Transgender adolescents: consent quandaries (Bell vs Tavistock)

Dr Jamie Speeden, FRACP (Paeds), FRANZCP (Child & Adol)

With thanks to Dr Zoe Kristensen

Transgender is an umbrella term encompassing all individuals who do not identify as the gender with which they were assigned at birth.

This does not necessarily include all intersex individuals, but does include those who have transgender identities.

Other terms used similarly might include:

Transsexual*, Gender Diverse, Gender Incongruent or Gender Variant

* Can be considered stigmatising

Outline

- Terminology
- Demographics and development
- Mental Health issues
- Diagnostic ideologies and the real world
- Challenges and Controversies

- Bell vs Tavistock – why the panic?
- Consent in adolescence

Key Terms around Gender Identity

Assigned Gender - The gender which was written upon your birth certificate (M or F)

Cisgender (“Cis”) - Wherein ones gender identity and assigned gender align

Intersex - An individual with phenotypically ambiguous or mixed gonadal or secondary sexual characteristics *(e.g. due to hermaphroditism, androgen insensitivity syndrome etc)*.

Binary - A fixed gender identity of either male or female.

Non-Binary - A gender identity beyond that of male or female. This may be due to identification with both or neither binary gender, or due a degree of fluidity within oneself.

Pronouns and honorific

Male identifying	He/Him	Master/Mr
Female identifying	She/Her	Miss/Ms/Mrs
Non-Binary	They/Them	Mx *(Most common)*

(Others include: zhe/zer, e/em, ae/aer, ey/em, ee/em)

Gender Dysphoria (DSM-V)*/Gender Incongruence** (ICD 11)

These are diagnostic terms used to describe the distress someone experiences as a result of the mismatch between their assigned sex and their gender identity.

* Previously Gender Identity Disorder (DSM-IV)
** Previously Transsexualism (ICD-10)

Children

In terms of gender variance and diversity, the “cut off” we tend to use is puberty (10-13yrs).

Why?

- Gender diversity and exploration is common in childhood.*
- Only 6-23%** *(evidence limited)* of gender expansive children will go on to be transgender adults.
- However, if these feelings present or worsen in puberty they usually persist into adulthood***.
- …and pragmatically there’s not much in the way of interventions prior to that point.

* *Source: Verhulst (1996), Achenback (119) - 2.6% M / 5% F*

** *Source: Newhook & Winters (2018)*

*** *Source: De Vries (2014), Smith (2005)*

Demographics

"We do not have definitive estimates on how many transgender people live in Aotearoa. Work is only starting on collecting such information through New Zealand's Official Statistics System, with the last Minister of Statistics committing to counting transgender people in the next Census.

It is likely around 1% of the population of Aotearoa is Transgender"

- PATHA (2020)

[Professional Association of Transgender Health Aotearoa]

Youth12 study (2020) found:

- 1.2% of students reported that they were transgender, and
- 2.5% that they were not sure of their gender.

Being transgender

Not a mental health problem!

Not a medical problem

Not a disorder

Depathologised by the WHO in 2018

- Normal Variation
- May be associated with other mental health problems *(i.e. due to Burden of Stigma/Minority Stress)*

- Access to healthcare is life saving and life changing.

** Adapted from slides by Dr Rachel Johnson*

Mental Health

Counting Ourselves (2019) found (N=1,178):

- **71%** reported high or very high psychological distress *(vs. 8% of the general population)*
- **56%** had seriously considered suicide in the last 12 months.
- **37%** had attempted suicide, and
- **12%** had attempted suicide in the last 12 months

- Participants' rate of cannabis use in the last year (38%) was more than three times that of the general population (12%).

