the sex assigned at birth, or a sense of regret. In some cases, detransition may be a stage during the development of gender identity and does not have to be associated with harm to mental health or a negative assessment of the previous decision about transition [9–11];
— detransition resulting from a change in the perception of gender identity does not have to be tantamount to making a mistake during the diagnosis of gender incongruence if due diligence was exercised during the diagnostic process.

2. Adopted terms

The following basic terms defined for practical purposes were used in the Guidelines. We are fully aware of the extremely rapid evolution of the language in the area of healthcare for transgender and non-binary people. Therefore, the glossary below should be referred primarily to the Guidelines.

Gender-affirming surgical interventions (GASI) — corrective surgical procedures within the chest and internal and external genitalia. It is important to emphasise that not all people with gender dysphoria/incongruence seek GASI.

Cisgender — a sense of congruence between the way of experiencing gender or the perceived gender and the sex assigned at birth.

Gender dysphoria (symptom) — distress experienced by a person in the context of a mismatch between

the way they experience their gender and the sex assigned at birth.

Gender dysphoria (GD; diagnosis in DSM-5) — diagnosis introduced to the DSM-5 classification [12]. The basis for the diagnosis of GD is the distress experienced by the person or disorganisation of functioning related to gender incongruence.

Gender-affirming hormonal interventions (GAHI) — inhibition of the hormonal activity of the gonads and replenishment of the deficiency of hormones specific to the gender with which the patient identifies. It should be emphasised that in the case of non-binary people, it can be the inhibition of the hormonal activity of the gonads alone.

Gender reassignment — an umbrella term for gender-affirming medical interventions, the process of judicial gender reassignment and accompanying changes in social functioning.

Gender-affirming medical interventions (GAMI) — medical interventions, including hormonal interventions (GAHI) and surgical interventions (GASI).

Neurodiversity — a term that describes the developmental diversity of society, encompassing different ways in which people think, communicate, learn, and interact with their environment. In this paper, it is primarily associated with people developing on the autism spectrum.

Non-binary (NB) — a term that collectively encapsulates the ways of experiencing one's gender that go beyond the traditional/conventional (binary) distinction between male and female genders. Non-binary individuals may identify as having more than one or no gender, deliberately refrain from defining their gender, or experience it as fluid and subject to change.

Gender incongruence (symptom) — a sense of discrepancy between the way a person experiences their gender and the sex assigned at birth.

Gender incongruence (GI; diagnosis in ICD-11) — a diagnosis introduced to the ICD-11 classification [13] to replace the class of gender identity disorders, including the category of transsexualism (ICD-10) [14]. The basis for the diagnosis of GI is the experience of persistent incongruence between the way of experiencing one's gender and the sex assigned at birth. It does not have to be associated with experiencing distress. Therefore, it is not the same as the diagnosis of GD.

Assigned sex is understood as sex determined at birth based on the appearance of external genitalia. The following acronyms were used in the Guidelines: AMAB (assigned male at birth) and AFAB (assigned female at birth).

Gender diversity — a term that collectively encompasses a variety of ways of experiencing and expressing one's gender, including being transgender and non-binary, as well as any alternative gender identities and forms of gender expression that are not included in any of these categories.

Healthcare service — any therapeutic service that is part of GAMI. Deliberate denial to perform diagnostic and therapeutic procedures may result in deterioration of health, which should also be considered in each case when deciding whether to provide/deny healthcare services (benefit-risk assessment).

Gender identity — a sense of being a person of a specific gender, multiple genders, or a sense of reluctance or lack of need to define one's own identity through the prism of gender categories.

Sexual identity — perceiving oneself as a person experiencing sexual attraction and forming romantic relationships with people of one gender (one's own or another), more than one gender, or regardless of gender.

Transgender (T) — a term that collectively encompasses all ways of experiencing one's gender as incongruent with the sex assigned at birth.

Transition — an umbrella term describing individual actions for a given person aimed at increasing the comfort of functioning in connection with the experienced gender. Social, medical, and legal transitions are the three most common types of transition.

3. Care and recommendations worldwide

The Guidelines are being formed at a time when the subject of medical interventions for adolescents experiencing gender dysphoria and incongruence is one of the most widely debated issues in the field of adolescent mental health. Current trends in models of care are given below.

This document is based on the Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (2022) [1] and an Endocrine Society Clinical Practice Guideline [15], both of which are intended to have a global reach.

In the USA, the recommendations consistent with the World Professional Association for Transgender Health (WPATH) (version 7 or 8) have been published by, e.g., the American Academy of Pediatrics (AAP) [16–19], the American Psychiatric Association (APA) [20], the American Psychological Association (APA) [21, 22], and the American Academy of Child and Adolescent Psychiatry [23, 24]. Despite the general consensus on the model of care among leading US specialist organisations, restrictive legislation banning hormonal and surgical interventions for adolescents was introduced at the same time in some states in 2022 and 2023, thereby ignoring evidence-based clinical guidelines for the management of gender dysphoria in this age group [25].

The Canadian Pediatric Society [26] recommends that the standard of care for adolescents who are diverse in experiencing their gender identity be an affirmative approach and that decisions about affirmative interventions be made in an individualised way based on a holistic assessment of the functioning of an adolescent. Similar conclusions can also be found in Australia [27] or Italy [28]. In the Netherlands, where the world's first medical intervention protocol for adolescents with gender incongruence was developed less than three decades ago, despite a sharp increase in referrals to clinics for gender dysphoria, which still cannot be explained based on the available data, the rate of detransition among those who ultimately decided to seek treatment remains steadily low [8].

Currently, no European guidelines recommend a complete abandonment of providing hormonal interventions to adolescents. However, several countries have called for increased caution in the face of a significant influx of patients reporting GD/GI with a profile different than the one reported several years ago. Unfortunately, in the absence of new procedures to operationalise this caution, many adolescent individuals have to wait longer for the first consultation.

The Norwegian Healthcare Investigation Board [29] recommends that the Ministry of Health establish a national registry of the quality of medical services offered to adolescents with GD/GI, at the same time proposing that hormonal interventions to inhibit puberty, induce puberty, and surgical interventions in adolescents be defined as experimental treatments with the aim of providing a research framework for collecting structured information on treatment outcomes rather than restricting its availability. A similar postulate about the need to centralise and systematise treatment as part of research procedures was formulated in Sweden [30]. The most recent systematic review commissioned by a government agency [31] recommended GAHI in adolescents as part of clinical trials to assess the potentially beneficial and potentially adverse effects of hormonal interventions. Swedish experts also propose that it is necessary to analyse different trajectories of gender identity development in adolescents with no history of GD/GI.

In the UK, the only centre providing care for adolescents with GD/GI was closed down. The aim of such an action was to decentralise it into smaller clinics across the country [32]. In practice, although hormonal interventions before the age of 18 are not arbitrarily prohibited, their availability has been temporarily limited due to the lack of new designated facilities. The above changes, criticised by the WPATH from the very beginning [33], were caused by the publication of an interim report by Dr. H. Cass [34], including the preliminary findings of an NHS-commissioned analysis of the quality of care for gender-diverse adolescents [35]. The full report was made public in the spring of 2024. Although it was initially intended to be related to the organisation of healthcare in England and Wales, it caused a stir in public opinion and immediate harsh criticism from the medical and patient communities worldwide [36–38]. A detailed discussion of the document, comprising several hundred pages, goes beyond the scope of the Guidelines. However, the author's concentration mainly on the absence of high-quality research on minors with GD/GI, and her lack of clinical experience indicate the low scientific value and credibility of the report [39, 40][2].

Finland is yet another country that has been given as an example of withdrawal from affirmative care in recent years. Although Finnish guidelines (2020) [41] emphasise that for many reasons the care of adolescents with a history of GD/GI in childhood is related to fewer confounding variables, hormonal interventions can be initiated before the age of 18, even in the case of people referred to the clinic after the onset/passing of puberty if gender dysphoria is severe, gender identity is persistent and stable over time, it is not the result of a transient search for identity or an adolescent crisis, and co-occurring complaints are taken care of.

In France, despite the conservative opinion expressed by the French Medical Academy [42], the national advisory body, the Haute Autorite de Sante (HAS), involved in developing scientific reviews and guidelines in healthcare, is in the process of developing guidelines for transgender adolescents. Before their publication, a preliminary note published by the HAS and a report by Dr. Jutant with recommendations on gender-affirming care for minors are the documents used by French healthcare, both of which allow GAMI in this group [43–45].

It should therefore be emphasised that most European countries still provide gender-affirming care for minors (e.g. Germany, Spain, Belgium, and Ireland).

[2]One of the overt criteria that the NHS followed in choosing Hilary Cass was her complete lack of experience in working with people with gender incongruence and dysphoria, which was to ensure her independence and impartiality. However, in practice it resulted in an unprecedented situation in healthcare when a non-expert in the field was invited to develop expert recommendations. The common thread of many objections to the Cass report is the multifaceted downplaying of the importance of the voices of adolescents and their families, clinical practice, the scientific knowledge base, and national and global recommendations, while misleading the public that a complete lack of clinical experience in a given field is a guarantee of reliability. As a multidisciplinary team of experts and patients, we consider such a trend to be harmful and completely contrary to the interests of adolescents in need of help.

4. Organisation of specialist care

Healthcare for adolescent T/NB individuals experiencing gender incongruence/dysphoria (GI/GD) should be provided by **an interdisciplinary team** with the competence and experience to care for T/NB individuals experiencing GI/GD and additionally the competence to work clinically with adolescents. They should also demonstrate appropriate cultural competence and sensitivity when providing care.

It is recommended that specialists work in interdisciplinary groups due to the challenges associated with the need to make decisions concerning minors. It is not recommended that the care of an adolescent T/NB individual be provided by a single specialist [1]. Because of the limited availability of facilities specialising in comprehensive healthcare for T/NB individuals, we recommend that specialists taking care of an adolescent and their family within various institutions aim for cooperation.

Due to the small number of medical doctors specialising in sexology working with minors, especially those under 16 years of age, their participation in the diagnostic and therapeutic process should not be obligatory. However, we recommended such care/consultation if it is possible without a significant extension of the assessment process.

Adolescent T/NB individuals experiencing GI/GD are a diverse group that must be considered in the care process, both at the stage of GI/GD diagnosis and in planning further management.

4.1. Psychiatric care

4.1.1. General recommendations

It is recommended that psychiatric care for persons ≤ 16 years of age be provided by a specialist in child and adolescent psychiatry, and care provided by a specialist in psychiatry is permissible for those > 16 years of age. However, this person should be experienced in working with adolescents and familiar with developmental psychology with particular emphasis on neurodiversity.

The person providing psychiatric care is responsible for the differential diagnosis and for the possible treatment of co-occurring disorders that change the clinical picture or limit the ability to make informed decisions.

Psychiatric assessment is part of psychiatric and psychological care, and decisions on whether to start GAMI should be made in consultation with specialists, legal guardians, and the patient.

