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REGULATING GENDER-AFFIRMING MEDICAL CARE FOR TRANS CHILDREN

TOWARDS A CHILDREN'S RIGHT-CENTERED APPROACH

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ABSTRACT

In recent years, the regulation of gender-affirming medical care for children has undergone significant changes in several Western jurisdictions. Gender-affirming medical care includes treatments recognized by major medical associations as the standard of care for adolescents with gender dysphoria. However, legislatures in 25 U.S. states have enacted laws banning this care and England and Wales have greatly restricted it. Other countries continue to allow access, though other questions have arisen. In Australia, recent case law has created uncertainty over whether courts should intervene in disputes between competent children and their parents about pursuing treatment or the child's competence.

Given the diversity of the law dealing with the matter in different jurisdictions, this study aims to identify common principles for the development of a children's rights centered approach for regulating gender-affirming medical care. To this end, it analyses three models: the 2021 Arkansas SAFE Act, as the example of the banning approach; restrictions adopted in England and Wales following the Cass Review, as the example of the restrictive approach; and Australia's case law, as the example of the gender-affirming approach. The Australian example, in particular, highlights issues that have emerged with regards to the ability of children to make autonomous choices about their healthcare.

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INTRODUCTION

Trans persons[1] have existed throughout history in different locations and cultures. From ancient civilizations to contemporary societies, their presence is a consistent element across human experience**.** In Greek, Roman and Norse mythology there are examples of deities that defied traditional understanding of gender[2]. Many Indigenous North American tribes have long recognized a third gender, and developed a language for the indigenous individuals who identify with it. In the 1990s, at the LGBT Native American Gathering "two spirit" was coined as a common term that includes all these indigenous members[3]. However, trans persons continue to face violence and exclusion across societies for their identity. Despite their historical presence and cultural significance, societal acceptance remains limited and inconsistent[4]. According to the UN Independent Expert on sexual orientation and gender identity, they are often rejected by their families, denied employment opportunities and forced into homelessness and the informal economy[5]. Furthermore, the majority of trans individuals in the world do not have access to legal recognition by their state, and when they do they are often forced to be evaluated psychiatrically or to undertake medical procedures. This means that the ability to access, among others, education and healthcare is compromised for many trans individuals worldwide. To address the issue, the UN Independent Expert on sexual orientation and gender identity has reiterated that states should implement the recommendations issued by the UN High Commissioner for Human Rights on the process of legal recognition of gender identity[6]. These include the recommendation that legal recognition should be based on self-determination and should not depend on medical interventions or other legal requirements[7]. Moreover, when the identities of trans persons intersect with other factors of marginalization, they are particularly exposed to physical

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[1] <<Transgender or trans are umbrella terms used to describe people whose gender identities and/or gender expressions are not what is typically expected for the sex to which they were assigned at birth>>, Eli Coleman and others, 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' (2022) 23 International Journal of Transgender Health S1, 252 https://doi.org/10.1080/26895269.2022.2100644.

[2] Edith Hemilton, 'Mythology: Timeless tales of gods and heroes' (2011) Grand Central Publishing.

[3] Jeremi M Carswell, Ximena Lopez and Stephen M Rosenthal, 'The Evolution of Adolescent Gender-Affirming Care: An Historical Perspective' (2022) 95(6) Hormone Research in Paediatrics 649 https://doi.org/10.1159/000526721.

[4] UN Human Rights Council, 'The Struggle of Trans and Gender-Diverse Persons: Report of the Independent Expert on Protection against Violence and Discrimination Based on Sexual Orientation and Gender Identity, Victor Madrigal-Borloz' (6 June 2023) UN Doc A/HRC/53/30.

[5] ibid

[6] ibid

[7] UN Human Rights Council, 'Discrimination and Violence against Individuals on the Basis of their Sexual Orientation and Gender Identity' (4 May 2015) UN Doc A/HRC/29/23.

violence. These intersecting vulnerabilities include race, ethnicity, migration status, HIV status and more[8].

Despite this reality, gender identity[9] is not explicitly listed as a prohibited ground of discrimination in any UN human rights treaty's non-discrimination provision. In recent years, though, several treaty-based UN committees have interpreted their respective conventions to include gender identity as a protected characteristic. These interpretations, while not altering the treaty texts, have expanded their application in light of evolving understandings of human rights. The Human Rights Committee, which interprets the International Covenant on Civil and Political Rights[10], has, for example, explained that article 6 on the right to life must be respected without distinction of, among others, gender identity[11]. The Committee on Economic, Social and Cultural Rights, which interprets the International Covenant on Economic, Social and Cultural Rights[12], regards gender identity a prohibited ground for discrimination in its non-discrimination provision[13]. The Committee on the Rights of the Child, which interprets the Convention on the Rights of the Child[14], has expressed the view that states have the obligation to ensure children and adolescents are not discriminated against on the ground of, among others, gender identity[15]. Together, these interpretations provide a growing body of soft law that strengthens legal protections for trans persons at the international level.

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[8] UN Human Rights Council, 'The Struggle of Trans and Gender-Diverse Persons: Report of the Independent Expert on Protection against Violence and Discrimination Based on Sexual Orientation and Gender Identity, Victor Madrigal-Borloz' (6 June 2023) UN Doc A/HRC/53/30.

[9] <<Gender identity refers to a person's deeply felt, in-ternal, intrinsic sense of their own gender>>, Eli Coleman and others, 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' (2022) 23 *International Journal of Transgender Health* S1, 252 https://doi.org/10.1080/26895269.2022.2100644.

[10] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171.

[11] Human Rights Committee, 'General Comment No 36: Article 6 (Right to life)' (30 October 2018) UN Doc CCPR/C/GC/36, para 61.

[12] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3.

[13] Committee on Economic, Social and Cultural Rights, 'General Comment No 20: Non-discrimination in economic, social and cultural rights (art 2, para 2, of the International Covenant on Economic, Social and Cultural Rights)' (2 July 2009) UN Doc E/C.12/GC/20, para 32.

[14] UN Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3.

[15] Committee on the Rights of the Child, 'General Comment No 15: The right of the child to the enjoyment of the highest attainable standard of health *(art 24)*' (17 April 2013) UN Doc CRC/C/GC/15, para 8; Committee on the Rights of the Child, 'General Comment No 20: The implementation of the rights of the child during adolescence' (6 December 2016) UN Doc CRC/C/GC/20, paras 34 and 37.

There is also another instrument that advances the protection of trans persons. In 2007 a group of human rights experts drafted 29 non-binding but influential principles, called the Yogyakarta Principles after the Indonesian city where they met, in which they applied existing international human rights law to the issues of sexual orientation and gender identity. The principles. among other things, emphasized that gender identity is a prohibited ground of discrimination, recognized the right to legal recognition of trans persons' gender identity and affirmed that no one should be forced to undergo medical or psychological procedures to receive legal recognition. They also address a wide range of issues, including the rights to health, privacy and education[16]. Ten years later, the Yogyakarta Principles +10 expanded on the original principles by, for example, guaranteeing the right of LGBT individuals to be protected by the state against violence and discrimination[17]. Discrimination and stigma against trans persons is also rooted in the historical pathologization of trans identities. In the International Classification of Diseases (ICD-11) trans-related categories were removed from the chapter on mental and behavioural disorder only in 2019[18]. This change marked a significant step toward depathologization, recognizing that being trans is not in itself a mental illness.

Medical and surgical interventions to affirm someone's gender have been available since the first half of the 20th century. In Germany, at the Berlin "Institut für Sexualwissenschaft (the Institute for Sexual Science)" founded by Magnus Hirschfeld, trans patients began to receive hormonal therapy and undergo surgeries. Gender-affirming medical treatments were instead prescribed to children[19] for the first time during the 1990s in a Dutch program for the care of adolescents with gender dysphoria, a distress caused by a marked incongruence between the sex assigned at birth[20] and gender identity of at least six months in duration[21].

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[16] International Commission of Jurists (ICJ) and International Service for Human Rights (ISHR), 'The Yogyakarta Principles: Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity' (March 2007).

[17] International Commission of Jurists and others, *Yogyakarta Principles plus 10: Additional Principles and State Obligations on the Application of International Human Rights Law in relation to Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics to Complement the Yogyakarta Principles* (10 November 2017).

[18] UN Human Rights Council, 'The Struggle of Trans and Gender-Diverse Persons: Report of the Independent Expert on Protection against Violence and Discrimination Based on Sexual Orientation and Gender Identity, Victor Madrigal-Borloz' (6 June 2023) UN Doc A/HRC/53/30.

[19] For the purposes of this study, the term children refers to anyone under the age of 18.

[20] <<Sex assigned at birth refers to a person's status as male, female, or intersex based on physical characteristics. Sex is usually assigned at birth based on appearance of the external genitalia>>, Eli Coleman and others, 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' (2022) 23 International Journal of Transgender Health S1, 252 https://doi.org/10.1080/26895269.2022.2100644.

[21] American Psychiatric Association, 'Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR' (5th edn, Text Revision, APA 2022) 451–53.

Recent studies on samples of student populations have shown that the percentage of adolescents identifying as gender diverse[22] is significant[23]. Some transgender and gender diverse persons experience gender dysphoria. In this context, referrals of children to gender identity services for gender dysphoria have significantly increased in Western countries[24]. Among these young people, the ones who are assigned female at birth are disproportionately represented, marking a shift in the assigned sex ratio. Indeed, in the past the percentage of children assigned male at birth that got referred for gender dysphoria was predominant.[25] Furthermore, this population has higher rates of mental health problems and neurodevelopmental presentations[26]. The increase in demand for gender identity services from

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[22] <<A term used to describe people with gender identities and/or expressions that are different from social and cultural expectations attributed to their sex as-signed at birth>>, Eli Coleman and others, 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' (2022) 23 International Journal of Transgender Health S1, 252. https://doi.org/10.1080/26895269.2022.2100644.

[23] Marla E Eisenberg and others, 'Risk and Protective Factors in the Lives of Transgender/Gender Nonconforming Adolescents' (2017) 61 Journal of Adolescent Health 521 https://doi.org/10.1016/j.jadohealth.2017.04.014; Kathryn M Kidd and others, 'Prevalence of Gender-Diverse Youth in an Urban School District' (2021) 147 Pediatrics e2020049823 https://doi.org/10.1542/peds.2020-049823; Yonghua Wang and others, 'Mental Health Status of Cisgender and Gender-Diverse Secondary School Students in China' (2020) 3(10) JAMA Network Open e2022796 https://doi.org/10.1001/jamanetworkopen.2020.22796.

[24]Care Quality Commission, '*The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report*'(CQC 2021); Riittakerttu Kaltiala and others, 'Time Trends in Referrals to Child and Adolescent Gender Identity Services: A Study in Four Nordic Countries and in the UK' (2020) 74(1) *Nordic Journal of Psychiatry* 40 https://doi.org/10.1080/08039488.2019.1667429.

[25]Madison Aitken and others, 'Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria' (2015) 12(3) *The Journal of Sexual Medicine* 756 https://doi.org/10.1111/jsm.1281.; Nienke M de Graaf and others, 'Evidence for a Change in the Sex Ratio of Children Referred for Gender Dysphoria: Data from the Gender Identity Development Service in London (2000–2017)' (2018) 15(10) *The Journal of Sexual Medicine* 1381 https://doi.org/10.1016/j.jsxm.2018.08.002; Nienke M de Graaf and others, 'Sex Ratio in Children and Adolescents Referred to the Gender Identity Development Service in the UK (2009–2016)' (2018) 47(5) *Archives of Sexual Behavior* 1301 https://doi.org/10.1007/s10508-018-1204-9; Thomas D Steensma, P T Cohen-Kettenis and K J Zucker, 'Evidence for a Change in the Sex Ratio of Children Referred for Gender Dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam (1988–2016)' (2018) 44(7) *Journal of Sex & Marital Therapy* 713 https://doi.org/10.1080/0092623X.2018.1437580; Qing Zhang and others, 'Changes in Size and Demographic Composition of Transgender and Gender Nonbinary Population Receiving Care at Integrated Health Systems' (2021) 27(5) *Endocrine Practice* 390 https://doi.org/10.1016/j.eprac.2020.11.016.

