

Continuity of hormone therapy for trans people deprived of liberty

Input to the UN Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, for the HRC65 report on LGBT persons deprived of liberty

From: Eden Openly, an independent open-access clinical health-education platform (edenopenly.com)

Questions addressed: 5 (primary), 4, 11 and 12.

Settings: all settings within article 4 of OPCAT named in the call.

Confidentiality: none; it may be published in full.

Date: 11 October 2026

About this submission

Eden Openly publishes open-access evidence reviews on transgender health. This submission draws only on published literature and guidance, with no primary data or individual cases.

Much of the evidence comes from people in the community or from cisgender menopausal women; we label each such read-across. We state where evidence is limited, including where it is limited for the position we support. It concerns adults; the treatment of young people in detention, including puberty suppression, raises separate questions.

Summary

Our central point: in custody, an established hormone regimen should be changed or stopped only at the person's request or for an individual clinical reason. Uncertainty does not make a non-clinical interruption neutral; it is the interruption that needs justifying.

1. In custody the detaining authority controls access to medication. A non-clinical stop on arrest, admission or transfer is an interruption no clinician decided on.
2. After bilateral gonadectomy, prolonged inadequate replacement is an established risk to bone; the skeletal effect of short interruptions has not been quantified.
3. Withholding part of a regimen can cause under-replacement, but the effect is drug-specific.
4. Evidence on what interruption does is thin: one small trial of planned stopping, and qualitative reports from custody. Thin evidence is not evidence of safety.
5. Equivalence of care means prompt medication reconciliation and continuation without undue delay.

Question 5: what interrupting hormone therapy does

Bone. Oestradiol is a major regulator of bone turnover in women and men; its loss increases resorption relative to formation, causing net bone loss [2]. Testosterone also contributes, directly and through conversion to oestradiol [2]. Menopause guidance treats stopping hormone therapy as a planned decision in which symptoms may recur, and notes that its fracture protection decreases once treatment stops [1], although a 2024 review found no short-term rise above baseline after stopping [12]. These cisgender data establish plausibility, not the size or timing of harm from an unplanned interruption of gender-affirming treatment.

Timescales differ. A missed dose, an interruption of weeks or months, and years without replacement are different exposures. Depot injections and long-acting suppressants keep acting after supply stops, and symptoms and skeletal harm run on different timescales. The bone evidence concerns prolonged deficiency.

Planned short-term stopping. Nineteen trans women aged 59–78, all after gonadectomy, stopped transdermal oestradiol for about 12 weeks, then restarted [22]. Off treatment, 37% reported hot flushes and 26% mood swings, and responses varied widely. Total symptom and sleep scores changed little; somato-vegetative symptoms and sleep disturbance crossed the study's 10% threshold, but imprecisely. Mean depression, anxiety, quality of life and body image did not change. In this selected sample, the authors identified no psychological or body-image barrier for those wishing to stop. The trial was small, unblinded, uncontrolled and voluntary (30 eligible women declined, not wanting to stop), and measured no bone outcomes; it does not describe involuntary interruption in custody.

After bilateral gonadectomy. People who have had a bilateral gonadectomy need hormone replacement, surveillance or both to prevent the effects of chronic deficiency [15]. A review concludes that gonadectomy is not itself a risk factor for bone when hormones are taken correctly [13]. The Endocrine Society recommends bone-density measurement when osteoporosis risk factors exist, specifically in those who stop sex hormones after gonadectomy (a strong recommendation on low-quality

evidence) [15]. In a cross-sectional study of 57 trans women at least two years after surgery, 40% had low bone mass by male reference ranges (30% by female ranges). Low bone mass was associated with low oestradiol and with collecting less than 80% of prescribed oestrogen, though the design cannot show cause and 93% of participants had low vitamin D [4]. In an observational cohort of trans men with substantial loss to follow-up, bone-density Z-scores fell at three sites five years after bilateral oophorectomy, without a change in absolute bone density [5]. In older work, trans men who stopped testosterone or took it irregularly after surgery had lower bone density, which rose again when treatment resumed [13].

UCSF's 2016 guidance stated that there was then no evidence to support either continuing or stopping hormones in older trans women, and that after gonadectomy stopping around the age of natural menopause may reasonably be considered through individual, shared decision-making [16]. That is a clinical decision made with the patient, not an administrative consequence of detention.

Partial supply. The consequences of supplying only part of a regimen depend on the drugs. GnRH agonists suppress gonadal sex-steroid production. Spironolactone mainly blocks androgen action at the receptor, with a smaller and less reliable effect on testosterone synthesis, and 5 α -reductase inhibitors do not lower testosterone [15, 16]. If potent gonadal suppression, for example from an active GnRH-agonist depot, continues while prescribed oestradiol is withheld, clinically important sex-steroid deficiency can result despite intact gonads. The same state cannot be assumed with spironolactone or a 5 α -reductase inhibitor. Splitting a regimen across a custodial formulary therefore needs medication-specific clinical review. This is a mechanism; we hold no data on how often it occurs.