It is recommended that the diagnosis process should be spread over a period of time depending on the individual situation of the person. At the same time, one should be aware of the fact that a long-term psychiatric assessment itself may pose a threat to the person's mental health due to the delay in the implementation of specific (affirming) treatment of gender dysphoria, the feeling of suspension of everyday life, and the risk of experiencing the diagnostic process as pathologising gender identity. The psychiatric assessment should not last longer than the implementation of the necessary elements of the psychiatric assessment.

Psychiatric assessment should last longer than six months only in justified cases.

Assessment and care should be initiated without any preconceived assumptions or beliefs; during this process, no identity should be favoured, and neither the permanent nor temporary nature of the examined person's experience of their gender should be assumed in advance.

4.1.2. Elements of psychiatric examination

1. Interview with parents/legal guardians/caregivers (if possible, with both persons, especially if they are in conflict), including the interview on psychosexual development and the interview on family history (including health, systemic, and environmental factors).
2. The interview with the examined person, including psychosexual development and the history of experiences related to the recognition and expression of one's own gender (with respect for intimacy and informing the patient about the relevance of the questions and their purpose); routine and very detailed interviews about sex life should be avoided if it is not clinically warranted; care should be taken to ensure that the patient's behaviors, such as toys, clothing, or other behaviors, do not limit access to gender-affirming care or determine further diagnostic and/or therapeutic procedures.
3. Information about the functioning of an adolescent from other sources, particularly from the school (if possible — if an adolescent is disclosed in the school environment and/or obtaining such information does not carry the risk of accidental disclosure).
4. Assessment of the somatic state.
5. Assessment of the mental state.
6. Analysis of the medical, psychological, and pedagogical documentation (if applicable).

4.1.3. Aim of psychiatric assessment

1. To verify/confirm GI/GD diagnosis (ICD-11/DSM-5) and to use codes from the F64 class for formal coding until ICD-10 is in force.
2. To verify whether an adolescent currently presents with mental disorders and, if so, whether:

— disturbances can be considered secondary to GI;

— establishing a reliable diagnosis of GI is difficult or not possible due to interfering symptoms of the other disorder;
— making rational decisions and/or giving informed consent to medical interventions is difficult or impossible for the adolescent due to interfering symptoms of the other disorder;
— if mental health condition is not secondary to GI, the question is whether and to what extent it is advisable to obtain improvement or stabilisation of mental health before initiating GAMI;
— the condition will not affect the course of GAMI.

3. To determine whether the person has a past history of mental disorders. We recommend that both an adolescent and their guardians should be told what this element of the diagnosis is for. It is important to avoid suggesting (or generating in the adolescent such an interpretation) that being transgender or non-binary is secondary to pre-existing mental disorders. One should also pay attention to the context of the occurrence of gender dysphoria.
4. To verify whether there are environmental factors that interfere with an adolescent's decision-making process or spoken content (domestic violence, peer violence, peer pressure, problematic emotional dependence on significant others and/or virtual reality). However, the patient's contact with the transgender community or transgender peers cannot be a reason for limiting access to GAMI in any manner.
5. To verify whether an adolescent can rationally and consciously discuss their treatment and GAMI.
6. To assess the development in the context of neurodiversity with particular emphasis on the features of the autism spectrum. Further management depends on the individual situation of the person and the extent of social difficulties they experience. If the intensity of autistic features causes difficulties in giving informed consent to GAMI, it is advisable to refer the patient for autism diagnosis before initiating GAMI (the ASD-focused diagnostic process usually consists of obtaining detailed information from parents/legal guardians/caregivers on early childhood development, games, sensory integration, social functioning, possible use of standardised questionnaires for an adolescent and parents/legal guardians/caregivers, and expanding the assessment with additional tools if necessary – they may require additional specialist skills).
7. To assess the occurrence of symptoms of addiction/abuse of psychoactive substances in terms of the problem severity and its impact on the process of cooperation in treatment (addiction/substance abuse as such cannot be a reason to deny GAMI; furthermore, the prevalence of addictions is above average among transgender people, including adolescents) [46].
8. To assess the symptoms of psychotic disorders.
9. To assess the symptoms of mood disorders, including assessment of the severity of suicidal thoughts and intentions.
10. To assess the cognitive maturity of an adolescent in terms of decision-making:

— does an adolescent have enough intellectual resources to understand the principles of GAMI? A situation in which a person can freely communicate their needs, even with the use of limited vocabulary, can aim to satisfy their needs and make choices with understanding the consequences is considered sufficient;
— does an adolescent understand the cause-and-effect relationships, reversibility, and irreversibility of the changes and know and understand the potential expected reactions (both desirable and undesirable) and the risks associated with the interventions an adolescent desires as part of the transition?
— does the emotional state allow an adolescent to make decisions freely (to the extent appropriate to the age of an adolescent)?

11. To assess the family situation of an adolescent, particularly the motivations of parents/legal guardians/caregivers in their decisions.
12. To assess the attitude of parents/legal guardians/caregivers toward the proposed interventions, it is advisable to examine whether they are in agreement regarding the acceptance of the gender dysphoria treatment plan, including GAMI. In the case of discrepancies, it is advisable to develop a uniform therapeutic plan accepted by a minor and both legal guardians, which is particularly important in the case of parents/legal guardians/caregivers in conflict.

4.1.4. Comments

Differential diagnosis is part of a comprehensive psychiatric diagnosis, but any potentially identified disorders and coexisting conditions do not exclude the diagnosis of GD/GI. Symptoms of psychiatric disorders that make it difficult for the patient to give informed consent to GAMI and/or to make a diagnosis of gender incongruence require prior appropriate management and sufficient monitoring before GAMI implementation.

A reasonable suspicion/diagnosis of autism spectrum disorder does not exclude the diagnosis of gender incongruence. However, complementing the GD care with support for ASD-associated difficulties may be necessary to achieve satisfaction with GAMI and improve the quality of life.

Given the relatively common coexistence of gender dysphoria and the autism spectrum, it is advisable for the professionals to be familiar with neurodiversity, or to include a person with such a specialisation in the team.

The presence of lower-than-average intellectual ability/intellectual disability in itself does not exclude the diagnosis of gender incongruence.

Psychological assessment and care are essential parts of the process. Teamwork is necessary.

4.2. Psychological and sexological care

4.2.1. General assumptions

Psychological or sexological assessment and care should be conducted by a person who is experienced in working with adolescents.

The person conducting psychological or sexological assessment and care should be familiar with the content of the current standards of care of the World Professional Association for Transgender Health [1] and comply with them, and they should be familiar with current scientific reports on GI/GD.

It is recommended that the person conducting the psychological assessment be competent to understand how gender identity intersects with other dimensions of identity, such as age, nationality, skin colour, origin, socioeconomic status, sexual identity, faith, religion, and others, and above all the dimensions of psychological functioning in terms of identity — cognitive, emotional, and social characteristics appropriate to a given age.

It is preferable that the person referring for GAMI has a psycho-sexological specialisation and/or a clinical sexologist certificate. However, due to the large number of adolescents in need of care and the insufficient availability of psycho-sexologists or certified clinical sexologists, it is permissible for the assessment to be conducted by a psychologist or clinical psychologist with sexological knowledge and experience in caring for adolescents experiencing gender incongruence, whose work undergoes supervision, and who is preferably experienced in working in an interdisciplinary team.

Bearing in mind how diverse the group of adolescents seeking care for experienced gender incongruence/dysphoria is, we recommend individualising the approach in terms of the duration of meetings, their number, the inclusion of people from the patient's environment in the diagnostic process, and questionnaire methods (optional).

Instead of a time criterion, we recommend that the contract with an adolescent and their legal guardians be based on a qualitative criterion, i.e. goals that should be achieved before enrolment for GAMI. Firstly, adolescents differ in terms of the number of required meetings (some require more meetings than others) with a mental and sexual health specialist to achieve the goals listed later in the Guidelines. Secondly, not all adolescents reporting uncertainty or difficulty in gender identity need/expect such a qualification.

It should be borne in mind that long-term psychological assessment may pose a threat to the mental health of the examined person due to prolonged untreated gender dysphoria, a sense of suspension of everyday life, and the risk of experiencing a diagnostic process as one that pathologises gender identity. Psychological assessment should not last longer than it takes to achieve the objectives listed below.

Co-occurring mental health difficulties do not constitute contraindications to GAMI provided that they do not make the diagnostic process and accurate diagnosis impossible and do not pose a risk to the successful course of GAMI. In such situations, it is recommended that these mental health difficulties/disorders be addressed first, and once adequate symptom control has been achieved, GAMI should be addressed. In other situations, it is recommended that these difficulties be worked on together with the implementation of GAMI. It is important to note that mental health difficulties may be secondary to GD/GI and may not improve without the initiation of GAMI.

The occurrence of GD/GI in adolescents on the autism spectrum requires consideration of the specificity of their development. However, the development in the autism spectrum itself cannot be the reason for denying access to affirmative interventions.

The occurrence of incongruence/dysphoria in people with significant learning difficulties, with lower-than-average intellectual ability and with intellectual disabilities requires the involvement of specialists experienced in working with people with such developmental characteristics. Lower intellectual ability cannot be the reason for denying access to affirmative interventions.

4.2.2. Objectives of psychological and sexological assessment and care

1. To conclude about meeting/not meeting the criteria for GI according to ICD-11 and possibly also for GD according to DSM-5 and to use codes from the F64 class until ICD-10 is in force.
2. To assess the symptoms of mental disorders from the spectrum of psychotic disorders that may manifest in changes in gender sense, or identity instability.
3. To support an adolescent in a free and conscious exploration of their gender identity and in making decisions about the shape and extent of possible transition.

4. To determine the ability for informed consent to hormonal interventions that considers the following:
— assessment of the adequacy of cognitive development in relation to the age of an adolescent and/or the one that allows for making informed decisions and the exclusion of the occurrence of developmental disorders in the field of individual cognitive functions that could hinder the ability to provide informed consent and to cooperate with specialists (to understand specialists' information, to understand the relationship between actions and their consequences, to verbalise one's experiences),
— assessment and confirmation of the relative stability of the mental state (exclusion of decompensation of the mental state of such a nature and intensity that would affect cognitive and intellectual functions and emotions, making it impossible to accurately assess the permanence and stability of the sense of belonging to a given gender and the presence of persistent gender dysphoria),
— assessment of personality development,
— psychoeducation and assessment of the knowledge of the patient and parents/legal guardians/caregivers in terms of:
  — action of sex hormones (also in relation to fertility and the possibility of its preservation),
  — assessment of the adequacy of perceptions and expectations about transition,
  — psychosocial consequences of transition also in the family and school areas,
  — discussing the procedure for determining the registered sex in the current legal system (currently under Article 189 of the Code of Civil Procedure) in relation to a minor,
  — coming out and the benefits and consequences of functioning in a role consistent with the perceived gender identity,
  — the possibility of undertaking psychotherapy that supports the transition process or consultation after the diagnosis,
  — normalising the transgender experience,
  — identification of community resources and non-governmental organisations that can provide support.
5. To assess possible co-occurring psychosocial difficulties, as well as the family's ability to communicate and support an adolescent person.
6. To provide psychological support for the family (including the provision of individual/family support as well as within therapeutic and/or support groups).
7. To strengthen the ability to regulate emotions and build a social support network (both of these features of functioning are related to possible dissatisfaction in the transition process).
8. To prepare for the possibility of dissatisfaction with the transition process and the desire to reverse its effects.