[26] Nienke M de Graaf and others, 'Suicidality in Clinic-Referred Transgender Adolescents' (2020) *European Child & Adolescent Psychiatry* https://doi.org/10.1007/s00787-020-01663-9; Kasia Kozlowska and others, 'Australian Children and Adolescents with Gender Dysphoria: Clinical Presentations and Challenges Experienced by a Multidisciplinary Team and Gender Service' (2021) 1(1) *Human Systems* 70, 72 https://doi.org/10.1177/26344041211010777; Scott Leibowitz and Annelou L C de Vries, 'Gender Dysphoria in Adolescence' (2016) 28(1) *International Review of Psychiatry* 21–35 https://doi.org/10.3109/09540261.2015.1124844; Rune Andre Øien, Domenic V Cicchetti and Anders Nordahl-Hansen, 'Gender Dysphoria, Sexuality and Autism Spectrum Disorders: A Systematic Map Review' (2018) 48(12) *Journal of Autism and Developmental Disorders* 4028–4037 https://doi.org/10.1007/s10803-018-3686-7**;** Jacopo Ristori and others, 'Gender Dysphoria and Anorexia Nervosa Symptoms in Two Adolescents' (2019) 48(5) *Archives of Sexual Behavior* 1625–1631 https://doi.org/10.1007/s10508-019-1396-7**;** Norman P Spack and others, 'Children and Adolescents with Gender Identity Disorder Referred to a Pediatric Medical Center' (2012) 129(3) *Pediatrics* 418–425 https://doi.org/10.1542/peds.2011-0907; Michelle A Tollit and others, 'The Clinical Profile of Patients Attending a Large, Australian Pediatric Gender Service: A 10-Year Review' (2023) 24(1) *International Journal of Transgender Health* 59, 59–60, 65 https://doi.org/10.1080/26895269.2021.1939221; Annelou I van der Miesen, Hannah Hurley and Annelou L C de Vries, 'Gender Dysphoria and Autism Spectrum Disorder: A Narrative Review' (2016) 28(1) *International Review of Psychiatry* 70–80 https://doi.org/10.3109/09540261.2015.1111199.

adolescents, the clinical profile and the demographic composition of this population are all reasons that have led to the current controversy about gender-affirming care for children. Since the 1990s gender-affirming care has been one of the primary gender-related healthcare models in the West. This model consists in the treatment of gender dysphoria by affirming the patient's gender identity through psychological support and medical interventions.[27]

The treatments that constitute the medical component of the gender-affirming model have recently been subject to laws or regulations in different Western jurisdictions to ban or restrict them. For example, despite the fact that gender-affirming medical care has been endorsed, among others, by the American Academy of Paediatrics and the American Medical Association[28] as the standard of care for children diagnosed with gender dysphoria, 25 federal US states have banned it.[29] In England and Wales, following the publication of the Cass Report[30], an independent review of the services offered by the National Health Service to children diagnosed with gender dysphoria, gender affirming medical care for children has been significantly restricted[31]. However, gender affirming medical care remains the primary model for the treatment of youth with gender dysphoria in other Western jurisdictions.

Given the diversity of the law dealing with the matter in different countries, the aim of this study is to find common principles for the development of a children's rights-centered approach for the regulation of gender affirming medical care for children. Chapter 1 will lay the groundwork for the discussion by

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[27] Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Interim Report* (Report, February 2022) 78 https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim□Report-Final-Web-Accessible.pdf; Melissa A Hidalgo and others, 'The Gender Affirmative Model: What We Know and What We Aim to Learn' (2013) 56 *Human Development* 285 https://doi.org/10.1159/000355235; Michelle Telfer and others, *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* (Guideline No 1.3, The Royal Children's Hospital Melbourne, 2020) 2 ('Australian Standards').

[28] American Medical Association, 'Clarification of Evidence-Based Gender-Affirming Care H-185.927' (AMA Policy, 2023) https://policysearch.ama-assn.org/policyfinder/detail/H-185.927; Jason Rafferty and others, 'Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents' (2018) 142 *Pediatrics* e20182162.

[29] Movement Advancement Project, *Equality Maps: Bans on Best Practice Medical Care for Transgender Youth* (<www.mapresearch.org/equalitymaps/healthcare/youth_medical_care_bans> accessed [16 April 2025])

[30] Hilary Cass, *The Cass Review: Independent Review of Gender Identity Services for Children and Young People – Final Report* (April 2024) https://cass.independent-review.uk/publications/final-report/

[31] Medicines (Gonadotrophin-Releasing Hormone Analogues) (Restrictions on Private Sales and Supplies) Order 2024, SI 2024/1319; NHS England, 'Clinical Commissioning Policy: Prescribing of Gender Affirming Hormones (masculinising or feminising hormones) as part of the Children and Young People's Gender Service' (NHS England, March 2024) https://www.england.nhs.uk/publication/clinical-commissioning-policy-prescribing-of-gender-affirming-hormones/; The National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) (Amendment) Regulations 2024, SI 2024/728.

providing an overview of gender affirming medical care and the children's rights legal framework. Chapter 2 will include an analysis of the regulatory frameworks related to gender affirming care for children in three jurisdictions. Each of them represents three approaches. The 2021 Arkansas SAFE Act, the first gender affirming medical care ban for children passed in a state legislature in the US, will be the model for the banning approach. The UK's government actions in response to the recommendations of the Cass Review will serve as the model for the restrictive approach. Indeed, other European countries that have gender affirming care as part of the healthcare services they offer to children, have in recent years published guidelines by their independent national healthcare authorities cautioning that the risks associated with these treatments outweigh the benefits., for example Sweden[32]. Finally, Australia's extensive case law on the right of children with gender dysphoria to access gender affirming care will be the model of the gender-affirming approach. Chapter 3 will develop the children's rights-centered approach, with an analysis of strengths and weaknesses of each model vis a vis the children's rights legal framework, other sources of international human rights law and domestic human rights and civil rights law.

CHAPTER 1

What Does Gender-Affirming Medical Care for Children Entail?

The World Professional Association for Transgender Health published in 2022 the 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8', the most widely applied guidelines for the treatment of transgender and gender diverse persons. These standards represent the culmination of years of evolving clinical practice and research in the field of transgender health[33]. The recommendations differentiate between prepubescent children and adolescents. A younger gender-diverse child can not access medical procedures[34]. It is not possible to predict the gender

[32] Socialstyrelsen, The National Board of Health and Welfare, Care of Children andAdolescents with Gender Dysphoria: Summary ofNational Guidelines (Report, December 2022) 3 <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf>.

[33] Eli Coleman et al, 'Standards of Care for the Health of Transgender and Gender Diverse People: Version 8' (2022) 23(sup1) International Journal of Transgender Health <https://doi.org/10.1080/26895269.2022.2100644>.

[34] Pediatric Endocrine Society, ' Position statement on genital surgery in individuals with differences of sex development (DSD)/intersex traits' (2020) https://pedsendo.org/ clinical-resource/position-statement-on-genital-surgery-i n-individuals-with-differences-of-sex-development -dsd-intersex-traits/.

trajectories of gender-diverse prepubertal children[35], with some who may never identify as trans and others who will[36]. If families seek professional support, it can only be of a psychological nature. The guidelines recommend healthcare professional to promote the well-being of gender-diverse children, who are especially vulnerable psychologically[37] due to, among other factors, gender-related rejection[38]. To this end, the recommendations embrace psychological gender-affirming care[39], encouraging families and healthcare professionals to support children exploring their gender and the eventual desire of the child to be acknowledged as the gender corresponding to the their internal sense of gender identity[40]. The medical model for the treatment of pubertal trans children is instead an evolution of the so-called Dutch Protocol[41], an approach developed in the first clinical program dedicated to adolescents with gender dysphoria. This protocol became a reference point for healthcare professionals working with gender-diverse youth in many Western contexts. Adolescents with gender dysphoria who had reached Tanner Stages[42] 2-3 of puberty, lived in a supportive environment and had no psychosocial problems interfering with diagnostic assessment or with treatment eligibility, were prescribed medications to pause pubertal development. The use of these medications, commonly referred to as puberty blockers, aimed to temporarily suppress physical changes associated with puberty, as they were considered to be fully reversible[43]. The aim of the treatment was to both give more time to the adolescents to explore their gender identity and to ease the distress related to their gender dysphoria. This period of reflection was considered essential to allow for more informed and comfortable decision-making regarding

[35] Thomas D Steensma and others, 'Gender identity development in adolescence' (2013) 64 Hormones and Behavior https:// doi.org/10.1016/j.yhbeh.2013.02.020.
[36] Kristina R Olson and others, 'Gender identity 5 years after social transition' (2022) Pediatrics. Advance Online Publication. https:// doi.org/10.1542/peds.2021-056082.
[37] Jiska Ristori & Thomas D Steensma 'Gender dysphoria in childhood' 28(1) International Review of Psychiatry https://doi.org/10.3109/09540261.2015.1115754.
[38] Eli Coleman et al, 'Standards of Care for the Health of Transgender and Gender Diverse People: Version 8' (2022) 23(sup1) International Journal of Transgender Health S67-68 <https://doi.org/10.1080/26895269.2022.2100644>.
[39] Melissa A Hidalgo and others, 'The Gender Affirmative Model: What We Know and What We Aim to Learn' (2013) 56 Human Development https://doi.org/10.1159/000355235.
[40] Eli Coleman et al, 'Standards of Care for the Health of Transgender and Gender Diverse People: Version 8' (2022) 23(sup1) International Journal of Transgender Health S69. <https://doi.org/10.1080/26895269.2022.2100644>.
[41] Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. European Journal of Endocrinology, 155(suppl_1), S131–S137. doi:10.1530/eje.1.02231
[42] <<Classification of puberty by stage of development. This ranges from Stage 1, before physical signs of puberty appear, to Stage 5 at full maturity>>. Hilary Cass, Independent Review of Gender Identity Services for Children and Young People: Interim Report (Report, February 2022), 84 <https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim□Report-Final-Web-Accessible.pdf>
[43] Annelou LC de Vries and Peggy T Cohen-Kettenis, 'Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach' (2012) 59(3) Journal ofHomosexuality 310-311 <http://dx.doi.org/10.1080/00918369.2012.653300>.

potential future medical steps[44]. These adolescents, once they turned 16, and if they still met the eligibility criteria, had the possibility to be prescribed cross sex hormones to start the puberty of the gender they identified with. The choice of 16 as threshold for hormone treatment, which is only partially reversible, was based on the fact that in the Netherlands this is the age after which adolescents can make independent medical decisions, although parental approval was still sought[45]. However, the most recent guidelines do not rely on a fixed age to recommend the prescription of cross sex hormones. Instead, they focus on the mental capacity of the adolescent to give informed consent[46], allowing individuals under 16 to initiate hormone therapy when there are compelling reasons to do so.