<u>This is in keeping with international figures</u>
(e.g. Trans Health Study (UK) (2012), Transgender Eurostudy (2008))

<u>Source</u>: Counting Ourselves (2019)

Mental Health

Comorbid Conditions

* **Depression**

* **Anxiety Disorders**
  [Social phobia, specific phobias, OCD and panic disorders - Millet (2018)]

* **Substance Abuse** *(including alcohol and tobacco)*

* **Autistic Spectrum Disorders - *[Up to 7x more prevalent]***
  [Paterski, (2014), Strang et al (2014, 2016, 2019), Kristensen (2016), Gilden (2016) etc]

* **Eating Disorders**
  [Diemer et al (2015), McGuire (2016), Bell et al (2019)]

Other Considerations

Institutional Barriers to Care:

- 42% reported their main healthcare provider lacked knowledge about healthcare for trans and non-binary people

- **36% had avoided seeing a doctor** because they were worried about disrespect or mistreatment as a trans or non-binary person, including 20% reporting this in the last 12 months.

- 13% of participants were asked unnecessary or invasive questions about being trans or non-binary, that were unrelated to their health visit.

- 17% reported they had experienced conversion therapy.

Source: Counting Ourselves (2019)

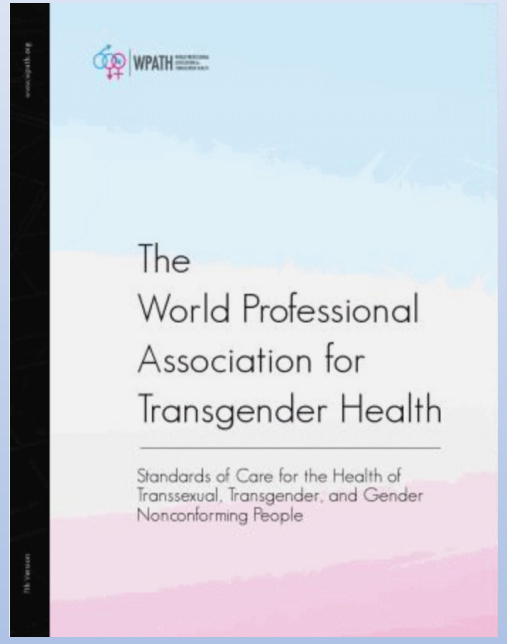
WPATH

Currently Standards of Care v. 7 (2012).

Version 8 is due imminently

Has numerous local-level affiliated bodies.

- In Aotearoa/New Zealand - PATHA *[Prev ANZPATH]*
- In Australia - AusPATH *[Prev ANZPATH]*



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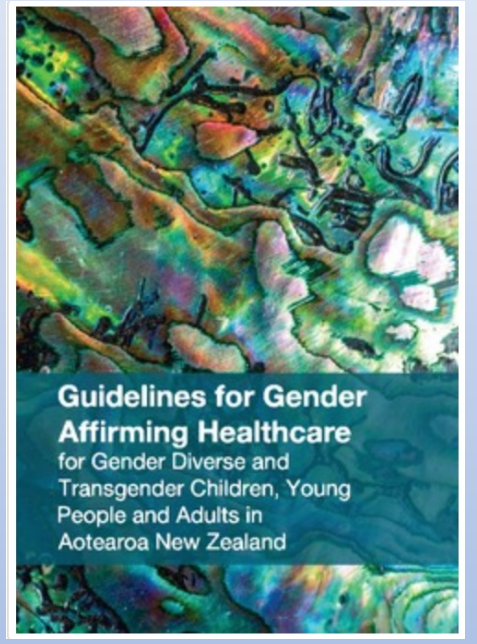

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Gatekeeping Model

1. Individual realises they have distressing sense of incongruence around gender.
2. Individual seeks support from the GP
3. The GP refers them on for a psychiatric evaluation who decides whether or not they are TGD and so eligible for treatment

… at various points historically then people had to have a second independent psychiatric assessment, or would have had evidence living "in role" for 1-2 years *(and initially this was prior to receiving any hormone therapy or surgery,* or have had ongoing therapy…

4. Onward referral to other providers for gender affirming treatments (e.g. surgery, hormones, voice therapy)
5. Patient "transitions" and sense of incongruence resolves.