4.2.3. Psychological assessment tools

The basis for the psychological/psycho-sexological assessment is an interview concerning the overall psychosexual development, cognitive, emotional, and social functioning, with particular emphasis on the development of mentalisation of feelings regarding gender identity and their integration with functioning in other spheres.

Personality questionnaires – tools for measuring cognitive functions or neuropsychic functioning should be an element used with the awareness of the goal. They serve to support/shorten the interview and facilitate the assessment of co-occurring difficulties **which may constitute a significant factor interfering with the ability to give informed consent** to GAMI and GAHI and the course of transition. We recommend that when deciding on the type of tools to use, the above rationales should be followed, and the purpose of the tools should be explained to both an adolescent and their guardians. The aim of the above is to avoid the false impression that being transgender or non-binary *per se* is a phenomenon subject to diagnosis. Psychological questionnaires are not used to verify gender identity. When interpreting the test results, it is important to consider the inadequacy of most questionnaires to the specificity of transgender individuals [47].

4.2.4. Psychological support and psychotherapy

Adolescents seeking help due to GI/GD or uncertainty about their gender identity may (but do not have to) require psychological or psychotherapeutic support.

Undertaking psychotherapy may not, by definition, be a criterion for access to GAMI.

The requirement to undertake psychotherapy may occur if the coexisting difficulties threaten the health/life of an adolescent, limit the possibility of meeting with a psychologist or other specialist, affect the lack of stable experiencing one's gender identity, or limit the ability to give informed consent to medical interventions and interfere with the achievement of goals of an adolescent related to transition.

In psychotherapeutic work with NB individuals, it is unethical to force an adolescent to experience their gender identity in a binary way. Non-binary identities were considered less important than binary identities and were often not accepted by medical standards. As a result, NB individuals often face discrimination or

are overlooked, which results in internalised stress due to the anticipation of stigmatisation and the feeling of compulsion to hide their gender identity.

In psychotherapeutic work with adolescents with dysphoria, it is always necessary to assess the family system and psychoeducation of the family, as well as to assess the possible need for interventions aimed at improving the functioning of the family system. The health and emotional well-being of adolescents largely depend on the security of relationships within the family. Therefore, the assessment is an essential part of support when making decisions to start GAMI.

When working with adolescents experiencing gender incongruence, it is unethical to assume that they require psychotherapeutic intervention in each case. However, it should be assumed that psychological counselling/psychoeducation is necessary in each case. The patient and their family should be informed about the differences in these forms of interactions and their goals.

4.2.5. Psychological and sexological certificates and opinions

Certificates and opinions issued during the healthcare of an adolescent experiencing gender incongruence/dysphoria should be appropriate in terms of content due to the purpose of their issuance.

Key certificates (psychological or psychosexual opinions) are issued for medical and legal transition, i.e. to be presented to a physician initiating GAMI and to the court in which the proceedings for determining the registered sex are pending.

In the case of a certificate/opinion issued for medical transition about the lack of contraindications from the point of view of the psychological assessment to start GAMI, it should include information on the assessment (time and the number of consultations, methods) and the diagnosis.

In the case of a certificate/opinion issued for legal transition that determining the registered sex would have a positive impact on the social and emotional functioning of the person in care.

Furthermore, the specialist issues certificates/opinions for the school, offices, etc. during care. In such a case, attention should be paid to particularly sensitive data. There is no need, and it is even inadvisable, for certificates/opinions issued by specialists to include details about the mental and sexual health of the person in care. We recommend that information in certificates vary depending on the purpose for which they were prepared.

It is particularly unethical to include details of sexual experiences of an adolescent patient in the opinion, especially sexual experiences resulting from violence.

5. Hormonal interventions to suppress puberty

Hormonal interventions to suppress puberty may be recommended [15] if:

— an adolescent presents with a long-term and intense pattern of gender incongruence/dysphoria (either suppressed or expressed) that occurs or is exacerbated during puberty: according to the current criteria, the diagnosis should be confirmed in writing by at least two mental health professionals and should also include an opinion on the person's personal and social readiness for hormonal interventions to suppress puberty;
— an adolescent has begun puberty (at least B2/G2 Tanner stage);
— any coexisting mental and somatic health problems are adequately monitored/treated;
— an adolescent and their parents/legal guardians/caregivers are informed about and understand the consequences of hormonal interventions that suppress puberty (including the effects on fertility) and the adolescent's mental capacity is sufficient to give informed consent to implement such a procedure (based on submitted certificates from mental health professionals);
— an adolescent (from the age of 16) has given written informed consent to implement hormonal interventions to suppress puberty, including off-label medications, and written informed consent from their parents/legal guardians/caregivers was also obtained;
— an adolescent should be under the care of a mental health specialist(s) during hormonal interventions to suppress puberty.

Gonadotropin-releasing hormone (GnRH) analogues (GnRHa) are preferred to suppress/block puberty regardless of the sex assigned at birth. They should be used for at least six months, and it is recommended that they continued after the implementation of gender-affirming hormonal interventions (primarily in AMABs, i.e. transgender girls). After discontinuation of GnRHa (without the inclusion of GAHI), puberty occurs according to the pattern for the sex assigned at birth. Currently, because of the global increase in the number of reports on adolescents with gender incongruence with a different profile of psychosexual development than the one in the past (without a history of conscious/documented gender incongruence in childhood) and the growing population of adolescents eligible for hormonal interventions to suppress puberty, there are more and more studies evaluating the impact of GnRHa on physical and psychosexual

Table 1. *Gonadotropin-releasing hormone (gonadoliberin) analogues (GnRHa) used in hormonal interventions to suppress/block puberty in adolescents (the dosing interval may need to be shortened based on the personalised approach)*

Preparation	Potential risks/adverse effects	Expected/potential benefits
Leuprorelin acetate powder and solvent for solution for injection: 7.5 mg *i.m.* every 4 weeks or 22.5 mg *i.m.* every 12 weeks Leuprorelin acetate implant 3.6 mg *s.c.* every 4 weeks or 11.25 mg *s.c.* every 12 weeks Triptorelin 3.75 mg *s.c.* every 4 weeks or 11.25 mg *s.c.* every 12 weeks Goserelin 3.6 mg *s.c.* every 4 weeks or 10.8 mg *s.c.* every 12 weeks	Climacteric symptoms (AFAB): hot flashes, headaches, emotional instability [57,58] Adverse changes in body composition: increase in body fat, decrease in lean body mass [59, 60] Decrease in bone mineral density, failure to achieve projected peak bone mass (the risk is reduced if GAHI is introduced) Potential risk of failure to achieve the projected final height* Increase in BMI If gender-affirming hormonal intervention is introduced immediately after or during the use of a GnRHa (to suppress puberty in the initial stages of the process), it may be difficult to obtain gametes for assisted reproductive procedures at a later stage (the effect of GnRH alone on the hormonal axis is considered reversible) Transgender girls/women: poor development of the external genitalia, which may hinder gender-affirming surgical procedures Unknown effects on the development of mental/cognitive functions	Suppression of puberty, inhibition of the development of undesirable sexual characteristics (in transgender boys: suppression of the development/enlargement of the breasts, female distribution of adipose tissue, menstrual bleeding; in transgender girls: suppression of the growth of the external genitalia, changes in the voice pitch, male features and hair pattern) Extension of the time for the diagnostic process Reduction of gender dysphoria, improvement of functioning, reduction in self-aggressive behaviors, reduction in anxiety and depression Reducing the extent of subsequent surgical interventions required to reduce gender dysphoria Possible gradual increase in the dose of sex hormones to induce puberty

BMI — body mass index; GnRH — gonadotropin-releasing hormone; * — according to the most recent retrospective study, the risk is not confirmed if gender-affirming hormonal interventions (GAHI) is used in the treatment in both AMABs and AFABs [61]; *i.m.* — intramuscularly; *s.c.* — subcutaneously

development, thus verifying the safety and purpose of their use [48–56].

In each case, the decision to use this form of hormonal intervention requires a detailed discussion of its benefits and risks (Tab. 1). There are no contraindications to using GnRHa treatment if the inclusion criteria are met (as above).

The use of progestogens other than cyproterone acetate (especially in AFAB adolescents to inhibit menstrual bleeding) or antiandrogens (cyproterone acetate, spironolactone) in AMAB adolescents (Tab. 2 and 3) is a pharmacological method for the suppression of puberty alternative to GnRHa (often unavailable, rare adverse effects, poor efficacy). In

Table 2. *Pharmacological methods for puberty suppression alternative to gonadotropin-releasing hormone (gonadoliberin) analogues (GnRHa) [62]*

Preparations	Dose	Notes, including potential adverse effects
Lynestrenol	5–10 mg/day *p.o.*	Partial inhibition of the secretion of gonadotropins (spotting/menstrual bleeding in transgender boys) Hot flashes Temporary increase in body weight/BMI Fatigue Acne Adverse changes in the lipid profile No contraceptive effect
Medroxyprogesterone acetate*	5–10 mg/day *p.o.*	*Partial suppression of testosterone secretion in transgender girls in the final stages of puberty
Medroxyprogesterone depot	150 mg *i.m.* every 3 months	Increase in BMI
Norethisterone acetate*	5 mg/day *p.o.*	*An oestrogenic effect is also reported

BMI — body mass index; *p.o.* (*per os*) — orally; *inconclusive literature data

Table 3. *Antiandrogens used in adolescent AMABs*

Preparation	Dosage	Adverse effects
Cyproterone acetate	Preferred (safe) dose < 10 mg/day *p.o.* (in Poland, tablets of 50 mg); 1/4 tablet every other day can be considered.	The risk of meningioma increases as the cumulative dose rises (documented risk after long-term treatment with a dose of ≥ 25 mg/day) [67]
		Delayed growth rate
		Decrease in BMD
		Increased risk of thromboembolic complications
		Depression, fatigue, hepatotoxicity (dose-dependent risk, potentially life-threatening at doses > 100 mg/day)
		Hyperprolactinemia
Spironolactone	100-300 mg/day *p.o.* (start with lower doses and increase gradually)	Hyperkalemia
		Polyuria
		Risk of dehydration
		Risk of hypotension

AMAB — assigned male at birth; BMD — bone mineral density; GnRH — gonadotropin-releasing hormone (gonadoliberin); *p.o.* — per os (orally)

Table 4. *Monitoring of hormonal interventions to suppress puberty and (masculinizing and feminizing) GAHI*

Monitoring of hormonal interventions to suppress puberty	Monitoring of (masculinizing and feminizing) gender-affirming hormonal interventions
Baseline and every 3-6 months: height, body weight, blood pressure, puberty stage (according to the Tanner scale)	
Baseline and every 1-2 years (and before GAHI if 7-12 months have elapsed since the previous examination): bone mineral density by DXA (preferably whole-body and lumbar spine DXA), bone age if clinically warranted (X-ray of the non-dominant hand/palm)	
Baseline: complete blood count, glucose, lipid profile, ALT, AST, FSH, LH, estradiol (E2), testosterone (T), prolactin, 25(OH) vitamin D, sodium, potassium, creatinine	
Diagnosis for congenital/acquired thrombophilia in the case of a history/family history of venous thromboembolism	
FSH, LH, E2 and T every 6–12 months after implementation of the intervention 25(OH) vitamin D and fasting glucose every 12 months	In the first year of treatment: complete blood count, E2 and T every 3 months; prolactin, lipid profile, fasting glucose and 25(OH) vitamin D every 6 months; creatinine, sodium and potassium every 3 months if treated with spironolactone; ALT and AST every 3 months when treated with cyproterone acetate In subsequent years of treatment: complete blood count, E2, T, lipid profile, and 25(OH) vitamin D every 6 months; fasting glucose and prolactin every 12 months; creatinine, sodium and potassium every 6 months if treated with spironolactone; ALT and AST every 6 months when treated with cyproterone acetate Pituitary MRI if persistent increase in prolactin is reported

ALT — alanine transaminase, AST — aspartate transaminase, DXA — dual-energy X-ray absorptiometry, MRI — magnetic resonance imaging

some countries, bicalutamide (antiandrogen) is also used, although there are no long-term follow-ups in this respect.