Long-term longitudinal follow-up studies conducted with adults who underwent gender-affirming medical care as adolescents show an improvement in psychological functioning for these individuals compared to the time before they started the treatments. These outcomes suggest that early medical interventions can play a positive role in alleviating psychological distress[47]. However, studies with other outcome designs show that mental health care utilization among adolescents did not change between the time before and after the start of gender affirming medical care[48]. Since there is a limited number of studies on the effectiveness of the early interventions and on the long term effects of the

[44] Jeremi M Carswell, Ximena Lopez and Stephen M Rosenthal, 'The Evolution of Adolescent Gender□Affirming Care: An Historical Perspective' (2022) 95(6) Hormone Research in Paediatrics 653 <https://doi.org/10.1159/000526721>.
[45] Annelou LC de Vries and Peggy T Cohen-Kettenis, 'Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach' (2012) 59(3) Journal ofHomosexuality 313 <http://dx.doi.org/10.1080/00918369.2012.653300>.

[46]Wylie C Hembree and others, 'Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline' (2017) 102(11) *Journal of Clinical Endocrinology & Metabolism* 3871

[47] Peggy T Cohen-Kettenis and Stephanie H M van Goozen, 'Sex Reassignment of Adolescent Transsexuals: A Follow-Up Study' (1997) 36(2) *Journal of the American Academy of Child & Adolescent Psychiatry* 263–271 https://doi.org/10.1097/00004583-199702000-00017; Annelou L C de Vries and others, 'Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment' (2014) 134(4) *Pediatrics* 696–704 https://doi.org/10.1542/peds.2013-2958; Yvonne L Smith, Stephanie H M van Goozen and Peggy T Cohen-Kettenis, 'Adolescents with Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-Up Study' (2001) 40(4) *Journal of the American Academy of Child & Adolescent Psychiatry* 472–481 https://doi.org/10.1097/00004583-200104000-00017; vonne L Smith and others, 'Sex Reassignment: Outcomes and Predictors of Treatment for Adolescent and Adult Transsexuals' (2005) 35(1) *Psychological Medicine* 89–99 https://doi.org/10.1017/s0033291704002776.

[48]Elizabeth Hisle-Gorman and others, 'Mental Health-Care Utilization of Transgender Youth before and after Affirming Treatment' (2021) 18(8) *The Journal of Sexual Medicine* 1444–1454 https://doi.org/10.1016/j.jsxm.2021.05.014; Riittakerttu Kaltiala, Eeva Heino, Maria Työläjärvi and Laura Suomalainen, 'Adolescent Development and Psychosocial Functioning after Starting Cross-Sex Hormones for Gender Dysphoria' (2020) 74(3) *Nordic Journal of Psychiatry* 213–219 https://doi.org/10.1080/08039488.2019.1691260.

treatments[49], more research needs to be conducted. The existing literature provides important insights, but significant gaps remain regarding the safety, efficacy, and long-term outcomes of these treatments. For example, it is unclear whether the short-term reduction in bone density, one of the well-recognised side effects of puberty blockers, can lead to long-term complications like osteoporosis and increased risk of fractures. This is particularly important given the fact that puberty blockers, unlike cross-sex hormones, were considered fully reversible[50]. Further research is also needed to assess the effects of puberty blockers and cross-sex hormones on fertility, including the extent to which these effects are reversible[51]. Indeed, although clinical guidelines recommend professionals to inform adolescents about the potential loss of fertility and about fertility preservation options[52], the number of young people who actually undergo these procedures is low.[53] Furthermore, individuals who start gender affirming treatments in early puberty have limited fertility preservation options[54]. This limitation raises ethical and clinical concerns about how best to support adolescents in making informed and future-oriented medical decisions. Another issue that needs to be addressed in research is the fact that, according to the data from two studies[55], only 1.9% or 3.5% of the adolescents that initiate puberty blockers decide not to go on to hormone therapy. This very low rate of discontinuation has prompted differing interpretations among researchers, clinicians. Some have argued that this is due to the careful evaluation undertaken by the healthcare professionals who authorize gender affirming medical care in the first place. In this view, the rigorous assessment process ensures that only adolescents who are

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[49] Hilary Cass, Independent Review of Gender Identity Services for Children and Young People: Interim Report (Report, February 2022) 19, 39. <https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim□Report-Final-Web-Accessible.pdf> ; Eli Coleman and others, 'Standards of Care for the Health of Transgender and Gender Diverse People: Version 8' (2022) 23(sup1) International Journal of Transgender Health 46 <https://doi.org/10.1080/26895269.2022.2100644>. Socialstyrelsen, The National Board of Health and Welfare, Care of Children andAdolescents with Gender Dysphoria: Summary ofNational Guidelines (Report, December 2022) 3 <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf>.

[50] Lisa Perl, Jae Y Lee and Stephen M Rosenthal, 'Chapter 7 – Medical Side Effects of GnRH Agonists' in Courtney Finlayson (ed), *Pubertal Suppression in Transgender Youth* (Elsevier 2019) 49–52.

[51] Po-Jung Cheng and others, 'Fertility Concerns of the Transgender Patient' (2019) 8(3) *Translational Andrology and Urology* 209–218 https://doi.org/10.21037/tau.2019.05.09.

[52] Eli Coleman and others, 'Standards of Care for the Health of Transgender and Gender Diverse People: Version 8' (2022) 23(sup1) International Journal of Transgender Health 57 <https://doi.org/10.1080/26895269.2022.2100644>.

[53] Leena Nahata and others, 'Low Fertility Preservation Utilization among Transgender Youth' (2017) 61(1) Journal ofAdolescent Health 40, 42-3 <http://dx.doi.org/10.1016/j.jadohealth.2016.12.012>.

[54] Practice Committee of the American Society for ReproductiveMedicine. (2019). Fertility preservation in patients undergoing gonadotoxic therapy or gonadectomy: A com-mittee opinion. Fertility and Sterility, 112(6), 1025 https://doi.org/10.1016/j.fertnstert.2013.08.012.

[55] Tom Brik and others, 'Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria' (2020) 49(7) *Archives of Sexual Behavior* 2611–2618 https://doi.org/10.1007/s10508-020-01660-8; Christel M Wiepjes and others, 'The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets' (2018) 15(4) *The Journal of Sexual Medicine* 582–590 https://doi.org/10.1016/j.jsxm.2018.01.016.

highly likely to continue with treatment begin medical interventions[56]. Others emphasize the need to understand the reasons why an intervention that also had the aim of giving more time to adolescents with gender dysphoria to explore their gender identity results in these individuals deciding to start hormone therapy in the overwhelming majority of cases[57]. Lastly, more research is needed on detransitioning, whereby individuals discontinue gender affirming treatments. The prevalence of these cases is unclear. Despite the fact that law rates of regret have been reported[58], some caution that clinical rates of detransition are likely underreported because individuals who detransition may not inform the health care professional that has authorized the treatments of their choice. This lack of follow-up reporting can obscure the full picture and limit the ability of researchers to draw reliable conclusions[59]. Moreover, while one study finds that external factors, like family pressure and societal stigma, are the reason behind detransition in most cases[60], in another study external factors are a less common explanation compared to reasons like realizing that their gender dysphoria was related to other factors or that alternatives to gender affirming medical care were better at treating their distress[61].

The Children's Rights Legal Framework

The Convention on the Rights of the Child[62] is a virtually universal treaty. All UN member states, with the exception of the United States, have ratified it.[63]. This broad ratification underscores the widespread commitment of the international community to the protection and promotion of children's rights. Given its universality, the Convention has been very influential in the development of both national and

[56] Annelou LC de Vries et al, 'Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274: Weighing Current Knowledge and Uncertainties in Decisions about Gender-Related Treatment for Transgender Adolescents' (2021) 22(3) International Journal ofTransgender Health 220, <https://doi.org/10.1080/26895269.2021.1904330>.
[57] Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Interim Report* (Report, February 2022) 38 https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim□Report-Final-Web-Accessible.pdf.
[58] Christel M Wiepjes and others, 'The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets' (2018) 15(4) *The Journal of Sexual Medicine* 582–590 https://doi.org/10.1016/j.jsxm.2018.01.016.
[59] Lisa Littman, 'Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners' (2021) 50(8) Archives of Sexual Behavior 3364-3365, 3367 <https://doi.org/10.1007/s10508-021-02163-w>.
[60]Jack L Turban and others, 'Factors Leading to "Detransition" among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis' (2021) 8(4) *LGBT Health* 273-280.
[61] Lisa Littman, 'Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners' (2021) 50(8) Archives of Sexual Behavior 3365, <https://doi.org/10.1007/s10508-021-02163-w>.

[62] UN Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3.
[63] UN Treaty Collection, 'Status of Treaties: Convention on the Rights of the Child' https://treaties.un.org accessed [15 May 2025].

international children's rights legal frameworks. Its provisions have shaped not only legal obligations but also policy standards and institutional practices across a wide variety of jurisdictions[64]. Before its entry into force in 1990, other international instruments dedicated to children's rights had been drafted. The 1924 Declaration on the Rights of the Child[65] and the 1959 Declaration on the Rights of the Child[66] focused on the obligations of states to provide children with special care and protection. These early instruments were primarily welfare-based, framing children as passive recipients of adult protection rather than as independent rights-holders[67].

The CRC was the first international instrument to treat children as holders of rights[68]. Despite its transformative approach, not all the provisions of the treaty are regarded as the highest possible standards for children's rights, as they were the results of complex negotiations. The final text reflects a delicate compromise among diverse legal systems, political ideologies, and cultural traditions represented by the negotiating states[69]. However, article 41 provides that state parties are not prevented by the Convention from having national laws or being bound by other international provisions containing higher standards for the realization of the rights of the child than those of the CRC[70]. Other fundamental provisions for the implementation of the rights set forth in the treaty are articles 43-45. Article 43 establishes the Committee on the Rights of the Child, a body made up by experts on children's rights and responsible for monitoring the implementation of the Convention[71]. It does so, according to article 44, by making recommendations to state parties following their submission of

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[64] John Tobin, 'Increasingly Seen and Heard: The Constitutional Recognition of Children's Rights' (2005) 21 South African Journal on Human Rights 86; John Tobin, 'Judging the Judges: Are Judges Adopting the Rights Approach in Matters Involving Children' (2009) 33 Melbourne University Law Review 579; Helen Stalford and E Drywood, 'Using the CRC to Inform EU Law and Policy-Making' in Antonella Invernizzi and Jane Williams (eds), *The Human Rights of Children: From Visions to Implementation* (Ashgate 2011).

[65] Declaration of the Rights of the Child (adopted 26 September 1924) League of Nations OJ Spec Supp 21, 43.

[66] UNGA 'Declaration of the Rights of the Child' (20 November 1959) UNGA Res 1386 (XIV).

[67] John Tobin, 'Introduction: The Foundation for Children's Rights' in John Tobin (ed), *The UN Convention on the Rights of the Child: A Commentary*, Oxford Commentaries on International Law (2019; online edn, Oxford Law Pro) 4-5 https://doi.org/10.1093/law/9780198262657.003.0001.

[68] Philip Alston, John Tobin, and Mac Darrow, *Laying the Foundations for Children's Rights* (UNICEF Innocenti Insight 2005) ix.

[69] Nigel Cantwell, 'Word that Speak Volumes: A Short History of the drafting of the CRC' in Jane Connors, Jean Zermatten, and Anastasia Panayotidis (eds), *18 Candles: The Convention on the Rights of the Child Reaches Majority* (Institut international des droits de l'enfant Switzerland, 2007) 21.

[70] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 41.

[71] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 43.

reports on the implementation of the treaty in their respective jurisdictions[72]. Moreover, according to article 45, the Committee provides clarity regarding the correct interpretation of the CRC through general recommendations[73].

