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Social work after BELL vs TAVISTOCK

The High Court has ruled that under 16-year-olds are unlikely to be able to consent to puberty blocking drugs. **Allan Norman** looks at what this judgement means for social workers

In the immediate hours after the High Court ruled in favour of Keira Bell and against the Tavistock and Portman NHS Trust's Gender Identity Development service, the internet was awash with both criticism and applause.

Whether those instant reactions had much to do with reading the judgment is debatable; much of it seems driven by hopes or fears about what it would mean for a cause.

Coming in the middle of a toxic debate about trans rights and gender self-identity, this was a case brought by a young adult who had transitioned female-to-male and wished she hadn't. Her chosen forum was a judicial review: rather than claiming compensation, she focused on the way her consent to puberty blockers had been procured, and asked the court whether it had been fair and lawful.

So what are the lessons from the judgement for social work? There are three key areas of relevance for us to consider: how we approach medical evidence; how we approach competence and consent in a child; when we need the court's oversight of, and approval for, our decision-making.

It may be a bold venture for a lawyer to comment about a judgment which has been appealed. But I suspect nothing I am about to say on any of these subjects would be particularly controversial if it were not contained in an article about gender re-assignment. The court has simply applied well-worn principles on consent and treatment of children to the approach of Tavistock's Gender Identity Development Service (GIDS).

Above: Keira Bell speaks to the media outside the Royal Courts of Justice in central London

Medical evidence

Social workers have long considered they have a role in reminding the medical profession not to place undue reliance on medical diagnoses and pharmaceutical interventions in circumstances where social factors may offer both alternative explanations and solutions. An example of this is our promotion of the social model of disability.

But we have been ambivalent to medical evidence. At times, medicine seems to offer a certainty that we crave. Some of us will remember Cleveland, where social services went along with a novel medical diagnosis for child sexual abuse. Or the more recent miscarriages of justice around shaken baby syndrome. It's not that medicine got it totally wrong, rather injustices arose because it could not get it totally right. And false positives and false negatives both give rise to injustice.

There are other times when medicine has failed to offer the certainty we crave. For example, when doctors are rightly cautious about confirming non-accidental injury.

What astonished the court in the Bell vs Tavistock case is that not only were the longer term risks and possible harms associated with puberty blockers relatively unknown, but there was conflicting evidence on what the purpose was in giving them, and the evidence was limited as to whether they

had any benefit at all. It is possible that the 25-fold increase in numbers referred to GIDS between 2009-2018 – and the shift towards more than three quarters of those presenting being natal girls (people assigned female at birth) – is the result of better understanding of a medical condition. And that pharmacological intervention turns out to be beneficial.

But those possibilities are not currently supported by the evidence, and it would be extraordinary if social work, with its experience of dealing with wider social context, with structural disadvantage, and with holistic assessment, had nothing to contribute to explaining the phenomenon.

If we have learned the lessons of the past, then we have learned that medicine does not have all the answers, that social context and structural disadvantage are relevant, and that without our contribution, relying solely on medicine, we cannot get the right answers.

Competence and consent

As the court readily acknowledged, its task in the Bell vs Tavistock case was not to evaluate the medical evidence, but to consider whether children could give informed consent to the medical intervention. That involved considering both what the state of the evidence used by GIDS is and how children make decisions.

Expert evidence before the court was that the neurological development of adolescents' brains meant teenagers' decision-making tended towards making more risky and more emotional decisions. Keira Bell herself suggested that she found information on the internet that supported her decisions, and that she was not sufficiently challenged in her decision-making.

As social workers, we certainly know the importance of children's rights, including their rights to autonomy. And we certainly know the importance of establishing a child's wishes and feelings. But the court acknowledged those things in Bell vs Tavistock as well. Tavistock argued "It would be an intrusion into the child or young person's autonomy if a decision about treatment with puberty blockers were to be made by the court not by the patient". The court disagreed: "In principle, a young person's autonomy should be protected and supported; however, it is the role of the court to protect children, and particularly a vulnerable child's best interests." This reference to child protection is perhaps the clearest reminder in the case that social work principles are at stake. We know, for example when a child subject to CSE seems to choose to go off with their grooming abuser, that they are a child in need of protection and not only one whose autonomy should be respected.

We know that many children will express a preference to stay in or return to family situations that are neglectful or abusive, but our court applications are made to protect them in their best interests, and not simply to uphold their wishes and feelings. We know that contextual safeguarding includes protecting children from the harms of their internet experience, and not simply protecting their right to seek out that internet experience.

In short, we know that Gillick competence is not the be-all-and-end-all in the discussion about rights, autonomy and best interests. It was not so before this judgment, and this judgment has not diminished the role of Gillick competence. It has simply restored it to its proper place.

'We certainly know the importance of establishing a child's wishes and feelings'

The role of the court

Bell vs Tavistock also gives explicit guidance that it is likely that cases of 16 to 17-year-olds seeking puberty blockers ought to be referred to the court for the requisite consent.

It is worth a reminder that the general principle is that a court can give consent in circumstances where the person themselves is unable to give valid consent for whatever reason, but only if doing so is in that person's best interests.

What is interesting here is that the court explicitly acknowledges that there is no statutory framework under which these cases could be referred to the court. This, in effect, means it has no legal right to insist that anyone refers cases involving 16 to 17-year-olds seeking puberty blockers to the court.

So why say it? Well, again, as social workers we can understand this. In the social work context perhaps the best-known recent example concerns Section 20. On the face of it, there is no role for the court here either - what is needed is proper informed consent. But we know that if we get the approach to informed consent wrong, either because the person cannot consent, or because the consent was not properly informed, it can come back to bite us.

The court may not have the right to insist that cases are brought to it, but it does have the right to retrospectively review cases where complaints are brought about what happened in the past. Bearing in mind the possibility of a later dispute, we have learned as a profession not to be too complacent about whether we should get the sanction of the court for what we think is the right thing to do. The Court Order immunises us from later criticism.

Of course in this case, later criticism is not just a theoretical possibility. Keira Bell was actually saying that the manner and circumstances in which her consent was obtained was not good enough in view of the seriousness of the decision. That she was not competent to make the decision. That she was in need of protection. That she was unduly influenced by what she read on the internet.

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The key message for social work

What does this case have to say about the current debate about trans-rights and self-identity? Nothing. What does it have to say about how we do social work? It says, carry on as before.

Just so long as carrying on as before means, as it should mean, being alert to the limits of medical science, and the importance of social work's contribution in terms of social context and structural oppression, when deciding interventions. It means being alert to safeguarding, child protection and nuanced best interests, and that this is more complex than the affirmation of wishes and feelings about identity. It reminds us to have the humility to accept that today's child may become an adult who questions whether we did what was best for them, and the wisdom to seek the Courts oversight in such situations.