Possible contraindications to the use (initiation or continuation) of the above preparations may result from the risk of adverse events.

An individualised monitoring regimen of hormonal interventions to suppress puberty is determined by the attending physician. The general principles of the regimen are given in the supplementary material (Tab. 4).

Health education should be provided to each adolescent during the use of hormonal interventions to suppress puberty. It should cover healthy eating and adequate physical activity, responsible use of dietary supplements (vitamin D as recommended for the general population, other vitamins in the case of deficient diets), prevention of stimulant and substance use, and prevention of sexually transmitted infections (including appropriate vaccinations).

It is important to emphasise that if an adolescent decides to discontinue hormonal interventions that suppress puberty, they should be provided with support, psychological assistance, and adequate medical care. Such support should be provided by the team that has already supervised the transition process.

6. Gender-affirming hormonal interventions (masculinising GAHI [mGAHI], feminising GAHI [fGAHI])

GAHI can be introduced as a continuation of puberty suppression interventions (initiation of puberty consistent with perceived gender) or as the first intervention in a person with gender incongruence at the later stages of puberty (IV–V Tanner). It is preferable to include these interventions in people who have achieved at least partial self-determination capacity (cumulative consent after the age of 16) unless delaying this decision poses a threat to the life, mental health (proven/confirmed by health providers), and somatic health of an adolescent. This is especially relevant to adolescents who have been using GnRHa in monotherapy for a long time due to their adverse effects on bone mineral density accrual, increased risk of osteopaenia and/or osteoporosis (their long-term impact on the risk of osteoporotic fractures is unknown) [63]. The age criterion should not be the leading one. In each case, the decision of when to initiate GAHI should be individualised (considering the following factors: the duration of puberty suppression interventions, the severity of adverse effects of such interventions, the severity of gender dysphoria and/or minority stress resulting from the desynchronisation of puberty in relation to the peer group, and intellectual development of an adolescent allowing them to give informed consent for GAHI earlier than the age of obtaining the ability of partial self-determination).

6.1. GAHI can be initiated under the following conditions:

— an adolescent presents with a prolonged and intense pattern of gender incongruence/dysphoria (either suppressed or expressed) that occurs or is exacerbated during puberty; the diagnosis based on the current criteria should be confirmed in writing by at least two mental health professionals and include the opinion on the personal and social readiness of this person for GAHI;
— in an adolescent who has previously used hormonal interventions to suppress puberty based on written confirmation of a long-lasting pattern of gender incongruence by two mental health professionals it is possible to implement GAHI based on the opinion given by one mental health professional (under whose care they were during interventions suppressing puberty) confirming the personal and social readiness of the person for GAHI;
— any coexisting mental and somatic health problems are adequately controlled and stabilised;
— an adolescent and their parents/legal guardians/caregivers are informed about and understand the aim and consequences of GAHI (including the impact on reproductive potential), and the mental capacity of an adolescent is sufficient to give informed consent to the implementation of such management (Tab. 4);
— an adolescent (16 years of age or older) has given informed written consent to start GAHI, including off-label medications, and written consent has been given by their parents/legal guardians/caregivers;
— an adolescent should remain under the care of a mental health specialist(s) during GAHI.

When GAHI has been initiated based on the opinion of mental health professionals practicing in countries other than the Republic of Poland in accordance with the rules binding in these countries, it is advisable to continue the intervention (after obtaining informed written consent to the continuation of GAHI by an adolescent and their parents/legal guardians/caregivers).

If an adolescent undergoing GAHI is unable to provide adequate documentation issued by mental health professionals, the continuation of GAHI should be considered for no longer than six months, assuming that during this time written confirmation issued by mental health professionals is provided according to which the required diagnostic process has been initiated and continued, and an adolescent and their parents/legal guardians/caregivers have given written informed consent to such management.

GAHI protocols and their potential adverse effects are presented in Tables 5 and 6. GnRHa may be maintained/included when these interventions are initiated. In the case of an AMAB adolescent, antiandrogens may be used instead of GnRH agonists. Monitoring of GAHI is given in the supplementary material.

It is important to emphasise that if an adolescent decides to discontinue GAHI, support, psychological assistance, and adequate medical care should be provided. Such support should be given to an adolescent by the team already supervising the transition process.

Benefits from adding progestogens other than cyproterone acetate (e.g. medroxyprogesterone) to the GAHI regimen in AMABs (improved quality of life, effect on breast development) in transgender girls/women in the context of a documented increase in thromboembolic risk and decreased high-density lipoprotein cholesterol ((HDL-cholesterol) are questionable, and such management is not recommended. Study results on the use of micronised progesterone are inconclusive (no benefits related to its use have been proven, but they also appear to be metabolically neutral in terms of the risk of thromboembolism). There are not many studies, and they have been conducted in a group of AMAB adults with gender incongruence. For this reason, its use in AMAB minors is not recommended [64–66].

Table 5. ***GAHI: puberty induction consistent with perceived gender in AFABs with gender incongruence based on the*** *Endocrine Society* ***2017 guideline (individualization of the management is indicated, depending on the course of the intervention).***

Initiating masculinizing interventions in transgender boys: testosterone esters (e.g., enanthate) *i.m.*, dose escalation every 6 months: 25 mg every 2 weeks — 50 mg every 2 weeks — 75 mg every 2 weeks — 100 mg every 2 weeks
Adult dose: 100–200 mg every 2 weeks
If therapy is started after puberty (IV–V Tanner): 50 mg every 2 weeks for 6 months, then 100 mg every 2 weeks
According to some experts, it is better to use transdermal testosterone (gel) at an initiating dose of 10 mg/day, which is increased every 3–6 months, depending on the stage of puberty.
Adverse effects: • reduced fertility/infertility • polycythemia • acne • androgenetic alopecia • weight/BMI gain (during growth) • dyslipidemia • sleep apnea • increased risk of type 2 diabetes (associated with weight gain) • hypertension

AFAB — assigned female at birth; BMI — body mass index; GnRH — gonadotropin-releasing hormone (gonadoliberin)

Table 6. ***Gender-affirming hormonal interventions (GAHI): pubertal induction consistent with perceived gender in assigned male at birt (AMABs) with gender incongruence based on the Endocrine Society 2017 guideline (individualisation of the management is indicated, depending on the course of the intervention)***

Initiating feminising interventions in transgender girls using oral 17-β-oestradiol, dose escalation every 6 months: 5 μg/kg/day — 10 μg/kg/day — 15 μg/kg/day — 20 μg/kg/day
Adult dose: 2–6 mg
1 mg/day for 6 months, then 2 mg/day if the intervention is initiated after puberty (Tanner IV–V)
Initiating feminising interventions in transgender girls with percutaneous 17-β-oestradiol (transdermal patches)
Dose escalation every 6 months, patch change every 3.5 days: 6.25–12.5 μg/day — 25 μg/day — 37.5 μg/day — 50 μg/day
Adult dose: 50–200 μg/day
The same dosage as in adults if the intervention is started after puberty (Tanner IV–V)
Adverse effects: • reduced fertility/infertility • risk of venous thromboembolism (higher with oral preparations) • weight/BMI gain • hypertriglyceridaemia • hypertension • hyperprolactinaemia • osteopaenia/osteoporosis if dosed inappropriately

BMI — body mass index

An individualised monitoring regimen for gender-affirming hormonal interventions is determined by the attending physician. The general principles of the regimen are given in the Table 4.

Health education should be provided to each adolescent during gender-affirming interventions. It should be related to healthy eating and adequate physical activity, proper use of dietary supplements (vitamin D according to the recommendations for the general population, other vitamins in the case of deficient diets), prevention of stimulant and substance abuse, prevention of sexually transmitted infections (including appropriate vaccinations), and prevention of unwanted pregnancy.

7. Gender-affirming surgical interventions

Irreversible genital surgery (hysterectomy, vaginoplasty, penectomy, phalloplasty, metoidioplasty, etc.) and procedures that result in permanent loss of the ability to procreate (gonadectomy) cannot be performed on minors.

Surgery to remove the mammary glands (mastectomy) in AFABs is acceptable in minors. The main aim of mastectomy is to improve the mental health of a person experiencing gender dysphoria, including distress resulting from the unacceptable presence of breasts, which must be associated with a strong need of the adolescent and their mental stability. The decision regarding the procedure must be individualised and requires certificates from two specialists.

8. Legal issues related to the care of adolescents with gender incongruence/dysphoria

8.1. Informed consent — legal principles (Fig. 1–3)

Explanations of the figures ([1], [2], [3] ...)

[1] The essential features of the consent to a healthcare service:

1. Consent must be free and informed;
2. Consent can be withdrawn at any time;
3. Before obtaining consent, a physician must provide accessible information on the circumstances relevant to giving consent:

"A physician is obliged to provide the patient or their legal representative with accessible information about the patient's health condition, diagnosis, proposed and possible diagnostic and therapeutic methods, foreseeable consequences of their use or abandonment, treatment results, and prognosis" (Article 31(1) of the Act on the Professions of Physicians and Dentists).