This section refers to some key child rights principles enshrined in the Convention. To that end, it is useful to clarify the definition of the individuals to whom these principles apply. Article 1 defines a child as someone who is under 18 years of age, while it also concedes that majority can be attained earlier according to the domestic law applicable to the child[74]. This flexible definition allows states to respect domestic legal traditions while upholding a general international standard.

The principle of non-discrimination contained in Article 2 binds State parties to guarantee all the rights recognized by the treaty to every child in their jurisdictions without discrimination on the basis of their, or their parents' or legal guardians', personal characteristics. Furthermore, it obliges state parties to take measures to protect children from discrimination on the basis of their parents' status[75]. While the article also contains a list of prohibited grounds of discrimination, like race and sex, the Committee has interpreted the term 'other status' to include a high and ever-evolving number of grounds not mentioned in the Convention[76]. The principle of non-discrimination is key to the implementation of the entirety of the CRC, as demonstrated by the Committee's recognition of Article 2 as one of the 4 general principles [77] that guide the interpretation of all the other provisions of the Convention[78].

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[72] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 44.
[73] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 45.
[74] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 1.
[75] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 2.
[76] Rachel Hodgkin and Peter Newell, *The Implementation Handbook for the Convention on the Rights of the Child* (3rd edn, UNICEF 2007) 24–25.

[77] CRC Committee, 'Overview of the reporting procedures' (1994) CRC/C/33; CRC Committee, 'General guidelines regarding the form and content of initial reports to be submitted by States Parties under article 44, paragraph 1 (a), of the Convention on the Rights of the Child' (1991) CRC/C/5 ('CRC Committee, General guidelines'), para 9; CRC Committee, 'General Comment No 5: General Measures of Implementation of the Convention on the Rights of the Child (arts 4, 42, and 44, para 6)' (2003) ('CRC GC 5') reproduced in 'Compilation of General Comments and General Recommendations adopted by Human Rights Treaty Bodies' (2008) HRI/GEN/1/Rev.9 (Vol II) 421, para 12.
[78] Laura Lundy and Bronagh Byrne, 'The Four General Principles of the United Nations Convention on the Rights of the Child: the Potential Value of the Approach in Other Areas of Human Rights Law' in Eva Brems, Ellen Desmet, and Wouter Vandenhole (eds), *Children's Rights Law in the Global Human Rights Landscape: Isolation, Inspiration, Integration?* (Routledge 2017) 52–70.

The right of the child to have their best interests treated as a primary consideration in all actions affecting them is another general principle of the CRC. The Committee affirmed it in General Comment No. 14, which provides an interpretation of the best interests principle, enshrined in subparagraph 1 of article 3 of the Convention[79]. Subparagraphs 2 and 3 of the same article set out, respectively, a general obligation for state parties to take all measures to ensure the well-being of the child, and a specific obligation to establish standards to be observed by institutions and services responsible for the care and protection of children[80]. Art. 3(1) has been criticized for its perceived indeterminacy[81]. The scope of the subparagraph is so broad that it encompasses not only actions taken by states that directly concern children, but also those which have an indirect effect on them[82]. However, despite the fact that virtually all actions taken by states affect children, not all warrant the same level of consideration. The ones that have a major impact on children need to be assessed through a more detailed process to determine the bests interests of the child than others[83]. Moreover, since art.3 (1) specifies that both bodies of the state and private bodies shall consider the best interests of the child, and since only states are parties to the Convention, states must ensure that all domestic actors apply the principle. This includes private institutions such as schools, hospitals, and care facilities that make decisions impacting children's lives[84]. In order to comply with these obligations, state parties have to, among other things, establish complaint procedures, implement policies to inform professionals whose activities affect children of the duty to take children's best interests as a primary consideration, organise campaigns to contrast negative perceptions about the principle[85].

Furthermore, in all decision-making processes involving actions that affect children, the potential positive or negative impact on them shall be explicitly assessed in advance and weighed against other

[79] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 para 1.
[80] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 3.
[81] Stephen Parker, 'The Best Interests of the Child: Principles and Problems' in Philip Alston (ed), *The Best Interests of the Child: Reconciling Culture and Human Rights* (Unicef and Clarendon Press 1994); Raymie H Wayne, 'The Best Interests of the Child: A Silent Standard—Will You Know it When You Hear it?' (2008) 2 Journal of Public Child Welfare 33.
[82] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 para 19 ('CRC GC 14').
[83] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 para 20 ('CRC GC 14').
[84] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 para 15 ('CRC GC 14').

[85] ibid

considerations[86]. Among these, the Committee has emphasised situations in which actions taken in the name of the child's best interests may conflict with other rights under the Convention. In such cases, the action would no longer be considered in the child's best interests[87] and would contravene the principle of internal system coherence within the treaty. This internal coherence ensures that the Convention is not interpreted or applied in ways that justify the restriction of one right through an expansive reading of another[88]. Thus, states have an obligation to ensure that children's views are heard and given due weight according to their age and maturity when assessing their best interests, as mandated by article 12(1) of the CRC[89]. Taking away this right from children would not only violate article 12(1), but also article 3(1), by denying them the possibility of influencing the process for the determination of their best interests[90].

A determination of the best interests of a child can not ignore article 5 either. It obliges state parties to respect the right and responsibility of parents and legal guardians to give guidance to children in the exercise of their rights. As affirmed by the Committee, one of their fundamental responsibility is ensuring the best interest of the child[91]. However, the Committee has also emphasized that parents do not have an absolute right to determine their child's best interests when their actions are in violation of other provisions of the CRC[92]. Other factors that need to be taken into consideration when applying the best interests principle are the specific needs of the children and their specific contexts[93]. Finally, available empirical evidence should also be used as an element to more objectively understand whether a specific action is in the best interests of children[94]. In any case, whenever an action that is not in the

[86] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 para 20 ('CRC GC 14').
[87] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 paras 6 and 32 ('CRC GC 14').
[88] John Tobin, 'Seeking to Persuade: A Constructive Approach to Human Rights Treaty Interpretation' (2010) 23 Harvard Human Rights Journal 1, 37–39.
[89] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 paras 85-91 ('CRC GC 14').
[90] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 para 53 ('CRC GC 14').
[91] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 para 25 ('CRC GC 14').
[92] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 para 4 ('CRC GC 14').
[93] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 para 14 ('CRC GC 14').

[94] John Tobin and Ruth McNair, 'Public International Law and the Regulation of Private Spaces: Does the Convention on the Rights of the Child Impose an Obligation on States to Allow Gay and Lesbian Couples to Adopt?' (2009) 23 International Journal of Law Policy and Family 110.

best interests of the child is taken because other considerations prevailed, the decision-maker must show that it was treated as a primary concern[95].

Article 5 establishes an obligation on State parties to respect the rights, responsibilities and duties of parents to guide their children, consistent with their evolving capacities, in the exercise of their rights under the Convention[96]. Although the Committee has not identified Article 5 as one of the CRC's general principles, scholars have noted that the principles of parental guidance and the child's evolving capacities are important interpretative tools for the implementation of other provisions of the treaty[97]. They reflect the multiple aims of article 5, which not only ensures that children enjoy their rights through the guidance of their parents[98], but also acknowledges and protects the special role of parents[99]. Parental guidance is protected by the obligation to respect set out in the article, which, under international human rights law, implies a negative obligation on the State parties not to interfere with parent's rights and responsibilities[100]. Furthermore, in order to fulfil their obligation under article 5, State parties must also implement legislation and regulations to ensure that non-state actors that interact with children, other than parents, are aware that their decisions must respect parental guidance[101]. However, not all interferences are prohibited: when the Committee excluded the possibility that article

[95] CRC Committee, 'General Comment No 14: The Right of the Child to Have his or her Best Interests Taken as a Primary Consideration' (29 May 2013) UN Doc CRC/C/GC/14 para 97 ('CRC GC 14').
[96] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 5.
[97] Jaap Doek, 'The CRC General Principles' in Jane Connors, Jean Zermatten, and Anastasia Panayotidis (eds),*18 Candles: The Convention on the Rights of the Child Reaches Majority* (Institut international des droits de l'enfant 2007) 31; John Tobin, 'Understanding a Human Rights Based Approach to Matters Involving Children: Conceptual Foundations and Strategic Considerations' in A Invernizzi and J Williams (eds), *Human Rights of Children: From Visions to Implementation* (Ashgate 2011) 61, 71–72; Karl Hanson and Laura Lundy, 'Does Exactly What it Says on the Tin? A Critical Analysis and Alternative Conceptualisation of the So-called "General Principles" of the Convention on the Rights of the Child', 2017 (25) The International Journal of Children's Rights 285.
[98] Garton Kamchedzera, 'Article 5—The Child's Right to Appropriate Direction and Guidance' in Andre Alen and others, *A Commentary on the United Nations Convention on the Rights of the Child* (Martinus Nijhoff 2012).
[99] John Tobin, 'Fixed Concepts but Changing Conceptions: Understanding the Relationship Between Children and Parents Under the CRC' in Martin Ruck, M Peterson-Badali, and Michael Freeman (eds), *Handbook of Children's Rights: Global and Multidisciplinary Perspectives* (Taylor & Francis 2016) 53.
[100] Manfred Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary* (2nd edn, NP Engel 2005) 37; Human Rights Committee ('HR Committee'), 'General Comment No 31: The Nature of the General Legal Obligation imposed on State Parties to the Covenant' (26 May 2004) CCPR/C/21/Rev.1/Add.13 ('HRC GC 31') para 6; Robin Geib, 'The Obligation to Respect and to Ensure Respect for the Conventions' in Andrew Clapham, Paola Gaeta, and Marco Sassoli (eds), *The 1949 Geneva Conventions: A Commentary* (OUP 2015) 111, 11.
[101] John Tobin and Sheila Varadan, 'The Right to Parental Direction and Guidance Consistent with a Child's Evolving Capacities', in John Tobin (ed.), *The UN Convention on the Rights of the Child: A Commentary*, Oxford Commentaries on International Law (2019; online edn, Oxford Law Pro), 167 https://doi.org/10.1093/law/9780198262657.003.0006, accessed 23 May 2025.

5 could justify corporal punishment by parents, it explained that the provision must always be interpreted consistent with the other rights guaranteed to children under the Convention[102].

Another limitation to the principle of parental guidance is found within the same article, through the concept of the child's evolving capacities. This principle requires parents to adjust parental guidance according to their child's capacity to understand their best interests and make autonomous decisions. This approach recognises the dynamic and developmental nature of childhood[103]. In practice, for young children, who usually need more guidance, this means that parents should use a child-centered way to enhance their capacity to enjoy their rights[104]. However, age alone does not determine how parents should respond to their child's evolving capacities, as individual variations among children of the same age must always be taken into account. This recognition of individual differences reinforces the need for case-by-case assessment in applying Article 5[105] . For adolescents, the Committee explained that a series of factors, including the level of risk and the potential for exploitation, need to be taken into consideration when balancing the respect for the generally well-developed capacity for autonomous decision-making of adolescents and the need to protect them[106]. Moreover, as the child matures, parents shall transform their guidance first to advice and then to exchanges[107].