Gender Affirming

1. Individual realises they have distressing sense of incongruence around gender.
2. Individual seeks support from the GP
3. Onward referral to other providers to consider gender affirming treatments (e.g. hormones, surgery, voice therapy)
4. Patient "transitions" and sense of incongruence resolves.

The paradigm shift means we empower individuals to define (and put a name to) their own sense of identity as opposed to this being assigned-at-birth or later reassigned by a psychiatrist.

Gender affirming care means encouraging an individual to question, explore, and come to their own conclusion about how they identify

The key is not presupposing an outcome, but instead supporting this journey. We facilitate access to treatments and interventions chosen by the individual, as opposed to taking a conveyer-belt or one-size-fits-all approach to gender-affirmation. It is sharing of knowledge and empowerment of the individual to see possibilities, rather than a paternalistic charting to an assigned gender.

This may result in a new gender identification, or may lead to better comfort in ones original gender. Both are valid outcomes.

Source: Kristensen (2021).

See also: Hindalgo et al, (2013), Radix et al (2016), HRCF (2016), Cavenaugh (2016) etc,

Hauora Tāhine

Pathways to Transgender Healthcare Services

Children and Adolescents (Age 12 to age 20 / 24 in CMDHB)

- Centre for Youth Health

Adults

- Auckland Regional Sexual Health Service

  (Northern Region Transgender Health Services)

- Will accept self-referrals, or referrals from: GP, Mental Health, Family Members or School
- HOWEVER: *Due to increasing volume they would prefer a GP referral as they're attempting to move toward shared-care and provide education to increase capacity!*

Transitioning

- Real Life Experience – safety
- Passing – behaviour, clothes
- Being out

- Blockers (phase one medical)
- Hormones (phase two medical)

- Top (chest) surgery
- Lower surgery
- Plastic surgery

Transitioning

- Real Life Experience – safety
- Passing – behaviour, clothes
- Being out

social

- Blockers (phase one medical)
- Hormones (phase two medical)

medical

- Top (chest) surgery
- Lower surgery
- Plastic surgery

surgical

Social Transition

Gender Affirmation

“Socially transitioned transgender children who are supported in their gender identity have developmentally normative levels of depression and only minimal elevations in anxiety, suggesting that psychopathology is not inevitable within this group. Especially striking is the comparison with reports of children with GID; socially transitioned transgender children have notably lower rates of internalizing psychopathology than previously reported among children with GID living as their natal sex.” - Olson et al (2018), N=73

Others: Durwood et al (2017) Pollitt et al (2019)

Connecting to TGD Spaces

- “Intragroup prosocial behaviors (i.e., developing TGD spaces)” are helpful as social supports and to sustain resilience (Gorman, et al 2020).

- Exercising self-compassion is an effective coping strategy for managing gender-related stress (Gorman, et al 2020).

Real Life Experience

- **Safety First**
- Choosing to live fulltime as preferred gender
- Important to consider effects i.e. target of bullying, abuse
- May choose to wait till normal transition period e.g. finish school, going to uni, starting new job

- **Preparation -** discussion with school may include teachers, pupils, and sometimes parents of other pupils
- Or discussion with co-worker(s), boss

- Who needs to know? wider family, friends, neighbours, workplace?