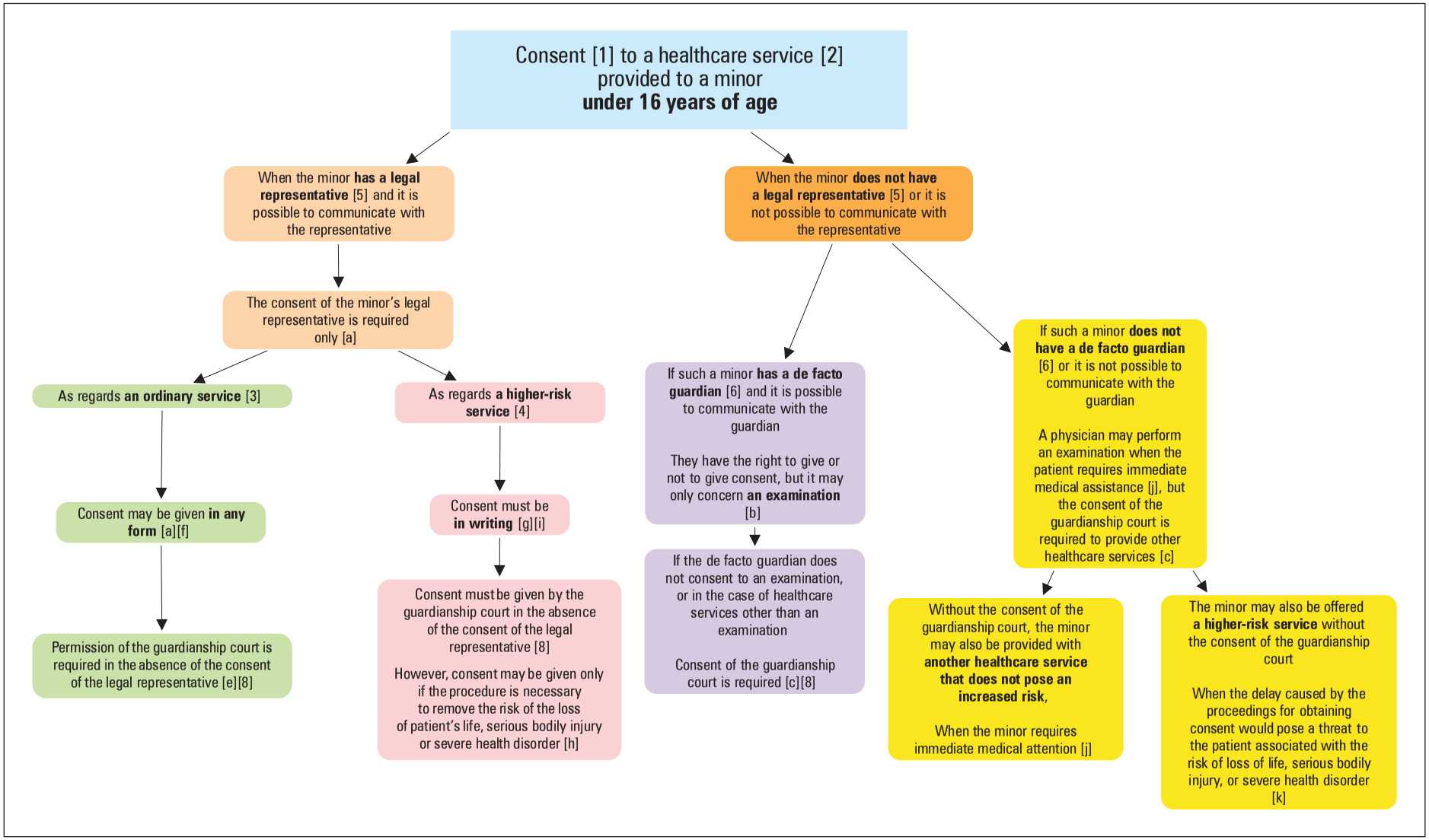

Figure 1. *Consent to a healthcare service provided to a minor under 16 years of age*

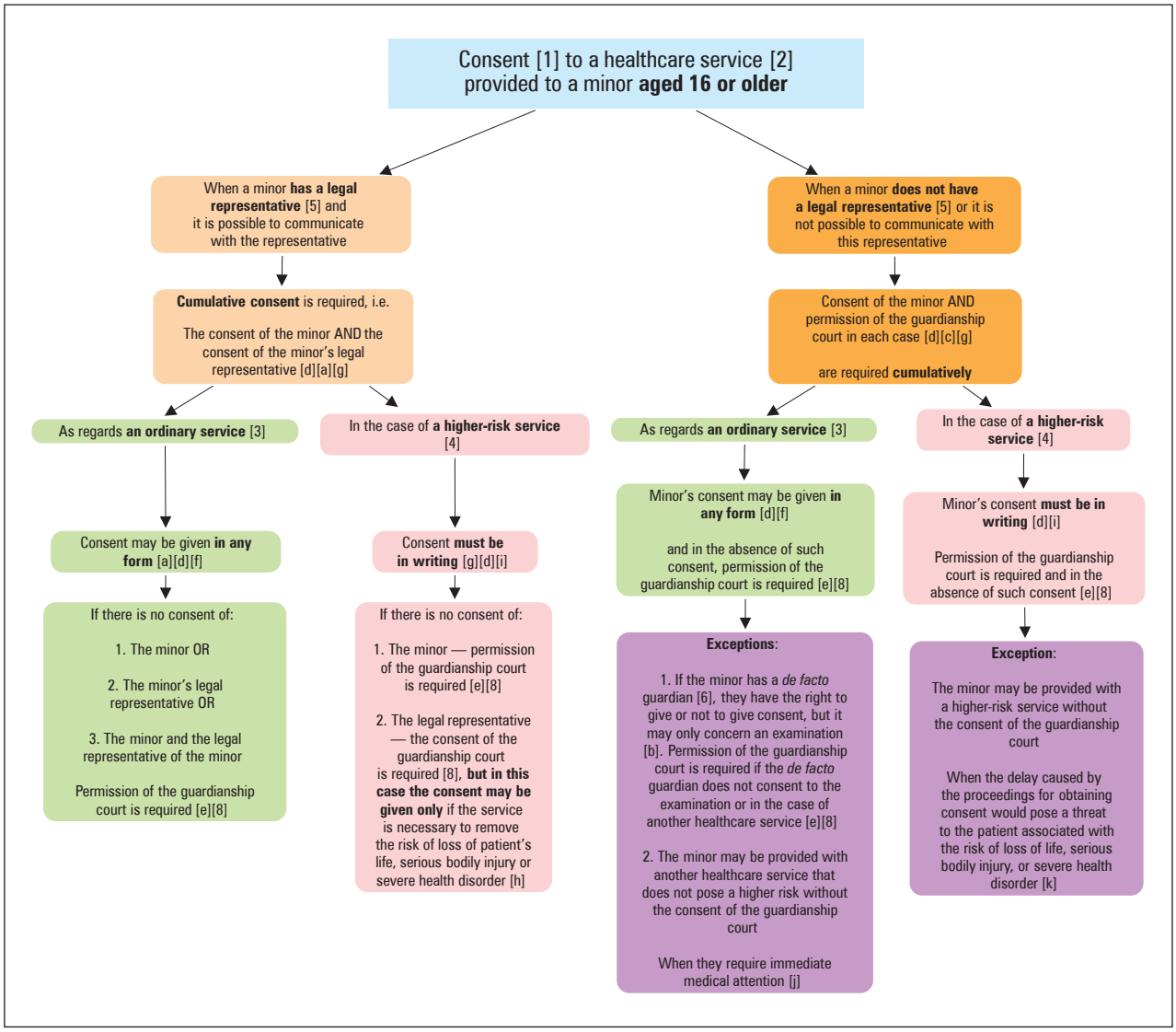

Figure 2. *Consent to a healthcare service provided to a minor aged 16 or older*

However, the patient may request a physician not to provide them with such information (Art. 31(3) of the Act on the Professions of Physicians and Dentists).

In the case of minors under 16 years of age, information must be provided only to the patient's legal representative. However, a physician must provide a minor patient under 16 years of age with "information to the extent and in the form necessary for the proper course of the diagnostic or therapeutic process" and must listen to the patient's opinion (Art. 31(7) of the Act on the Professions of Physicians and Dentists).

In the case of minors aged 16 or older, information (complete information in accordance with Article 31(1) of the Act on the Professions of Physicians and Dentists) is provided to both the patient's legal representative and the patient (Article 31(5) of the Act on the Professions of Physicians and Dentists).

See also the provisions of Articles 9 and 16 of the Act on Patients' Rights and Patients' Ombudsman.

[2] *Healthcare service* is the most general term to designate all activities that a physician may perform in relation to a patient. They can be divided into an ordinary service (see [4]) and higher-risk services (see [5]). The term *healthcare service* is used primarily in the provisions of Articles 15–19 of the Act on Patients' Rights and Patients' Ombudsman, indicating that the patient has the right to consent to healthcare services.

[3] Ordinary service is a term used to designate the following:

1. Examinations;
2. Other healthcare services that do not pose a higher risk to the patient (Article 32(1) of the Act on the Professions of Physicians and Dentists with consideration given to Article 34(1) of the Act on the Professions of Physicians and Dentists).