Like article 5, article 12 recognizes children's evolving capacities[108]. It is among the four articles that should guide the interpretation of all the other provisions of the Convention[109]. According to article 12(1), states must assure that children capable of appropriately forming their own views can enjoy their right to express them in matters that affect them. Furthermore, these views must be given due weight in accordance with the age and maturity of the child[110]. This creates an active obligation on State parties to

[102] CRC Committee, 'General Comment No 8' (2 March 2007) CRC/C/GC/8, para 28.
[103] CRC Committee, 'General Comment No 7: Implementing child rights in early childhood' (20 September 2006) CRC/C/GC/7/Rev.1 ('CRC GC 7') para 17.
[104] ibid
[105] ibid
[106] CRC Committee, 'General Comment No 20 on the implementation of the rights of the child during adolescence' (6 December 2016) CRC/C/GC/20 ('CRC GC 20') para 20.
[107] CRC Committee, 'General Comment No 14' (29 May 2013) UN Doc CRC/C/GC/14 ('CRC GC 14') para 44.
[108] John Tobin and Sheila Varadan, 'The Right to Parental Direction and Guidance Consistent with a Child's Evolving Capacities', in John Tobin (ed.), *The UN Convention on the Rights of the Child: A Commentary*, Oxford Commentaries on International Law (2019; online edn, Oxford Law Pro), 175 https://doi.org/10.1093/law/9780198262657.003.0006, accessed 23 May 2025.
[109] CRC Committee, 'General Comment No 12: The Right of the Child to be Heard' (1 July 2009) CRC/C/GC/12 ('CRC GC 12') para 2.
[110] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 12.

seek children's views and to give them due weight[111]. When the Committee interpreted this provision, it explained that children do not need to have a comprehensive understanding on the matter to be able to form their own views[112]. Rather, they must have a sufficient understanding, with the required threshold varying depending on the context[113]. Medical decisions, for example, typically require a higher level of understanding[114]. Furthermore, states must start with an assumption that children are capable of appropriately forming their own views, not the other way around[115]. The Committee has also interpreted the obligation for states to give due weight to children's views according to their age and maturity by developing guidance for assessing a child's level of understanding of a given matter. In determining the appropriate weight to be given to their views, states must also take into account the short-, medium- and long- term consequences of implementing their views and their impact on the rights of others or on legitimate public policy considerations[116]. Indeed, while some national jurisprudence affirms that the child's views are determinative of their best interests when children reach the same level of maturity required of an adult[117], other national jurisprudence clarifies that such views can never be determinative of the actions to be taken without a proper balancing against their impact on others and against other considerations. This divergence illustrates the nuanced legal debates around children's autonomy[118].

The right of the child to be heard embedded in article 12 has been recognized by the Committee among the provisions of the Convention of great relevance for the effective implementation of article 24[119], which establishes the right of children to the highest attainable standard of health[120]. This includes attention to poverty, housing, nutrition, and access to education and healthcare services. Article 24(1)

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[111] CRC Committee, 'General Comment No 12: The Right of the Child to be Heard' (1 July 2009) CRC/C/GC/12 ('CRC GC 12') para 81.
[112] CRC Committee, 'General Comment No 12: The Right of the Child to be Heard' (1 July 2009) CRC/C/GC/12 ('CRC GC 12') para 21.
[113] ibid
[114] Gillick v West Norfolk & Wisbeck Area Health Authority [1986] AC 112 (England, House of Lords); *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 (Australia, High Court)para 237.
[115] CRC Committee, 'General Comment No 12: The Right of the Child to be Heard' (1 July 2009) CRC/C/GC/12 ('CRC GC 12') para 20.
[116] Lothar Krappman, 'The Weight of the Child's View (Article 12 of the UN Convention on the Rights of the Child)' (2010) 18 International Journal of Children's Rights 501, 505.
[117] Re Jamie [2013] Fam CAFC 110 (Australia, Family Court) para 134.
[118] C v Finland App No 18249/02 (ECtHR, 9 May 2006) para 58.
[119] CRC Committee, 'General Comment No 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health' (17 April 2013) CRC/C/GC/15 ('CRC GC 15') para 19.
[120] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 24.

does not oblige State parties to guarantee the health of each child under its jurisdiction, but to use its available resources to ensure that all children can attain the best possible standard of health, taking into account their biological and socio-economic circumstances[121]. Indeed, socio-economic circumstances are among the underlying determinants of health which, in light of the Committee's interpretation of article 24, must be addressed by States to effectively guarantee that the conditions in which children live enable them to enjoy the highest attainable standard of health[122]. This partly explains the emphasis the Committee has put on the interdependence between the right enshrined in article 24 and the other rights recognized in the Convention, whose realization depends on the enjoyment of the right to the highest attainable standard of health[123]. The Committee has identified several provisions of the Convention closely linked to the right to health: the prohibition against discrimination, the evolving capacities of the child, the right to life, the right to social security, the right of the child to be heard and the best interests principle[124]. This last principle is at the basis of every decision regarding the treatment of children[125] and provides parents with the authority to give informed consent on behalf of their child when they lack the capacity to do so[126]. Even in these cases, however, the principle of evolving capacities and the right of the child to be heard ensures the involvement of the child in the decision-making process[127]. When children are deemed of sufficient maturity, instead, they have the right to provide informed consent for their own procedures[128].

In this context, fulfillment by states of the obligations set out in articles 28 and 29 of the Convention of the Rights of the Child, respectively on the right to education and on the aims of education, is key to increase the level of involvement that children can have in decisions affecting them. Indeed, education shall provide children with the opportunity to develop, together with their talents and personality, their physical and mental abilities[129].

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[121] CRC Committee, 'General Comment No 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health' (17 April 2013) CRC/C/GC/15 ('CRC GC 15') para 23.
[122] CRC Committee, 'General Comment No 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health' (17 April 2013) CRC/C/GC/15 ('CRC GC 15') para 2.
[123] CRC Committee, 'General Comment No 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health' (17 April 2013) CRC/C/GC/15 ('CRC GC 15') para 7.
[124] CRC Committee, 'General Comment No 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health' (17 April 2013) CRC/C/GC/15 ('CRC GC 15') para 8-22.
[125] CRC Committee, 'General Comment No 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health' (17 April 2013) CRC/C/GC/15 ('CRC GC 15') para 14.
[126] American Academy of Pediatrics Committee on Bioethics, 'Informed Consent in Decision-Making in Pediatric Practice' (2016) 138 Pediatrics e20161484.
[127] CRC Committee, 'General Comment No 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health' (17 April 2013) CRC/C/GC/15 ('CRC GC 15') para 27.
[128] ibid
[129] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, artt. 28-29.

CHAPTER 2

Bans on Gender-Affirming Medical Care for Children: The Case of Arkansas

In 2021 Arkansas was the first of many US federal states to ban gender-affirming medical care for children in their jurisdictions[130], through what its proponents in the state legislature called "Save Adolescents From Experimentation (SAFE) Act"[131]. The Arkansas ban will be used as an example to describe this regulatory approach because, other than being the first of its kind, it is also the only ban that has been reviewed by a federal court after a full trial on the merits[132]. This makes the Arkansas case particularly significant as it provides a judicial examination of both the legal rationale and the factual basis for such legislation. While other states' bans have been reviewed by federal appellate courts, those reviews have occurred at the preliminary injunction stage, without a full trial[133].

The law prohibits healthcare providers from offering to patients under the age of 18 "gender transition procedures"[134], like puberty blockers or cross-sex hormones, when used to develop physiological or anatomical characteristics that do not align with the individual's sex assigned at birth[135]. To make its intent even clearer, the bill lists all the other purposes for which the same procedures are not prohibited, like the treatment of children with sexual development disorders[136]. Finally, the ban's enforcement provision exposes healthcare providers not only to disciplinary action by their respective licensing boards for unprofessional conduct, but also to civil lawsuits brought by private individuals[137]. This combination of professional and civil liabilities underscores the severity of the law's potential consequences for clinicians.

Following the bill's passage in the state legislature, three adolescents undergoing hormone therapy, a prepubertal child diagnosed with gender dysphoria, their parents, and the physician treating them filed a lawsuit seeking to permanently enjoin the law from taking effect[138]. The plaintiffs alleged a violation

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[130] Movement Advancement Project, *Equality Maps: Bans on Best Practice Medical Care for Transgender Youth* (<www.mapresearch.org/equalitymaps/healthcare/youth_medical_care_bans> accessed [4 June 2025]).
[131] Save Adolescents From Experimentation (SAFE) Act, Ark Code §§ 20-9-1501–1504 (2021).
[132] Brandt v. Rutledge, 677 F. Supp. 3d 877 (E.D. Ark. 2023).
[133] *Brandt v Rutledge* 47 F.4th 661 (8th Cir. 2022), Doe v Thornbury 83 F.4th 460 (6th Cir. 2023), *Eknes-Tucker v Governor of the State of Alabama* 80 F.4th 1205 (11th Cir. 2023), L.W. v Skrmetti 83 F.4th 460 (6th Cir. 2023).
[134] Ark Code Ann § 20-9-1502(a) (2021).
[135] Ark Code Ann § 20-9-1501(6)(A)(ii) (2021).
[136] Ark Code Ann § 20-9-1502(c) (2021).
[137] Ark Code Ann § 20-9-1504 (2021).
[138] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para II.

of the Equal Protection Clause and of the Due Process Clause of the US Constitution[139]. They claim that the law violates the Equal Protection Clause because it treats children who seek the same medical procedures differently[140], failing to treat similarly situated individuals alike[141]. The plaintiffs argue that the classification is based on sex and transgender status, and therefore warrants heightened scrutiny[142]. Under well-established precedent, when a law classifies based on sex, the state must show not merely that the law is rationally related to a legitimate interest[143], but that the classification is substantially related to an important governmental objective[144]. This means that the state, whose actions are usually presumed to be lawful[145], needs to demonstrate an "exceedingly persuasive" justification for the differentiated treatment under heightened scrutiny[146]. The other claim is based on the Due Process Clause, which protects certain fundamental rights against governmental interference[147]. Among them, the right of parents to direct their children's medical care[148], as they are presumed to act in the best interest of their child[149].

The state, on the other hand, defends the law by asserting that the classification is not based on sex or transgender status, but on procedure[150]. The defendant cited a district court decision establishing that patients seeking the same procedure for different purposes are not similarly situated[151]. Based on the same reasoning, the state argues that prohibiting certain treatments only for children seeking them for gender affirmation, while allowing them for other medical purposes, does not trigger heightened scrutiny. This argument attempts to reframe the legal question as one of medical classification rather than identity-based discrimination. Thus, the defendant reasons, the ban does not violate the Equal Protection Clause because it is rationally related to the state's legitimate interest of ensuring the safety of its citizens. In the state's view, regulating emerging medical treatments for children falls within its traditional authority to protect public health[152].

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[139] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para I.
[140] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para III.
[141] City of Cleburne v Cleburne Living Center, 473 US 432, 439 (1985).

[142] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para III.
[143] City of Cleburne v Cleburne Living Center, 473 US 440 (1985).
[144] United States v Virginia 518 US 515 (1996).
[145] City of Cleburne v Cleburne Living Center, 473 US 440 (1985).
[146] United States v Virginia 518 US 533 (1996).
[147] *Washington v Glucksberg*, 521 US 702, 719–20 (1997)
[148] *Troxel v Granville*, 530 US 57, 65 (2000); *Kanuszewski v Michigan Department of Health and Human Services*, 927 F.3d 396, 419 (6th Cir 2019).
[149] Parham v J.R., 442 US 584, 602 (1979).
[150] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para III.
[151] *McMain v Peters* (D Or, No 2:13-CV-01632-AA, 2 August 2018) 2018 WL 3732660.
[152] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para III.