Mental health, at its true strength. A 2025 systematic review of 13 studies in adults found low-certainty evidence that gender-affirming hormone therapy may improve depression, suicidality and quality of life; its uncontrolled longitudinal studies were at serious to critical risk of bias [17]. Its one randomised trial (open-label, 64 adults starting testosterone) found greater three-month reductions in depressive symptoms and suicidality than delayed treatment [6]. A prospective cohort found lower depression scores at 18 months, though anxiety did not change significantly and only 20% of participants completed follow-up [7]. Improvement on starting does not establish an equal and opposite deterioration on stopping.

Two scoping reviews of healthcare for incarcerated trans people, covering 15 and 57 publications, identified no study designed to estimate the frequency, magnitude or causal effect of clinical outcomes after interruption of an established hormone prescription; reports of such outcomes are qualitative [14, 21]. In interviews in one US county jail, a woman whose oestrogen injections stopped at intake described hot flashes and returning facial hair within a week [18]. A US survey analysis of 913 trans adults with incarceration histories found that, among those incarcerated for more than a year, living in a state whose prison system offered several trans-specific health services was associated with lower odds of reporting a lifetime suicide attempt [19]. The outcome was lifetime history and the policy measure was assigned by state of residence, so the analysis cannot show when attempts occurred or that policy caused the association.

The WPATH Standards of Care warn that abrupt withdrawal, or failure to start medically necessary hormones, carries a significant likelihood of depressed mood, increased dysphoria, suicidality and surgical self-treatment [8]. Its supporting citations are legal and case material and one clinical report, not studies of withdrawal [8]; the report describes four people in prison who attempted or completed genital self-surgery, three in detail [9]. Those detailed cases followed persistent denial of assessment and treatment, not withdrawal of a prescription [9]. They support concern about denial of indicated care; they do not estimate the effect or frequency of harm after withdrawal.

This evidence supports serious concern but does not measure how often harm occurs; our conclusion is a human-rights one, not a scientific finding.

Standards. In the text supporting its Statement 11.3, WPATH says that people entering an institution on an appropriate regimen should continue the same or similar therapy, and calls a "freeze frame" approach inappropriate and dangerous [8]. A 2026 US correctional-health position statement recommends continuing hormone medications on entry, with informed consent and subject to law, unless medically contraindicated, and an adequate medication supply on discharge to bridge care [23]. The Nelson Mandela Rules provide that prison administrations shall take account of prisoners' individual needs, in particular those of the most vulnerable (Rule 2(2)); that prisoners should enjoy the same standards of health care as in the community, delivered in a way that ensures continuity of treatment and care (Rule 24); that every prisoner is examined on admission to identify health-care needs, including withdrawal symptoms from medication (Rule 30); that medical files follow the prisoner on transfer (Rule 26); and that clinical decisions may be taken only by health-care professionals and may not be overruled or ignored by

non-medical staff (Rule 27(2)) [10]. The expert-developed Yogyakarta Principles call on States to provide access in detention to hormonal or other therapy where desired (Principle 9(b)) [11], and their 2017 additions call for policies on "access to and continuation of gender affirming treatment" for people deprived of liberty, and for hormonal therapy for asylum seekers [20]. These differ in status: clinical guidance, a professional position statement, UN minimum rules for prisoners, and expert human-rights principles.

Question 4: where continuity is lost

Transitions into, within and out of custody are recurrent points at which continuity can fail. In interviews with ten trans women of colour in a county men's jail in the southern US, seven reported hormone use and six reported disruption at intake, largely because they could not produce a prescription [18]. That shows the failure occurs, not how often. Continuity has also changed on transfer between a jail and a federal prison [14].

- **Arrest and police custody:** medication may not be with the person, and usual prescribers and pharmacies may be out of reach.
- **Admission:** the regimen must be reconciled promptly.
- **Transfer:** records, formularies and prescribers may change, including into immigration, psychiatric or social-care settings.
- **Release:** medication supplied at discharge may run out before community prescribing resumes.

Question 11: evidence gaps

- Neither scoping review, covering 15 and 57 publications, identified a study designed to estimate how often interrupting an established prescription in custody causes harm, how large the effect is or how fast it appears, for bone, symptoms, mental health or self-harm. Qualitative reports describe symptoms, but neither review analyses outcomes of interruption separately from failure to start treatment [14, 21].
- Bone evidence on withdrawal is cisgender or concerns poor adherence; none measures skeletal harm from interruptions of days, weeks or months.
- Neither review gives population-level estimates of how many people enter custody on hormone therapy, or how many keep it. The larger review found most evidence from the US, only three articles focused on trans men, and no primary study from Asia or Africa [21].

Data collection should record continuity of prescribed treatment as a measure of care quality, not anyone's gender history, respecting self-identification and "do no harm".