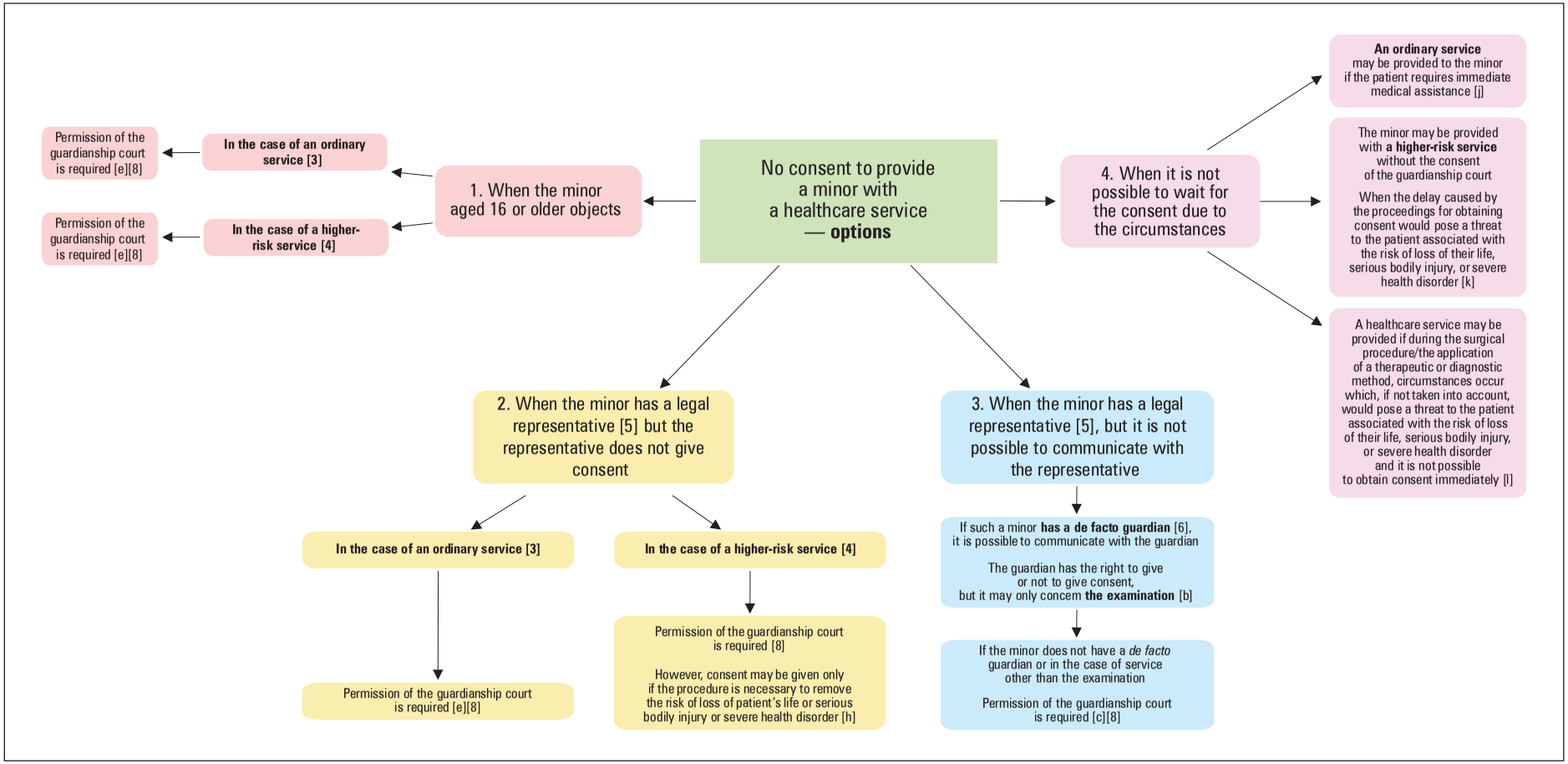

Figure 3. *No consent to provide a minor with a healthcare service – options*

"The term *examination* within the meaning of the Act shall be associated with the most basic form of a physician's activity, consisting of visual examination of the body and physical examination (see T. Duket-Nagórska, Świadoma zgoda... *[Informed consent…]*, pp. 78, 88). These are routine and risk-free medical activities that do not significantly interfere with the patient's physical integrity. *Other healthcare services* shall be understood, for example, as administration of a drug, installation of a medical device when it does not involve the interference with the body, application of a plaster cast" (M. Malczewska, *Komentarz do art. 32, w: Ustawa o zawodach lekarza i lekarza dentysty. Komentarz [Commentary on Article 32*, in *Act on the Professions of Physicians and Dentists. Commentary]*, WKP 2022).

[4] *Higher-risk service* is the term used to designate:

1. Surgery;
2. A treatment method that poses a higher risk to the patient;
3. A diagnostic method posing a higher risk to the patient (article 34(1) of the act on the professions of physicians and dentists).

[5] A legal representative of a minor is any of the child's parents with parental authority (Article 98 § 1 of the Family and Guardianship Code), the adopter (known as an *adoptive parent*; Article 121 § 1 of the Family and Guardianship Code), the legal guardian, or the court-appointed guardian.

A legal guardian is a person appointed by the court to protect the property and personal interests of a minor (mostly when a minor does not have a parent with parental authority). However, the guardian is subject to the supervision by the guardianship court (Article 155 § 1 of the Family and Guardianship Code).

[6] A *de facto* guardian is "a person who, without a statutory obligation, provides permanent care to a patient who requires such care due to their age, health condition or mental condition" (Article 3(1)(1) of the Act on Patients' Rights and Patients' Ombudsman).

[7] Rules for giving consent to the provision of a service to a minor by the legal representative:

1. One parent or both of them? If both parents of a minor have parental authority, they must both consent to the service (these will usually be "important matters of the child"[3] within the meaning of Article 97 § 2 of the Family and Guardianship Code).

However, this does not mean that both parents must assist at every medical visit. One of them may present the position they have both adopted, and a physician has the right to assume that it is the consensus position of both legal representatives (or at least the position to which the other parent has not objected). Then, it is sufficient for a physician to obtain the consent only of the present parent, assuming that the parent expresses the will in a legitimate manner.

Therefore, when the patient comes with one of the parents, and the medical history and medical records do not show a discrepancy between the parents' opinions, it is sufficient for a physician to obtain consent only from the present parent as in the case of other medical procedures.

2. However, if information is obtained (e.g. from the documentation, information given during the interview by the parent or the patient on their own) that there is no agreement between the parents regarding the provision of healthcare services, it is necessary to obtain the substitute consent of the court. A physician cannot then choose the position of the parent that a physician considers more correct but must wait for the court's decision. Therefore, if a physician knows about a difference of opinion between the parents, they should ask the present parent to refer the case to the guardianship court or do it themselves[4].
3. The above remarks apply only to a situation in which parental authority is vested in both parents. If the court limits the parental authority of one of the parents, e.g. to the right to make joint decisions on the education and rules of raising the child, then the decision regarding the treatment of the child — because it does not fall within the designated scope — can be made autonomously by the parent whose parental authority has not been limited.

[8] Substitute consent (permission) is given by the guardianship court (district court). The competent court is the district court in whose district the medical procedures are to be performed. The court acts *ex officio* in these cases, which means there is no need to file an application - it suffices to notify the court (e.g.

[3]Undoubtedly, important matters include surgical procedures, the use of a method of treatment or a diagnostic procedure posing a higher risk, but also ordinary healthcare services, provided that their recognition as such is supported by the conditions of a specific medical intervention, and particularly the type of disease or the child's health condition (J. Kosonoga-Zygmunt, Zgoda rodziców na udzielenie świadczenia zdrowotnego małoletniemu pacjentowi [Parents' consent to provide healthcare services to a minor patient], "Prokuratura i Prawo" 2018, No. 5, p. 74).

[4]"...lack of agreement may take the form of consent of one of the parents to a specific healthcare service with the objection of the other parent, which is known to a physician. In such a situation, the physician cannot consider the consent of one of the parents to be sufficient and provide a healthcare service. In such a case, the guardianship court decides on conducting the examination, performing a surgical procedure, applying a treatment method or a diagnostic procedure of increased risk" (A. Augustynowicz, I. Wrześniewska-Wal, Dopuszczalność… [Admissibility...], p. 50).

by phone) of the need to give consent to the provision of healthcare services to a minor. A notification can be submitted, for example, by a physician or by another representative of a medical facility.

Legal basis for the figures ([a], [b], [c] ...)

[a] "If the patient is a minor ..., the consent of their legal representative is required, and if the patient does not have a legal representative or it is impossible to communicate with that representative, the permission of the guardianship court is required" (Article 32(2) of the Act on the Professions of Physicians and Dentists).

[b] "If there is a need to perform the examination of a person referred to in Section 2 [a minor, among others], the *de facto* guardian may also consent to the examination" (Article 32(3) of the Act on the Professions of Physicians and Dentists).

[c] "If the patient ... has no legal representative or *de facto* guardian, or it is impossible to communicate with these persons, the physician may proceed to provide further healthcare services after the examination only after obtaining the consent of the guardianship court, unless otherwise provided for in the provisions of the Act" (Art. 32(8) of the Act on the Professions of Physicians and Dentists).

[d] "If the patient is 16 years of age or older, their consent is also required" (Article 32(5) of the Act on the Professions of Physicians and Dentists - in relation to ordinary services and Article 34(4) of the Act on the Professions of Physicians and Dentists - in relation to higher-risk services).

[e] "However, if a minor who has reached the age of 16 ... opposes medical procedures, next to the consent of their legal representative or the *de facto* guardian, or in the event of their refusal to give consent, the permission of the guardianship court is required" (Art. 32(6) of the Act on the Professions of Physicians and Dentists in conjunction with Article 34(5) of the Act on the Professions of Physicians and Dentists).

There is no doubt that based on this provision it is possible for the guardianship court to "overcome" the objection of a minor in any situation (both in terms of an ordinary service and a higher-risk service). Additionally, there is no doubt that it is possible for the guardianship court to "overcome" the lack of consent of the legal representative to a higher-risk service. Such "overcoming" is possible under Article 34(6) of the Act on the Professions of Physicians and Dentists (see point [h]).

However, there is a serious dispute in the doctrine as to whether it is possible for the guardianship court to "overcome" the lack of consent of the legal representative to provide an ordinary service[5].

Nevertheless, physicians should be advised to notify the guardianship court of this fact when they consider it necessary to provide an ordinary service and the legal representative does not give consent. It is the court that is the entity competent to resolve disputes over the proper interpretation of the law, and it is the court that will decide whether it is possible to "overcome" the lack of consent of the patient's legal representative in a given situation. Therefore, the above figures include information that in such a situation, the consent is given by the guardianship court.

[f] "Unless the act provides otherwise, consent ... may be given orally or even through their behaviour in such a way that it clearly indicates the will to undergo the medical procedures proposed by a physician" (Art. 32(7) of the Act on the Professions of Physicians and Dentists).

[g] "A physician may perform a procedure or apply the method referred to in Section 1 [higher-risk service] to a minor patient ... after obtaining the consent of their legal representative, and if the patient does not have a representative or when it is impossible to communicate with the representative after obtaining the permission of the guardianship court" (Article 34(3) of the Act on the Professions of Physicians and Dentists).

[h] "If the legal representative of a minor patient ... does not consent to the activities performed by a physician that are listed in Section 1 [higher-risk services] and necessary to remove the risk of loss of patient's life or serious bodily injury or serious health disorder, a physician may perform such activities after obtaining the consent of the guardianship court" (Art. 34(6) of the Act on the Professions of Physicians and Dentists).

[i] "A physician may perform a surgical procedure or apply a method of treatment or diagnostic procedure that poses a a higher risk to the patient after obtaining

[5]Positive opinions about such a possibility were reported, for example, by, T. Dukiet-Nagórska, Podmiot wyrażający zgodę [The entity giving consent], in: idem, Autonomia pacjenta a polskie prawa karnego [Patient's autonomy and Polish criminal law], Oficyna 2008; Ł. Caban, M. Urbańska, Komentarz do art. 32 ustawy [Commentary on Article 32 of the Act], in: Ustawa o zawodach lekarza i lekarza dentysty. Komentarz [Act on the professions of physicians and dentists. Commentary], M. Kopeć (ed.), WK 2016. On the other hand, a negative opinion was expressed by B. Janiszewska, Niewyrażenie zgody przez przedstawiciela ustawowego pacjenta [Refusal to consent by the patient's legal representative], in: System Prawa Medycznego. Tom II. Część 1. Regulacja prawna czynności medycznych [Medical Law System. Volume II. Part 1. Legal regulation of medical activities], ed. M. Boratyńska, P. Konieczniak, E. Zielińska, WKP 2019.

the patient's written consent" (Art. 34(1) of the Act on the Professions of Physicians and Dentists).

[j] "1. Examination or providing the patient with other healthcare services without the patient's consent is permissible if the patient requires immediate medical assistance and, due to their health condition or age, they cannot give consent and there is no possibility of communicating with their legal representative or the *de facto* guardian.

2. The decision to undertake medical activities in the circumstances referred to in Section 1 should be consulted by a physician with another physician as far as possible.

3. The circumstances referred to in Sections 1 and 2 shall be entered by a physician in the patient's medical records" (Article 33 of the Act on the Professions of Physicians and Dentists).

[k] "A physician may perform the activities referred to in Section 1 [higher-risk service] without the consent of the patient's legal representative or the consent of the competent guardianship court if the delay caused by the proceedings for obtaining consent would pose a threat to the patient associated with the risk of loss of life, serious bodily injury or serious health disorder. In such a case, a physician is obliged, if possible, to consult another physician of the same specialty if possible. A physician shall immediately notify the legal representative, the *de facto* guardian, or the guardianship court of the performed activities" (Art. 34(7) of the Act on the Professions of Physicians and Dentists).