The arguments of both the plaintiffs and the state make clear that a central point of contention is whether bans on gender affirming medical care for children discriminate based on sex. This legal question is crucial because its answer determines the level of judicial scrutiny that courts must apply to the law. The same question of law had already been addressed, before the full trial, by the Court of Appeals for the Eight Circuit, when the state appealed the district court's preliminary injunction blocking the implementation of the ban[153]. In its order upholding the injunction, the appellate court cited the precedent of Heckler v Mathews[154] to explain that, since a child's sex assigned at birth is the determining factor in who may receive certain medical procedures and who may not, the Act discriminates based on sex and warrants heightened scrutiny. The court provided the example of a child assigned male at birth who can receive testosterone, while a child assigned female at birth can not[155].
However, other courts of appeal have reached a different conclusion on the same question[156]. The Sixth Circuit reversed a district court's injunction that had blocked the implementation of a Tennessee law similar to the Arkansas ban[157]. In its ruling, the Sixth Circuit reasoned that the Tennessee law does not discriminate based on sex and therefore does not warrant heightened scrutiny[158]. According to the court, the reason for that conclusion is that the law regulates treatments for all children, regardless of sex, thus classifying on a non prohibited ground[159]. The Sixth Circuit found that none of the circumstances identified in previous case law which would indicate sex-based classification were present[160]. The court acknowledged that a child's sex assigned at birth may be relevant in determining who may access certain treatments[161]. For instance, a treatment may be prohibited for a child assigned female at birth who seeks to affirm her gender identity, while allowed for a child assigned male at birth when used for another medical purpose. Still, the Sixth Circuit concluded that this does not amount to sex-based discrimination. Instead, the Court argues, since testosterone, for example, is a treatment that only people assigned female at birth can use to affirm their gender identity, the procedures in question are

[153] *Brandt v Rutledge* (8th Cir, No 21-2875, 25 August 2022) 47 F4th 664.
[154] Heckler v. Mathews, 465 U.S. 728, 744 (1984).
[155] *Brandt v Rutledge* (8th Cir, No 21-2875, 25 August 2022) 47 F4th 667.
[156] *Eknes-Tucker v Ivey* (11th Cir, No 22-11707, 21 August 2023) 80 F.4th 1205; *L. W. by Williams v Skrmetti* (6th Cir, No 23-5600/5609, 28 September 2023) 83 F.4th 460; *K.C. v Individual Members of the Medical Licensing Board of Indiana* (7th Cir, No 23-2366, 13 November 2024).
[157] *L. W. et al v Skrmetti* (MD Tenn, No 3:23-cv-00376, 28 June 2023).
[158] *L. W. by Williams v Skrmetti* (6th Cir, No 23-5600/5609, 28 September 2023) 83 F.4th 484.
[159] *Geduldig v Aiello* 417 US 484, 496–97 (1974); *Palmer v Thompson* 403 US 217, 226 (1971).
[160] *Craig v Boren* 429 US 190, 192 (1976); *J E B v Alabama ex rel T B* 511 US 127, 140 (1994); *Michael M v Superior Court* 450 US 464, 466 (1981); *Mississippi University for Women v Hogan* 458 US 718, 729 (1982); *Orr v Orr* 440 US 268, 271 (1979); *Palmer v Thompson* 403 US 217, 226 (1971); *Reed v Reed* 404 US 71, 73, 76 (1971); *Sessions v Morales-Santana* 582 US 47, 58 (2017); *Virginia v Virginia* 518 US 515, 519–20 (1996).
[161] *L. W. by Williams v Skrmetti* (6th Cir, No 23-5600/5609, 28 September 2023) 83 F.4th 485.

inherently sex-specific[162] and therefore do not trigger heightened scrutiny[163]. However, as the Fifth Circuit's opinion was not a binding precedent for the Arkansas district court, it permanently enjoined the state from enforcing the law after the full trial on the merits, finding that it constituted sex-based discrimination and thus warranted heightened scrutiny[164]. Applying this standard, the judge concluded that the state had failed to demonstrate an important governmental interest sufficient to justify the ban[165]. The court refuted all assertions made by the State to justify its ban on the basis that it had an interest in protecting children from experimental care. Specifically, it held that the evidence presented by the plaintiffs showed the efficacy of these treatments[166]. During the trial, the parents of the child plaintiffs who had already started gender affirming care explained how it greatly improved their children's mental health, who went from depression and anxiety to being healthy adolescents. The lived experiences of these families were supported by the plaintiffs' expert witnesses, doctors treating adolescents with gender dysphoria, who not only testified about the body of scientific research supporting gender-affirming medical care but also talked about the mental health benefits they have observed in their patients in the course of their clinical experience[167]. In the opinion of the court, instead, the state failed to prove the experimental nature of the treatments, as its only expert witness who had treated adolescents with gender dysphoria called for caution, but conceded that when certain conditions are satisfied such treatments can be initiated. Moreover, the State's claim that the risks associated with gender-affirming medical procedures justified the ban was deemed unpersuasive[168]. At trial, evidence demonstrated that the side effects of such care are no greater than those associated with other permitted treatments[169]. In light of this, the judge found that the defendant failed to provide a valid reason to explain why it did not prohibit them[170]. The state also argued that it was pursuing an important governmental interest in banning puberty blockers and cross-sex hormones for children because the gender affirming model allows healthcare providers to prescribe them on demand without a proper mental health evaluation. However, no evidence was provided to substantiate this claim[171].

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[162] ibid
[163] *Dobbs v Jackson Women's Health Organization* 597 US 215, 232-33 (2022)

[164] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para III.
[165] ibid
[166] ibid
[167] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para II.
[168] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para III.
[169] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para II.
[170] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para III.
[171] ibid

The district court also held that the law violates the Due Process Clause. It found that the statute infringed upon the fundamental right of parents to seek medical care for their children and to make decisions concerning that care[172]. As such, the law was subject to strict scrutiny, requiring it to be narrowly tailored to serve a compelling state interest[173]. In this case, the judge found that at trial that the parents showed they acted in the best interest of their child in allowing them to initiate gender affirming treatments after careful consideration, their children's consent and their doctor's recommendation[174]. While acknowledging that the state has a compelling interest in safeguarding children's well-being[175], the court held that the evidence presented during the trial failed to show that gender affirming care is detrimental for the well-being of adolescents with gender dysphoria. Furthermore, a categorical ban is not, in the opinion of the court, narrowly tailored to achieve the eventual aim of preserving children's health. Other entities, like the Arkansas Medical Board, would be better suited to regulate this evolving area of medicine. [176]

In June 2025 the United States Supreme Court, which had been asked to issue an opinion on whether the Sixth Circuit's ruling that bans on gender-affirming medical care for children do not discriminate based on sex, upheld the Court of Appeals' decision, providing a definitive answer to the constitutional question[177]. This ruling created a binding national precedent.

Restrictions on Gender-Affirming Medical Care: The Case of England and Wales

In recent years the regulation of gender-affirming medical care for children has evolved significantly through actions taken by the courts and the Government in England and Wales.

In 2021 the Court of Appeal was asked to clarify, in the case Bell v Tavistock, whether clinicians must always seek and receive the consent of a court before prescribing puberty blockers to children[178]. The decision by the Divisional Court, the court of first instance in this case, had been appealed by the Tavistock and Portman NHS Foundation Trust, which run what was at the time of litigation the only clinical service commissioned by the National Health Service to give medical support to trans children,

[172] ibid
[173] *Washington v Glucksberg*, 521 US 702, 721 (1997).

[174] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para III.
[175] *Globe Newspaper Co v Superior Court for Norfolk County*, 457 US 596, 607 (1982).
[176] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para III.
[177] *United States v Skrmetti* (US, No 23-477, 18 June 2025) 605 US.
[178] Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, (Lord Burnett CJ for the Court).

the Gender Identity Development Service[179]. A former patient of Tavistock who had been treated with puberty blockers during adolescence and came to regret the treatment and the mother of a child with gender dysphoria who had been referred to the Gender Identity Development Service asked the court to declare the practice of Tavistock to prescribe puberty blockers to children, without a judicial order establishing that the procedure is in the best interest of the child, unlawful[180]. This request raised fundamental questions about the legal capacity of children to consent to complex medical interventions The Divisional Court found the practice lawful[181]. With regards to 16 and 17 year old adolescents, it restated domestic legislation that equated consent to medical treatments given by people over 16 years of age to that given by adults[182]. As to children under 16 years of age, the judge applied the precedent established in Gillick, in which it was held that the responsibility of parents to make decisions about their children's medical treatments ceases, even when the child is younger than 16, when a determination by a clinician is made that the child is competent to fully understand the medical procedure that is proposed[183]. This test, often referred to as "Gillick competence", has become a cornerstone in UK jurisprudence on children's autonomy in healthcare decision-making.

However, the Divisional Court also gave guidance, specifying it was not a legal requirement, that clinicians seek court approval before prescribing puberty blockers[184]. It explained that it gave this recommendation because it concluded it was unlikely for children under 14 years of age and improbable for 14 and 15 years olds to give valid consent to puberty blockers[185]. The Divisional Court gave the same recommendation even for adolescents over 16 when there are doubts about the fact that the treatments will serve their long-term best interests[186].

The appeal by Tavistock then was only focused on the guidance, despite the fact that it was not a legal requirement, as it was understood by clinicians as suggesting that seeking court approval should be the

[179] Bell v The Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274 (Admin) (Sharp P, Lewis LJ and Lieven J).

[180] Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, 1 All ER 416, [4] (Lord Burnett CJ for the Court).
[181] Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, 1 All ER 416, [6] (Lord Burnett CJ for the Court).
[182] Family Law Reform Act 1969, ss 1, 8(1).
[183] Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112, 188–9 (Lord Scarman).
[184] Bell v The Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274 (Admin), [149] [152] (Sharp P, Lewis LJ and Lieven J).
[185] Bell v The Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274 (Admin), [145] (Sharp P, Lewis LJ and Lieven J).
[186] Bell v The Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274 (Admin), [147] (Sharp P, Lewis LJ and Lieven J).

norm[187]. The Court of Appeal concluded that it was inappropriate for the lower court to provide this guidance[188], noting that puberty blockers are not in a special category of procedures whose prescription always requires court approval[189]. Only if there is disagreement between clinicians, parents and patients over the appropriateness of the child going forward with puberty blockers court involvement is necessary[190]. Even in those cases in which there is disagreement between the child and their parents, the Court held that a decision taken by a Gillick competent child can not be overridden by their parents[191].

This reaffirmation of children's autonomy in medical decision-making reinforced the principle that competence, not age alone, is determinative, placing trust in the judgment of clinicians.In the same judgment, the Court clarified that it was not asked to decide on whether puberty blockers should be available, stating that this is a decision that should be taken by the National Health Service, the medical profession, Government and Parliament[192].

Indeed, in the years following the judgment, most of these actors took a series of actions that significantly restricted the availability of gender affirming treatments. In 2020 the National Health Service and the National Health Service Improvement's Quality and Innovation Committee commissioned an independent review to make recommendations on how to improve the gender identity services offered to children by the National Health Service. The reason for the review was the significant increase in the number of referrals to the Gender Identity Development Service concurrent with the shift of the services offered by the clinic from psychosocial and psychotherapeutic ones to gender affirming medical treatments[193]. Chaired by Doctor Cass, the review lasted four years and led to the release of a final report in 2024[194], which followed the release of an interim report in 2022[195].

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[187] Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, 1 All ER 416, [10] (Lord Burnett CJ for the Court).
[188] Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, 1 All ER 416, [89, [91] (Lord Burnett CJ for the Court).
[189] Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, 1 All ER 416, [48] (Lord Burnett CJ for the Court).