Hormone Blockers (GnRHa)

- At puberty onset (12*- 14yrs)
- Physical check-up every 3-6 mo, Blood tests every 6-12 mo

- Leuprorelin (Lucrin) intramuscular injection every three months
- Goserrelin (Zoladex) chip implant every 10-12 wks
- Tablets: Cyproterone, Spironolactone
- Fully funded (with caveats)

- Lucrin / Zoladex blocks FSH/LH production and Gonadal sex steroid production
- Halts puberty = buying time to let the young person make informed treatment decisions
- Prevents physical changes that may require surgical intervention to reverse them e.g chest, laryngeal prominence

- Are **not** experimental – used for decades in precocious puberty

Gender Affirming Hormone Therapy

- To either feminise or masculinise a person's appearance
- These therapies are considered to be **partially reversible**
- Some effects (e.g. deepening of voice, hair growth, breast tissue development) are permanent. Others (e.g. fat distribution, loss of fertility) will gradually be reversed on stopping treatment

- WPATH SOC v7 criteria for access to gender affirming hormone treatment:
  - Persistent, well-documented gender dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Age of majority.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled

In New Zealand young people aged 16 years and older are considered to be able to consent to medical care (Care of Children Act 2004)

Olsen KP, et al. Pediatrics 2016
Hughto JM, Reisner SL. Transgender Health 2016

Gender-Affirming care

npr

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CHILDREN'S HEALTH

Texas governor calls to label gender-affirming care for trans kids as 'child abuse'

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The Tavistock has been at the centre of controversy over its treatment of young people for gender dysphoria

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Alabama bill to criminalize gender-affirming care passes committee, moves to full House

House lawmakers argued that minors were not mature enough to make decisions about their long-term health and called gender-affirming care "abuse," parroting claims made by high-profile Republican lawmakers like Texas Gov. Greg Abbott.

By Brooke Migdon | March 3, 2022

Potential Challenges & Controversies

Regret and "De-Transition"

- Best estimates are that these lie at >1%, and within those most who "de-transition" do so because they consider themselves to have a non-binary gender identity (i.e. coming back to the "middle", as opposed to swinging back entirely).
- These often get a large amount of media attention, thus giving the impression of it being more common than it is (i.e. moral panic)

Impact of [Historical] "Gatekeeping" on the Therapeutic Alliance

Exponential increase in numbers of people presenting to services

- Increasing referral times for tertiary clinics. [Supply outstripping demand].
- Particular increase in younger people.
- Suggested to be largely due to gender exploration becoming more acceptable as part of adolescent identity formation, with more awareness of non-binary identities. Seeing a shift of referrals from the older to the younger population.

Regret and "De-Transition"

Contrary to the impression you might get from the media, detransition is actually very rare!

A UK survey of 3398 TGD individuals found only 16 – **about 0.47%** – experienced transition-related regret. Of these, even fewer went on to actually detransition.

US Study of around 28,0000 people showed around 8% reported some kind of detransition, of which 62% did so temporarily. Amongst detransitioners, 90% detransitioned due to external factors *(e.g. job security, discrimination, family pressure, access issues).*

Overall only 1.3% had ever detransitioned for some period of time (i.e. not necessarily permanently) due to at least one intrinsic factor)

That study noted also: "It is important to highlight that detransition is not synonymous with regret. Although we found that a history of detransition was prevalent in our sample, this does not indicate that regret was prevalent. All existing data suggest that regret following gender affirmation is rare."

Source: Yurban (2021)

Bell vs Tavistock and Portman NHS Foundation Trust [2020]

- Judicial review: Oct 2019, legal complaint lodged against the NHS Gender Identity Development Service (GIDS) by “Mrs A” whose 15-yr-old was on the GIDS waiting list, and Sue Evans, a former nurse at the GIDS. Evans passed her complainant role to Keira Bell in Jan 2020.
- Claimant Quincy Bell, treated at age 15yr with puberty blockers, progressed to GAHT, and then surgical intervention (double mastectomy age 20yr). “[She] now regrets transitioning, which has left her with 'no breasts, a deep voice, body hair, a beard[, and] affected sexual function'. She may well be infertile as a side effect of the drugs.”
- They contend that the practice of prescribing puberty-blocking drugs to children under 18 was unlawful as they lacked competence to give valid consent to treatment