[l] "1. If, in the course of performing a surgical procedure or using a therapeutic or diagnostic method, circumstances occur, the non-inclusion of which would pose a threat to the patient associated with the risk of loss of their life, serious bodily injury, or severe health disorder, and it is not possible to immediately obtain the consent of the patient or their legal representative, a physician has the right to change the scope of the procedure or the method of treatment or diagnostic procedure without obtaining such consent in a way that allows these circumstances to be taken into account. In such a case, a physician is obliged, as far as possible, to consult another physician of the same specialty if possible.

2. A physician shall include appropriate notes in the medical records about the circumstances referred to in Section 1 and inform the patient, the legal representative or the *de facto* guardian or the guardianship court" (Article 35 of the Act on the Professions of Physicians and Dentists).

Legal acts containing provisions on consent to provide a healthcare service

1. The Act of 5th December 1996 on the Professions of Physicians and Dentists (uniform text, Journal of Laws of 2022, item 1731).
2. The Act of 6th November 2009 on Patients' Rights and Patients' Ombudsman (uniform text, Journal of Laws of 2022, item 1876).
3. The Act of 25th February 1964 - The Family and Guardianship Code (uniform text, Journal of Laws of 2020, item 1359).

8.2. Informed consent forms for off-label use of the drug [27]

8.2.1. Informed consent form for hormonal intervention/masculinising therapy

The model of care based on informed consent respects your fundamental right to self-determination and bodily autonomy. The purpose of this document is to confirm in writing that you consent to a masculinising hormonal intervention as part of the gender-affirming process.

This form can be signed by any adult who can make an informed decision (over 18 years of age) or their legal guardians in the case of minors. With regard to adolescents who are over 16 years of age but under 18 years of age, informed consent must be given by both an adolescent and their legal representatives. For individuals under 16 years of age, it is not legally required to provide informed consent by signing the form, but we recommend you consider this option to further involve you in the decision-making process.

This document refers to testosterone preparations. Your physician will discuss with you all the information you need to start hormone therapy (including different methods/regimens). Please read the following information carefully and ask your physician questions if you have any doubt.

A physical examination of the genitals in order to start administration of sex hormones is not required, and if you do not wish it, ask your physician to waive this part of the physical examination (Fig. 4).

8.2.2. Informed consent form for hormonal intervention/feminising therapy

The model of care based on informed consent respects your fundamental right to self-determination and bodily autonomy. The purpose of this document is to confirm in writing that you consent to a feminising hormonal intervention as part of the gender-affirming process.

This form can be signed by any adult who can make an informed decision (over 18 years of age)

I, ..., confirm that on the day of ..... I had the opportunity to read, understand, and ask questions to the physician with respect to the following information. I understand that the preparation (drug) is used off-label, i.e. it is not registered (nor reimbursed) in Poland for this purpose. (*delete as appropriate*)
Tick/add next to each point (☐) to confirm that you understand the following:

Changes expected during masculinising hormone therapy
Permanent changes:
☐ increase in facial and body hair
☐ lowered pitch of voice
☐ enlargement of the external genitalia during arousal and erection (phallus/clitoris)
☐ possibility of baldness

Reversible changes:
☐ increased libido
☐ redistribution of adipose tissue
☐ thickening of the skin and skin greasiness
☐ (exacerbation of) acne on the face, chest, and back
☐ stopping menstruation
☐ vaginal dryness
☐ elevated cholesterol levels
☐ increased blood pressure
☐ mood changes

I acknowledge the following potential adverse events and risks associated with masculinising hormone therapy. My physician will continue to monitor my health and take care of any problems if they occur.
— polycythaemia — increased red blood cell count, resulting in blood thickening
— increased risk of cardiovascular disease
— difficulty in controlling blood glucose levels in diabetes
— occurrence or exacerbation of obstructive sleep apnoea
— osteoporosis
— liver damage
— increased sodium and water retention

° I understand that masculinising hormone intervention/therapy works differently for everyone and that it is impossible to predict exactly how my body will change under its influence. Some of the long-term effects of masculinising hormone therapy are not yet known.
° I was advised to consider storing/preserving egg cells in case I decide to have children in the future. I was given the option to delay/postpone the medical transition until the material (egg cells/ovarian tissue) is secured if I wish to do so.
° I was informed that the use of masculinising hormones does not guarantee infertility and that I should use contraception during sexual intercourse, which puts me at risk of pregnancy. I was informed that becoming pregnant while taking testosterone can put the foetus/baby at serious risk.
° It is my duty to learn about safe sex. I was encouraged to take active steps to protect myself from HIV infection or other sexually transmitted infections. My physician can help me make the best choice.
° I understand that gender-affirming hormone therapy means having to visit my physician regularly for the rest of my life and undergoing follow-up blood tests at regular intervals. Visits will initially be more frequent, and when the concentrations of hormones stabilise, the frequency of visits will decrease to once every 6–12 months. I make this commitment for the sake of my health.
° I acknowledge that gender-affirming hormonal intervention is only responsible for part of my overall health and that many preventative health measures are recommended to maintain my broadly understood HEALTH. These include, among others:
— cervical screening at appropriate intervals, as recommended by my physician
— regular check-ups of my chest/breast for lumps, even after mastectomy
— mammography from the age of 50, as recommended by my physician
— regular screening for sexually transmitted infections, depending on the risk level
— smoking cessation
— vaccination
— regular physical activity if clinically recommended, including resistance exercise for bone health
— healthy eating
° I can decide to discontinue my gender-affirming hormone therapy at any time. If I decide to discontinue taking hormones, it is best for my safety and health if I do so after consulting my physician.

Patient's name and surname:
Patient's signature: date: .....

Legal guardian's name and surname:
Legal guardian's signature: date: .....

Doctor's name and surname:
Doctor's signature: date: .....

Figure 4. *Informed consent form for hormonal intervention/masculinising therapy*

or their legal guardians in the case of minors. With regard to adolescents who are over 16 years of age but under 18 years of age, informed consent must be given by both an adolescent and their legal representatives. For individuals under 16 years of age, it is not legally required to provide informed consent by signing the form, but we recommend you consider this option so that you are further involved in the decision-making process.

This document refers to oestrogen and progesterone preparations/hormones as well as testosterone-blocking drugs. Your physician will discuss with you all the information you need to start hormone therapy (including different methods/regimens). Please read the following information carefully and ask your physician questions if you have any doubt.

A physical examination of the genitals in order to start administration of sex hormones is not required,

I, ..., confirm that on the day of ..... I had the opportunity to read, understand, and ask questions to the physician with respect to the following information. I understand that the preparation (drug) is used off-label, i.e. it is not registered (nor reimbursed) in Poland for this purpose. (*delete as appropriate*)
Tick/add next to each point (Ö) to confirm that you understand the following:

Changes expected when using feminising hormone therapy
Permanent changes:
☐ breast and nipple development
☐ reduced testicular size
☐ penile shrinkage/atrophy leading to possible penile pain during erection

Reversible changes:
☐ skin softening
☐ decreased muscle mass and increased body fat
☐ decreased libido
☐ decreased spontaneous morning erections
☐ reduced ability to achieve or maintain an erection
☐ decreased ability to ejaculate and decreased volume of ejaculatory fluid
☐ slowing or stopping baldness
☐ slowing hair growth on the face and body
☐ improved cholesterol levels

I acknowledge the following adverse effects of feminising hormone therapy:
☐ headaches
☐ nausea
☐ fluid retention and flatulence
☐ breast and nipple tenderness
☐ mood disorders such as tearfulness, depression, or anxiety
☐ fatigue

I acknowledge the following potential risks associated with feminising hormone therapy:
☐ blood clots, deep vein thrombosis, or potentially fatal pulmonary embolism
☐ stroke
☐ increased risk of heart disease or myocardial infarction
☐ increased blood pressure
☐ liver damage
☐ osteoporosis
☐ potentially increased risk of breast cancer
☐ development of prolactinoma (a pituitary tumour that can cause breast galactorrhoea)
☐ difficulty controlling blood glucose levels in individuals with diabetes
☐ meningioma (a proliferative lesion in the brain in some individuals on high doses of cyproterone acetate)

° I understand that feminising hormone therapy works differently for everyone. It is impossible to predict exactly how my body will change under its influence. Some of the long-term effects of feminiSing hormone therapy are not yet known.
° I acknowledge that continuing to smoke while taking oestrogen increases the risk of blood clots, deep vein thrombosis, or potentially fatal pulmonary embolism.
° My physician recommended that I consider storing sperm if I decide to have children/offspring in the future. I was informed of the possibility of delaying the medical transition until sperm was stored if I wish to do so.
° I was informed that the use of feminising hormones does not guarantee infertility and that contraception should be used to avoid unwanted pregnancy in the event of intercourse with a person who may become pregnant.
° I understand that gender-affirming hormone therapy means having to visit my physician regularly for the rest of my life and undergoing follow-up blood tests at regular intervals. Visits will initially be more frequent, and when the concentrations of hormones stabilise, the frequency of appointments will decrease to once every 6–12 months. I make this commitment for the sake of my health.
° I acknowledge that gender-affirming hormonal intervention is only responsible for part of my overall health and that many preventative health measures are recommended to maintain my broadly understood HEALTH. These include, among others:
— monthly breast self-examination. I should tell my physician if I detect any new lumps.
— regular breast mammography from the appropriate age after consultation with a physician
— smoking cessation
— vaccination
— regular screening for sexually transmitted infections, depending on the risk level
— prevention of HIV and other sexually transmitted infections, depending on my risk level
— regular physical activity, including resistance exercise for bone health
— healthy eating
° I can decide to discontinue my gender-affirming hormone therapy at any time. If I decide to discontinue taking hormones, it is best for my safety and health if I do so after consulting my physician.

Patient's name and surname:
Patient's signature: date: .....

Legal guardian's name and surname:
Legal guardian's signature: date: .....

Doctor's name and surname:
Doctor's signature: date: .....

Figure 5. *Informed consent form for hormonal intervention/feminising therapy*

and if you do not wish it, ask your physician to waive this part of the physical examination (Fig. 5).

8.2.3. Informed consent form for puberty-suppressing/blocking hormonal intervention/use of GNRH analogues

The model of care based on informed consent respects your fundamental right to self-determination and bodily autonomy. The purpose of this document is to confirm in writing that you consent to a puberty-suppressing intervention in the form of intramuscular injections using GnRHa.