[190] Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, 1 All ER 416, [89] (Lord Burnett CJ for the Court).
[191] Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, 1 All ER 416, [48] (Lord Burnett CJ for the Court).
[192] Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, 1 All ER 416, [3] (Lord Burnett CJ).
[193] NHS England and NHS Improvement, *Terms of Reference for Review of Gender Identity Development Service for Children and Adolescents* (October 2020).
[194] Hilary Cass (chair), *Independent Review of Gender Identity Services for Children and Young People: Final Report* (NHS England and NHS Improvement 2024).
[195] Hilary Cass (chair), *Independent Review of Gender Identity Services for Children and Young People: Interim Report* (NHS England 2022).

The review was intended to provide an evidence-based framework for policy reform and clinical guidance in a field that had grown rapidly but also faced growing criticism regarding long waiting times and uncertainty about the robustness of available scientific data. One of the findings of the review was that puberty blockers have clearly defined benefits in narrow circumstances while carrying significant risks to the health of children. As a consequence, a review's letter sent to the National Health Service in July 2023 recommended the prescription of puberty blockers only under a research protocol[196]. Already in August of 2023, the National Health Service published an interim clinical policy which prohibited the routine prescription of puberty blockers through the public health service outside research. A national multidisciplinary team was tasked to approve cases involving exceptional circumstances that warranted the prescription of puberty blockers on a case by case basis. Furthermore, children who had already started these treatments or that had already been referred to an endocrine clinic were exempt by this policy[197]. This transitional approach aimed to safeguard continuity of care for existing patients while instituting stricter criteria for new ones.

With an updated March 2024 clinical policy, the National Health Service also eliminated the possibility of allowing for the prescription of puberty blockers under exceptional circumstances[198]. It remains possible, however, for clinicians to make an application for them under the National Health Service's Individual Funding Request process[199]. In April 2024, the Royal College of General Practitioners published its position on the matter reinforcing the clinical policy by advising its members against prescribing puberty blockers to new patients outside of research[200]. This position statement from a leading professional body consolidated the shift toward restrictive access based on emerging scientific uncertainty. In June 2024, the Government amended the 2004 Regulations on the prescription of medicines by the National Health Service to give legal effect to the new clinical policy, adding the

[196] Hilary Cass (chair), *Independent Review of Gender Identity Services for Children and Young People: Final Report* (NHS England 2024) 32, para 84.

[197] NHS England, *Interim Clinical Policy: Puberty Suppressing Hormones (PSH) for the Purpose of Puberty Suppression for Children and Adolescents Who Have Gender Incongruence/Dysphoria* [1927] (2023).

[198] NHS England, *Clinical Policy: Puberty Suppressing Hormones (PSH) for Children and Young People Who Have Gender Incongruence/Gender Dysphoria* [1927] (2024).

[199] NHS England, *Consultation Report for the Clinical Policy on Puberty Suppressing Hormones for Children and Adolescents Who Have Gender Incongruence/Gender Dysphoria* (2024).

[200] Royal College of General Practitioners, Position Statement on the Care of Trans and Gender Questioning Adults and Young People (26 April 2024).

prescription of puberty blockers, subject to the same exceptions of the clinical policy, to the list of drugs that the Regulations prohibit or restrict general practitioners from prescribing[201].

However, a problem remained with overseas providers. Indeed, UK legislation allows pharmacists to dispense medicines prescribed by healthcare personnel in EEA or Switzerland[202]. The final Report of the Cass Review states the concern that children might be prescribed puberty blocker by private overseas prescribers who are not subject to UK regulations[203]. This regulatory gap created concern among policymakers, who feared that restrictive domestic measures could be circumvented through online or cross-border channels, undermining the public health rationale behind the new framework. Already in January 2023, following the publication of the Interim Report, the General Pharmaceutical Council cautioned its members to make sure, before dispensing puberty blockers for gender-affirming purposes, that overseas prescriptions comply with UK regulations[204]. Furthermore, to deal with this issue, in June 2024 the Government issued an emergency order prohibiting the sale and supply of puberty blockers by private prescriptions. The Order includes an exception to the prohibition for people who had already been provided with a private prescription for puberty blockers before its entry into force. However, this exception applies only to private prescriptions issued by UK based prescribers[205]. A new indefinite order replaced the emergency one at the beginning of 2025 [206].

With regards to cross sex hormones, the Final Report of the Cass Review cites a research carried out by the University of York as part of the studies done for the review in concluding that there is a lack of high-quality research assessing the outcomes of cross sex hormones therapy in adolescents with gender dysphoria[207]. In March 2024, the National Health Service restricted the prescription of masculinising and feminizing hormones only to adolescents over the age of 16 with a clinical policy. It also added the requirement that a national multidisciplinary team, which includes clinicians not directly involved in the formation of the individual's care plan, agrees that the adolescent receives this treatment[208].

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[201] The National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) (Amendment) Regulations 2024, SI 2024/728.

[202] Human Medicines Regulations 2012, SI 2012/1916, reg 214(6).

[203] Hilary Cass, *The Cass Review: Independent Review of Gender Identity Services for Children and Young People – Final Report* (NHS England 2024) 228, para 19.39.

[204] General Pharmaceutical Council, *Gender Identity: Pharmaceutical Care for Children and Young People* (January 2023).

[205] The Medicines (Gonadotrophin-Releasing Hormone Analogues) (Emergency Prohibition) (England, Wales and Scotland) Order 2024, SI 2024/727.

[206] The Medicines (Gonadotrophin-Releasing Hormone Analogues) (Restrictions on Private Sales and Supplies) Order 2024, SI 2024/1319.

[207] Hilary Cass (chair), *Independent Review of Gender Identity Services for Children and Young People: Final Report* (NHS England 2024) 32, para 85.

[208] NHS England, *Clinical Commissioning Policy: Prescribing of Gender-Affirming Hormones (Masculinising or Feminising Hormones) as Part of the Children and Young People's Gender Service* (2021).

The Gender-Affirming Model: The Case of Australia

In recent years the regulation of gender affirming medical care for children in Australia has changed significantly. The courts are the institutional actors that have shaped this evolution through their case law. Prohibiting or restricting the prescription of puberty blockers and/or cross-sex hormones to children, however, has never been a question that has come before the courts. What they have decided on is instead whether court approval is required before these treatments are provided.

In 2004 Re Alex was the first decision by the Family Court, which is a federal court with authority over children's welfare, on a case involving an adolescent with gender dysphoria seeking gender-affirming medical procedures. That decision changed the process for obtaining them. Until then, parents could consent to their trans children's treatments through the welfare legislation of their federal State. Medical decisions, including those related to gender-affirming interventions, were generally regarded as falling within the scope of parental authority unless otherwise indicated by exceptional circumstances[209]. In the opinion of the judge in Re Alex, instead, court authorization was necessary because he made the determination that gender-affirming treatments were special medical procedures[210]. Also known as non-therapeutic procedures, they had been excluded from the ordinary scope of parental power by previous case law, unlike therapeutic ones that can instead be consented to by parents. These non-therapeutic procedures are typically defined as those that are not directly aimed at treating a medical condition but at altering bodily features for psychological, social or identity-related purposes. Non-therapeutic procedures will require court authorization, especially when they are irreversible and carry significant consequences if a wrong decision is made[211].

In 2013 the Full Court of the Family Court reversed the determination made in Re Alex when it concluded in Re Jamie that both puberty blockers and cross-sex hormones are therapeutic procedures, as they address what the court called at the time a "disease". However, the judges allowed only puberty blockers to be prescribed without court approval, as the court found them reversible[212]. In contrast, the prescription of cross sex hormones, due to their irreversible nature and the possible risks associated with an eventual wrong decision, could not be authorized by parents. In such cases, the judges found that courts were required to determine first whether the adolescent had the capacity to consent[213], in line

[209] Fiona Kelly, 'Australian Children Living with Gender Dysphoria: Does the Family Court Have a Role to Play?' (2014) 22(1) *Journal of Law and Medicine* 105, 107–08.
[210] Re Alex (2004) 180 FLR 92 [4], 94 [19]–[21], 124–5 [196], [200]–[201] (Nicholson CJ).
[211] *Secretary, Department of Health and Community Services v JWB (1992) 175 CLR* 229, 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).
[212] Re Jamie (2013) 278 FLR 178 [106]–[108],184-5 [140] (Bryant CJ).
[213] Re Jamie (2013) 278 FLR 184-5 [140] (Bryant CJ).

with Australian case law which recognizes the right of competent children to make medical decisions for themselves[214]. If the court concluded that the child was competent, then they could consent to the treatment. If it made the opposite determination, the court would be responsible to decide whether to approve the treatment[215]. In any case, if there were disagreement between clinicians, parents and the child on the competence of the child and/or on the procedure, whether it be puberty blockers or cross sex hormones, the court should intervene in the best interest of the child[216].

In 2017 the Full Court changed its position once more with the case Re Kelvin. The judges concluded that, for a prescription of cross sex hormones to be consented to, an assessment of the child's competence by the court was not required[217]. Furthermore, even if clinicians do not consider the adolescent seeking the treatment competent, the parents can consent on their behalf[218]. The court justified the difference between the earlier decision and this later one by explaining that, according to the latest medical evidence, the risks of the procedure did not outweigh the benefits anymore[219]. In the same decision, it was reaffirmed that the court could be involved in case of a dispute between clinicians, parents and the child[220].

In 2020, a judge of the Family Court in Re Imogen interpreted Re Jamie and Re Kelvin as requiring an application to the court even in the case of a dispute between parents and a child that has been deemed competent[221]. In light of this, he found the recommendation by the 'Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents' that clinicians do not need to receive parental consent when they conclude that the child is competent to consent[222] not in line with case law[223]. If the disagreement is only about the child's competence, the court is asked to make a determination about their capacity to consent[224]. If the disagreement is about the treatment, the court must decide whether it is appropriate for the child, having their best interests as a primary consideration[225]. This interpretation by the court introduces potential uncertainty for healthcare providers and families. Legal clarification may be necessary to clarify where the law stands on this.

[214] *Secretary, Department of Health and Community Services v JWB (1992) 175 CLR* 237 (Mason CJ, Dawson, Toohey and Gaudron JJ).
[215] Re Jamie (2013) 278 FLR 184-5 [139]-[140] (Bryant CJ).
[216] Re Jamie (2013) 278 FLR 184 [140] (Bryant CJ).

[217] *Re Kelvin* (2017) 327 FLR 44-5 [178]–[184] (Thackray, Strickland and Murphy JJ).
[218] *Re Kelvin* (2017) 327 FLR 42 [163]–[166] (Thackray, Strickland and Murphy JJ).
[219] *Re Kelvin* (2017) 327 FLR 42 [162] (Thackray, Strickland and Murphy JJ).
[220] *Re Kelvin* (2017) 327 FLR 42[167] (Thackray, Strickland and Murphy JJ).
[221] *Re Imogen* [No 6] (2020) 61 Fam LR 351–52 [35], [38], 357 [63] (Watts J).
[222] *Re Imogen* [No 6] (2020) 61 Fam LR 349 [27] (Watts J).
[223] ibid
[224] *Re Imogen* [No 6] (2020) 61 Fam LR 351 [35] (Watts J).
[225] ibid

Indeed, the judgment, however persuasive, is not binding, as it was not given by the Full Court[226]. In the case Re A, for example, the judge remarks that Re Imogen does not state the law correctly[227].