- High Court judgement delivered 1 Dec 2020
- Appealed and quashed 17 Sept 2021

Initial ruling

4. The court held that in order for a child to be competent to give valid consent the child would have to understand, retain and weigh the following information:

(i) the immediate consequences of the treatment in physical and psychological terms;

(ii) the fact that the vast majority of patients taking puberty blocking drugs proceed to taking cross-sex hormones and are, therefore**, a pathway to much greater medical interventions**;

(iii) the relationship between taking cross-sex hormones and subsequent surgery, with the implications of such surgery;

(iv) the fact that cross-sex hormones may well lead to a loss of fertility;

(v) the impact of cross-sex hormones on sexual function;

(vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships;

(vii) the **unknown** physical consequences of taking puberty blocking drugs; and

(viii) the fact that the evidence base for this treatment is as yet **highly uncertain**.

5. The court considered that it was highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers.

6. It was also doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences of the administration of puberty blocking drugs.

7. In respect of young persons aged 16 and over, the legal position is that there is a statutory presumption that they have the ability to consent to medical treatment. Given the long-term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet **innovative and experimental**, the court recognised that clinicians may well regard these as cases where the authorisation of the court should be sought before starting treatment with puberty blocking drugs

Concerned doctors …

“This legal precedent is likely to influence Australian law and medical practice”

“It is possible that in the future litigation for damages against psychiatrists who prescribe puberty blockers and other hormones to gender transition children and adolescents will use the UK High Court decision in support of claims.

“are you concerned that the College will be joined as a defendant in litigation against psychiatrists who have prescribed these medications? ”

“That judgement contains many important points, including the experimental nature of gender-affirming treatment for young people, the likelihood that young people are in most cases unable to provide informed consent for these treatments, and the fallacy that puberty blockade is reversible. ”

Consent issues

- Individual legally classified as ‘child’ until age 18
- Adolescents over the age of 16 have a statutory right to consent to medical treatment (*Gillick* competency 1985)
  - Understand the nature of their medical condition and proposed treatment
  - Understands the moral and family issues involved
  - Has sufficient life experience and maturity
  - Is capable of weighing up the risks and benefits

  - If not competent then is needed from someone with parental responsibility or the courts

- So no-one under the age of 18 can consent to treatment?
- Nor can their parents?
- Why would a doctor offer a treatment not in the best interest of their patient?

- Is the decision too complex hence invalidating consent?
- What about other treatments e.g. cancer treatments? ADHD?

- Puberty blockers are used in precocious puberty and endometriosis.
- Parents and/or adolescents consent to these currently

Conveyor belt argument

- Does starting blockers always lead to GAHT?
- Those who start blockers have strong transgender identification, persistent gender dysphoria after puberty onset or their distress increases with puberty.

- Starting GAHT is a separate consent process, sometimes years after blockers started

- Individuals have a right to ‘change their mind’ at any stage of treatment e.g. cancer treatment, shoulder rehab post accident
- Hypothetical decision changes should not prevent starting a treatment

Possible detransitioning

- Problematic ‘desistance’ evidence, better evidence emerging now
- ‘Detransitioning’ is not evidence of invalid consent process but normal adolescent exploration of their individuality
- Some do detransition or pause transitioning for various reasons – this should not prevent ***all*** adolescents from seeking treatment

Appeal Sept 2021

- The Court of Appeal decided that the declaration made by the Divisional Court covered areas of disputed fact, expert evidence and medical opinion, which were not suitable for determination in judicial review proceedings
- The case of Gillick v. West Norfolk and Wisbech Health Authority had decided that it was for doctors, not judges, to decide on the capacity of under-16s to consent to medical treatment.
- “the court should not be used as a general advice centre”

- It recognised the difficulties and complexities associated with the question of whether under 18s were competent to consent to the prescription of puberty blockers, but it was for clinicians to exercise their judgment knowing how important it was for the patient’s consent to be properly obtained according to the particular individual circumstances.