This form can be signed by any adult who can make an informed decision (over 18 years of age) or their legal guardians in the case of minors. With regard to adolescents who are over 16 years of age but under 18

I, ..., confirm that on the day of ..... I had the opportunity to read, understand, and ask questions to the physician with respect to the following information. I understand that the preparation (drug) is used off-label, i.e. it is not registered (nor reimbursed) in Poland for this purpose. (*delete as appropriate*)
Tick/add next to each point (☐) to confirm that you understand the following:

Expected and reversible changes when using GnRHa:
☐ inhibition of puberty and the development of undesirable sexual characteristics
— in transgender boys/non-binary persons assigned female at birth: inhibition of breast growth/enlargement, female fat distribution, and menstrual bleeding;
— in transgender girls/non-binary persons assigned male at birth: inhibition of external genital growth, changes in voice tone, and male features and hair type;
☐ reduction in the scope of subsequent surgical interventions needed to reduce gender dysphoria;
☐ extension of the time for the diagnostic process;
☐ reduction of gender dysphoria, improvement of functioning, reduction of self-aggressive behaviour, reduction of anxiety and depression;
☐ a possible gradual increase in the dose of sex hormones (more physiologically) to induce puberty.

I acknowledge the following adverse effects and risks associated with the use of GnRHa:
☐ in transgender boys/non-binary persons assigned female at birth: climacteric symptoms, i.e. hot flashes, headaches, emotional instability;
☐ in transgender girls/non-binary persons assigned male at birth: decreased libido [57, 58];
☐ adverse modification of body mass composition: increase in body fat, decrease in muscle mass;
☐ increase in BMI;
☐ potential risk of failure to achieve projected final height*;
☐ if a gender-affirming hormonal intervention (GAHI) is introduced immediately after or during the use of a GnRH analogue (to inhibit puberty in the initial stages of this process), it may be difficult to obtain gametes for assisted reproductive procedures at a later stage (the effect of GnRH alone on the hormonal axis is considered reversible);
☐ the impact on the development of mental/cognitive functions is unknown;
☐ transgender girls/women: insufficient development of the external genitalia, which may hinder gender-affirming surgical interventions;
☐ decrease in bone mineral density, failure to achieve peak bone mass (this risk is reduced if GAHI is implemented).

° I understand that blocking intervention with intramuscular injections of GnRHa works differently for everyone and its effects may depend on its duration. Some of its long-term consequences are not yet known.
° I was informed that the use of blocking intervention is assumed to cause temporary infertility.
° My physician recommended that I consider securing the genetic material (sperm storage, egg cell protection) in case I decide to have children/offspring in the future. I was informed about the possibility of delaying the medical transition until the material was secured (as above) if I wish to do so.
° I understand that hormone therapy to block puberty means that I need to see my physician regularly and undergo blood check-ups at regular intervals. Visits will initially be more frequent, and over time, with good tolerability, their frequency will decrease to approximately once every six months. I make this commitment for the sake of my health.
° I acknowledge that puberty-suppressing intervention is only responsible for part of my overall health and that many preventive health measures are recommended to maintain my broadly understood HEALTH. These include, among others:
— regular physical activity, including resistance exercise for bone health;
— healthy eating (including taking care of proper parameters of calcium and phosphate metabolism, such as vitamin D3);
° I may decide to discontinue puberty-suppressing therapy with a GnRHa at any time. If I decide to discontinue taking a GnRHa, it is best for my safety and health to do so after consultation with my physician.

Patient's name and surname:
Patient's signature: date.....

Legal guardian's name and surname:
Legal guardian's signature: date.....

Doctor's name and surname:
Doctor's signature: date.....

Figure 6. *Informed consent form for puberty-suppressing/blocking hormonal intervention/use of GnRH analogues*

years of age, informed consent must be given by both an adolescent and their legal representatives. For individuals under 16 years of age, it is not legally required to provide informed consent by signing the form, but we recommend you consider this option so that you are further involved in the decision-making process.

A physician will discuss with you all the information to start puberty-suppressing therapy (including different methods/regimens). Please read the following information carefully and ask your physician questions if you have any doubt.

Physical assessment of the degree of puberty to initiate the administration of GnRHa is required (the condition for the initiation is confirmation of entry into puberty, i.e. the presence of sexual characteristics). A physician experienced in this respect will provide appropriate intimate conditions for this part of the physical examination (Fig. 6).

9. Appendix: the use of names, pronouns, organisation of medical records, and space for the patients

Language and communication are an important (though often overlooked) issue in the healthcare of

transgender and non-binary people. It applies to both communication with patients and between specialists, e.g. in the form of opinions or referrals. The importance of language and communication was expressed by the position statement of the Polish Sexological Society [68], Recommendations of the Polish Sexological Society on medical care in transgender adults [3], and the paper by Prof. Walter Bouman et al. (*Language and trans health*) [69].

The study results confirm the health benefits and the advantages of building a therapeutic alliance, and the correct relationship between a specialist and a patient resulting from the use of language that considers names and gender forms consistent with the needs of patients [70].

During the assessment and care process, we recommend referring to individuals according to their wishes. This allows a reduction in the tension arising in connection with the patient's struggle for recognition of their feelings. It improves contact and allows for building a good relationship (therapeutic alliance) that is necessary for the process of assessment and further care, and it normalises the phenomena of transgender, non-binary, or the search for one's gender identity in contact with parents/legal guardians/caregivers.

In hospitals, psychotherapy centres, social therapy centres, schools, and other places where adolescents are grouped, we recommend the development of a consistent procedure for addressing the individual at every stage of their contact with healthcare personnel. We recommend addressing the individual as they desire, at the request of an adolescent, and indicating the patient's preferred name in the documentation because the use of a name and grammatical gender inconsistent with the gender identity of an adolescent may lead to deterioration of mental health and refusal to cooperate. Some non-binary minors may use neutral genders that omit gendered phrases and pronouns that indicate the masculine or feminine gender. Such forms include, e.g., the increasingly popular neutral gender. Understandably, these forms will be difficult and unintuitive in flection for those using them for the first time. However, we recommend adopting an attitude that is open to a non-binary minor and adapting the forms to their preferences. If problems occur, it is suggested that flection instructions be asked for and/or online glossaries of neutral genders be used (e.g. www.zaimki.pl).

Efforts should be made to ensure that all locations where work is done with transgender or non-binary adolescents have at least one gender-neutral toilet/bathroom. Transgender minors, regardless of transition stage and diagnosis, should be guaranteed the opportunity to choose a toilet according to their judgment of their identity and safety. We recommend that 24/7 treatment centres (i.e. those where adolescents spend the night) develop standards (create the norm) for assigning transgender or non-binary adolescents to bedrooms according to their perceived identity if this is the patient's wish.

We recommend providing training in gender diversity to the staff of institutions and facilities.

We recommend that attention be paid to gender dysphoria during the necessary physical examinations by acknowledging it, ensuring privacy, explaining subsequent activities, and refraining from activities that arouse the greatest resistance in justified cases.

10. Medical certificates

In Polish practice, physicians mostly issue certificates regarding diagnosis, current treatment (not only pharmacological) as well as sick leaves, and recommendations related to the patient's condition. When issuing a medical certificate, the following should be borne in mind (Tab. 7):

— apart from specific situations of issuing certificates for the needs of offices, there are no standards for writing them and each physician decides individually what to include in the certificate;
— a certificate describing the actual state of affairs should be issued each time at the request of parents/legal guardians/caregivers and/or the patient, and its content should be consistent with the result of the examination and medical knowledge;
— the certificate should be issued after the examination;
— it is good practice to discuss the content of the certificate with the patient and their parents/legal guardians/caregivers.

Acknowledgments

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The authors would like to thank the authorised medical translator and interpreter Assistant Professor Arkadiusz Badziński, DHSc for translating the manuscript.

The guidelines were consulted and recommended by Trans-Fuzja, Foundation for Transgender People.

The guidelines were recommended by the tranzycja.pl team. The following individuals were involved in the formation of the comments to the guidelines:

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Table 7.

Addressee	Purpose	Content of the certificate	Comments
School	Using appropriate grammatical forms and the name	Information on the positive impact of the use of the chosen name and preferred grammatical forms on health	A certificate can be issued (and it is often advisable) before a complete formal diagnosis is made (it can be issued during the diagnosis, of which the patient is informed)
School	Exemption from physical education classes	The school principal excuses the student from physical education classes based on an opinion on the student's inability to participate in the classes issued by a physician for the period specified in the opinion. The regulation does not specify any information which the certificate should contain. However, the authors' practice shows there are sometimes expectations to determine the reasons for exemption. Dysphoria can and often does exacerbate anxiety and depressive symptoms - if there is a need to describe the reasons for exemption from physical education classes, it may be necessary to describe the symptoms that may be caused by participation in such classes	Exemption is sometimes necessary when the level of dysphoria affects the mental state, and it is not possible to organise lessons in such a way that they do not increase dysphoria (locker rooms, division into groups according to assigned sex, clothing). It is important to discuss alternatively realised forms of physical activity with an adolescent and parents/legal guardians/caregivers
School	Certificate for the application for individual teaching	Being transgender/non-binary is not an illness, so it is not *per se* an indication for individual teaching	Sometimes symptoms of other disorders may be a reason to consider including individual teaching, but in such a situation one should be particularly careful because individual teaching does not solve a basic problem, such as discrimination or minority stress. In such situations, it is advisable to search for schools that support diversity and therapeutic schools or daycare centres for people with more severe difficulties in functioning
Registry Office	Name change	Information on the lack of contraindications to such a change Information on the potential positive effect of such a change on mental health	Because the clerical practice is diverse in this respect (some offices require a diagnosis, while others do not), we recommend consulting a patient in this regard in each case before issuing the certificate
Endocrinologist	Implementation of puberty-suppressing interventions GAHI implementation	Verification of gender incongruence diagnosis Verification of whether the patient currently presents with mental disorders. If so, whether: • symptoms do not make it impossible or difficult to reliably diagnose gender incongruence; • the complaints do not make it impossible or difficult to rationally make decisions by an adolescent; • the improvement in mental health was achieved before GAMI; • the complaints should not affect the course of the gender-affirming procedure; • complaints can be considered secondary to gender incongruence A detailed purpose of issuing the certificate: • information on the specialist to whom it is directed • information on the procedure in connection with which the certificate is issued	The person issuing the certificate should ensure that an adolescent remains and will remain under adequate care and that their health will be monitored after the implementation of GAMI
Surgeon	Surgical interventions		

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Table 7.

Addressee	Purpose	Content of the certificate	Comments
Court		Verification of gender incongruence diagnosis Information on the patient's current mental disorders and illnesses should be associated with the explanation of how they affected the diagnostic process Information on the positive impact of judicial gender reassignment on mental health	Judicial gender reassignment of a minor is possible and frequent in practice - a representative (formerly a court-assigned guardian) files a claim on behalf of a minor. In addition, the specialist who diagnoses and treats a transgender adolescent often continues this process after an adolescent reaches the age of majority The court hearing the case for gender reassignment may ask for a copy of medical records during the proceedings, which may also involve former specialists who diagnosed an adolescent. A precisely described diagnostic process may significantly impact the course of the court proceedings (e.g. the need to seek additional opinions)
Military Medical Board	Exemption from military service	Diagnosis of transsexualism, according to the current classification (F64.0 ICD-10), is the basis for determining permanent and complete inability to perform military service in peacetime, mobilisation, and wartime	Regulation of the Minister of National Defence of 7th June 2022 and 7th June 2023 [57, 58]

The following guidelines are supported by the Polish Sexological Association, the Polish Psychiatric Association, the Polish Society of Paediatric Endocrinology and Diabetology

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