Question 12: measures

1. Reconcile medication on arrival from every available source: the person's account, labelled medicines, and pharmacy, prescriber and clinical records. Continue an established, appropriate regimen without undue delay; where documents are incomplete, decide clinically on interim supply rather than let paperwork cause a gap.
2. Change or stop established treatment only at the person's request or for an individual clinical reason, with medication-specific assessment, discussion where possible, documentation and monitoring.
3. Treat indicated sex-steroid therapy after bilateral gonadectomy as medically necessary chronic treatment while it is indicated, and do not interrupt it for non-clinical reasons.
4. Supply clinically coherent regimens: do not maintain potent gonadal suppression while withholding the replacement prescribed with it. Formulary substitutes should provide clinically appropriate same or similar therapy, monitored where needed.
5. After prolonged sex-hormone cessation following bilateral gonadectomy, assess osteoporosis risk and measure bone density when clinically indicated, as current guidance recommends [3, 15].
6. Ask national preventive mechanisms and national human rights institutions to monitor continuity of hormone treatment, including at transfer and release.
7. Include an adequate bridging supply of medication and linkage to community care in release planning.

Competing interests, funding and licence

Competing interests (as at 11 October 2026). Every interest is listed in full, with its start date, in Eden Openly's public register, whose entries are never edited: edenopenly.com/about/declared-interests.

- **Position and declared prior.** The author is a transgender woman receiving gender-affirming hormone therapy, and a dermatologist. She holds a declared prior in favour of access to gender-

affirming hormones for adults, and of adolescent access to puberty blockers and gender-affirming hormones. Findings that cut against that position are reported at full weight.

- **(a)** Founder and sole funder of a non-profit transgender healthcare and education organisation.
- **(b)** Founder and sole funder of Eden Institute, a transgender health research institute.
- **(c)** Public advocacy on the NHS Wales Welsh Gender Service surgical referral pause.
- **(d)** Parliamentary advocacy on the UK Health Bill's single patient record provisions.
- **(e)** A structured appraisal of the Cass Review.
- **(f)** Eden Openly evidence reviews grading evidence in this field; none overlaps this submission.
- **(g)** Reporting of errors in published literature, recorded in the Evidence Transmission Register. No report concerns a source cited here.
- **(h)** Co-owner and lead researcher of a commercial skincare business, and a planned aesthetic dermatology and surgery hospital. These are the only commercial interests.

Funding. This submission is unfunded; the author accepts no third-party funding and pays all costs personally. The declared prior and interests (a) and (b) create a plausible incentive toward findings favourable to access to gender-affirming care. Our independence statement is at edenopenly.com/independence.

Licence. This submission is licensed CC BY 4.0.

Eden (she/her), for Eden Openly
editor@edenopenly.com

References

1. NICE. Menopause: identification and management (NG23), recs 1.8.6–1.8.7, Table 1.
2. Khosla S, et al. Trends Endocrinol Metab 2012;23:576–81. doi:10.1016/j.tem.2012.03.008
3. Radix A, Deutsch MB. Bone health and osteoporosis. UCSF Transgender Care Guidelines, 2nd ed., 2016, §13.
4. Motta G, et al. J Bone Miner Metab 2020;38:885–93. doi:10.1007/s00774-020-01127-9
5. Sanna E, et al. Front Endocrinol 2024;15:1416121. doi:10.3389/fendo.2024.1416121
6. Nolan BJ, et al. JAMA Netw Open 2023;6:e2331919. doi:10.1001/jamanetworkopen.2023.31919
7. Aldridge Z, et al. Andrology 2021;9:1808–16. doi:10.1111/andr.12884
8. Coleman E, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Int J Transgend Health 2022;23(S1), ch. 11. doi:10.1080/26895269.2022.2100644
9. Brown GR. Int J Transgend 2010;12:31–9. doi:10.1080/15532731003688970
10. UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules). GA res. 70/175, annex, 2015.
11. The Yogyakarta Principles, 2007, Principle 9.
12. Anagnostis P, et al. Hormones 2024;23:339–44. doi:10.1007/s42000-024-00526-1
13. Giacomelli G, Meriggiola MC. Ther Adv Endocrinol Metab 2022;13. doi:10.1177/20420188221099346
14. Fuller C, et al. Int J Transgend Health 2026;27:143–61. doi:10.1080/26895269.2024.2443753
15. Hembree WC, et al. J Clin Endocrinol Metab 2017;102:3869–903. doi:10.1210/jc.2017-01658
16. Deutsch MB. Overview of feminizing hormone therapy. UCSF Transgender Care Guidelines, 2nd ed., 2016, §7.
17. Cooney EE, et al. eClinicalMedicine 2025;88:103460. doi:10.1016/j.eclinm.2025.103460
18. McCauley E, et al. Transgend Health 2018;3:34–41. doi:10.1089/trgh.2017.0046
19. Drakeford L. J Correct Health Care 2018;24:171–82. doi:10.1177/1078345818764110
20. The Yogyakarta Principles plus 10, 2017, additional obligations to Principles 9 and 23.
21. Maycock M, et al. Soc Sci Med 2026;393:118972. doi:10.1016/j.socscimed.2026.118972
22. van Heesewijk JO, et al. Hum Reprod 2026;41:1387–96. doi:10.1093/humrep/deag087
23. National Commission on Correctional Health Care. Transgender and Gender Diverse Health Care in Correctional Settings. Position statement, adopted July 2026.