CHAPTER 3

Towards a Children's Rights-Centered Approach

As the descriptions of the regulation of gender-affirming medical care for children in three different jurisdictions has shown, this is an area of law that is still evolving, both because this model of care itself is one that has been subject to a relatively low number of studies and medical evidence is still emerging[228] and because there is much public debate about it, with positions that have been described as very polarized on both sides of the issue[229]. This lack of scientific consensus and the politically charged atmosphere surrounding the topic have led to markedly different legal and policy approaches.
At the same time, given that the Convention on the Rights of the Child is binding on all UN member states except the United States[230], which, by signing the treaty, has committed itself not to take actions that would defeat the Convention's object and purpose[231], all countries are expected to respect the rights enshrined in the CRC, including when regulating gender-affirming treatments for children. All the laws on the matter should then, in theory, center children's rights. Different jurisdictions have interpreted this obligation in different ways. In the US' federal states, like Arkansas, that have passed bans on these medical procedures, the stated aim was the protection of children from harm[232] because the risks associated with the procedures outweighed those linked to their prohibition[233]. However, that has not been the opinion of many medical professional organizations in the country, which have cautioned

[226] Fiona Kelly and others, 'Parental Consent and the Treatment of Transgender Youth: The Impact of Re Imogen' (2022) 216(5) *Medical Journal of Australia* 219.
[227] *Re A* (2022) 11 Qd R 6 [27] (Boddice J).

[228] Eli Coleman and others, 'Standards of Care for the Health of Transgender and Gender Diverse People: Version 8' (2022) 23(sup1) International Journal of Transgender Health 46 <https://doi.org/10.1080/26895269.2022.2100644>.
[229] Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Interim Report* (Report, February 2022) 28 https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim□Report-Final-Web-Accessible.pdf.
[230] UN Treaty Collection, 'Status of Treaties: Convention on the Rights of the Child' https://treaties.un.orgaccessed [27 June 2025].
[231] Vienna Convention on the Law of Treaties (adopted 23 May 1969, entered into force 27 January 1980) 1155 UNTS 331, art 18.
[232] 'Outlawing Trans Youth: State Legislatures and the Battle over Gender-Affirming Healthcare for Minors' (2021) 134(6) *Harvard Law Review* 2175.
[233] Gabrielle Wolf, 'Gender-Affirming Medical Treatment for Minors: International Legal Responses to an Evolving Debate' (2024) 47(3) *UNSW Law Journal* 776.

about the possible negative consequences on trans adolescents' health of these laws and have criticized them[234]. According to some, animus towards trans persons is the real rationale for these bans[235]. In turn, they also lead to more discrimination against trans individuals in society[236].

In a visit to the US, the UN Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, Victor Madrigal-Borloz, characterized the bans as part of a series of regressive legislative measures in US federal states, whose intent is to deliberately roll back the rights of LGBT individuals. According to the same Report, the laws that restrict access to healthcare for trans youth violate their right to the enjoyment of the highest attainable standard of physical and mental health recognized in the Convention on the Rights of the Child[237]. The determination by the UN Independent Expert that the ban violates the CRC is in line with the one made by the international human-rights non-governmental organization Human Rights Watch, in its report '*They're Ruining People's Lives": Bans on Gender-Affirming Care for Transgender Youth in the US*"[238]. The NGO evaluated these bans under international human rights law, including the children's rights framework. It concluded that they are inconsistent with the fundamental principles of the Convention on the Rights of the Child[239]. These principles include articles 2(1)[240], 3[241], 5[242], 12(1)[243]. They respectively establish a right of children to be free from discrimination, the best interests of the child principle, the right and duty of parents to guide their children in the enjoyment of their rights, the right of children to be heard on all matters affecting them and to have their views taken into account in a manner consistent with their age and maturity. The bans, according to the organization, interfere with

[234] Jennifer Block, 'Raft of US State Laws Restrict Access to Treatments for Gender Dysphoria' (2023) 380 British Medical Journal p533:1; Laura E Kuper, M Brett Cooper and Megan A Mooney, 'Supporting and Advocating for Transgender and Gender Diverse Youth and Their Families within the Sociopolitical Context of Widespread Discriminatory Legislation and Policies' (2022) 10(3) *Clinical Practice in Pediatric Psychology* 338 https://doi.org/10.1037/cpp0000456.

[235] Outlawing Trans Youth: State Legislatures and the Battle over Gender-Affirming Healthcare for Minors' (2021) 134(6) *Harvard Law Review* 2181-3.

[236] Kacie M Kidd et al, '"This Could Mean Death for My Child": Parent Perspectives on Laws Banning Gender-Affirming Care for Transgender Adolescents' (2021) 68(6) Journal of Adolescent Health 1087.

[237] UN Human Rights Council, *Visit to the United States of America: Report of the Independent Expert on Protection against Violence and Discrimination Based on Sexual Orientation and Gender Identity, Victor Madrigal-Borloz* (17 June 2022) UN Doc A/HRC/50/26/Add.1.

[238] Human Rights Watch, *"They're Ruining People's Lives": Bans on Gender-Affirming Care for Transgender Youth in the US* (HRW, 3 June 2025), 91-95.

[239] Human Rights Watch, *"They're Ruining People's Lives": Bans on Gender-Affirming Care for Transgender Youth in the US* (HRW, 3 June 2025), 91-95.

[240] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 2.

[241] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 3.

[242] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 5.

[243] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 12.

the right of children and their parents to make, in consultation with their healthcare providers, decisions about medical treatment[244] . Additionally, Human Rights Watch finds that the bans are inconsistent with provisions of international human rights law binding on the US. The International Covenant on Civil and Political Rights, ratified by the US, binds state parties to protect children and families and prohibits arbitrary interferences with family life[245]. It also guarantees the right to equal protection of the law without discrimination, which has been interpreted by the UN Human Rights Committee to prohibit, among other grounds, discrimination based on gender identity[246]. Therefore, Human Rights Watch finds laws that deny treatment for gender dysphoria, which is based on one's gender identity, in violation of this obligation[247].

These international assessments offer an important perspective on the impact of domestic legislation on the enjoyment of human rights by trans youth.

Another one of the rationales used to justify these bills is the fact that children lack the capacity to understand the risks in which they might incur[248]. The categorical determination that children always lack the capacity to make medical decisions for themselves, regardless of their age and maturity, is not in line with article 12 or its interpretation by the Committee. Such blanket assumption contradicts the principle of evolving capacities that is a key component of the CRC's approach to children's rights [249]. The above mentioned principle of the evolving capacities of the child stems from article 5 of the CRC, which is concerned with parental rights and responsibilities[250]. The US Constitution, with the Due Process Clause, protects the rights of the parents to make decisions on behalf of their children. Indeed, the US Supreme Court has recognized parental rights as the oldest of the fundamental liberties the Constitution protects from government interference[251]. That is because parents are deemed to be in a better position to determine their child's best interests, another one of the principles also enshrined in

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[244] Human Rights Watch, *"They're Ruining People's Lives": Bans on Gender-Affirming Care for Transgender Youth in the US* (HRW, 3 June 2025), 93.

[245] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171.

[246] UN Human Rights Committee, *General Comment No 18: Non-Discrimination* (10 November 1989) UN Doc HRI/GEN/1/Rev.1, para 7.

[247] Human Rights Watch, *"They're Ruining People's Lives": Bans on Gender-Affirming Care for Transgender Youth in the US* (HRW, 3 June 2025), 94.

[248] Teresa Baron and Geoffrey Dierckxsens, 'Two Dilemmas for Medical Ethics in the Treatment of Gender Dysphoria in Youth' (2022) 48(9) Journal of Medical Ethics 605; ; Michael Laidlaw, Michelle Cretella and G Kevin Donovan, 'The Right to Best Care for Children Does Not Include the Right to Medical Transition' (2019) 19(2) American Journal of Bioethics 75-77; Kasia Kozlowska et al, 'Australian Children and Adolescents with Gender Dysphoria: Clinical Presentations and Challenges Experienced by a Multidisciplinary Team and Gender Service' (2021) 1(1) Human Systems 85.

[249] CRC Committee, *General Comment No 12: The Right of the Child to Be Heard* (1 July 2009) UN Doc CRC/C/GC/12.

[250] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 5.

[251] *Troxel v Granville*, 530 US 57, 65 (2000).

the Convention on the Rights of the Child[252]. Since in the US children can never consent to medical procedures, it is the parents' right to provide informed consent on behalf of their children that is impacted by the bans. However, parental rights are not absolute, as harmful treatments, even if consented to by parents, can be prohibited by the state[253]. The balance between protecting children and respecting parental authority remains a central tension in legal challenges to these laws. The lack of scientific consensus on gender affirming medical care for children does not allow, then, for a clear understanding of whether this apparent violation of parental rights is legitimate.

Respecting the right of parents to consent to their child's gender-affirming procedures, on the other hand, can lead to situations of conflict between one parent and the other or between both of them and their child in case they take opposite views of what is the best way forward[254]. In some of these instances, parents have doubts about the treatments and may feel pressured by their trans child to consent to them[255]. Furthermore, parents, who normally do not possess the medical knowledge to make an independent assessment on the efficacy and safety of gender-affirming procedures, often face the dilemma of consenting to their child accessing them. However, this does not mean that they are incapable of making the decision that serves the best interests of their child, especially following guidance by clinicians[256].

In Australia, case law from the Family Court, which has jurisdiction over matters of children's welfare, has made clear that parents can give informed consent for their child's gender affirming procedure, when they are not deemed competent to consent to it themselves, without having to receive court approval[257]. The decision in Re Imogen, though, interpreted the Full Court of the Family Court's precedents, Re Jamie and Re Kelvin, as requiring an application to the Court when there is disagreement between parents and their child, either regarding their competence or the appropriateness of the treatment, even when clinicians have concluded that the child is competent[258]. This interpretation is problematic because it does not appear to be in line with the principle, which aligns with the CRC's

[252] *Troxel v Granville*, 530 US 57, 69-70 (2000).
[253] *Prince v Massachusetts*, 321 US 158, 166–67 (1944).
[254] LM Shirley, 'Dismantling Obstacles to Gender Affirmation: Reimagining Consent to Medical Treatment by Transgender, Gender Diverse and Non-Binary Minors' (2022) 29(2) *Journal of Law and Medicine* 553.
[255] Gabrielle Wolf, 'Gender-Affirming Medical Treatment for Minors: International Legal Responses to an Evolving Debate' (2024) 47(3) *UNSW Law Journal* 782.
[256] Simona Giordano, Fae Garland and Soren Holm, 'Gender Dysphoria in Adolescents: Can Adolescents or Parents Give Valid Consent to Puberty Blockers?' (2021) 47(5) Journal of Medical Ethics 325.
[257] *Re Kelvin* (2017) 327 FLR 15 (FamCtFC).
[258] *Re Imogen* [No 6] (2020) 61 Fam LR 351–52 [35], [38], 357 [63] (Watts J).

one on the evolving capacities of the child , established by the Australian High Court in Marion's Case, that when a child is regarded as competent, the parental power to consent ceases[259].

In England, the Court of Appeal in Bell concluded that clinicians, not courts, are the actors responsible for determining whether a child that seeks gender-affirming care is competent[260]. It is possible that this decision could have an impact on Australian law, where the case law on children's competency to consent to medical procedures adopted the principle established in English case law since the case Gillick[261].

The argument that competent children's medical decisions can not be overridden, since they are in the best position to further their best interest[262] is opposed by others, according to whom it can be restricted in case the treatments the competent child has consented to risk harming them[263]. England and Wales' actions that have limited puberty blockers go in this direction, having found their implications too serious to allow them to be prescribed without more high-quality studies regarding their efficacy and safety[264]. This is why puberty blockers can be prescribed to children enrolled in a formal research study, allowing the gathering of data that is fundamental for medical certainty to emerge and that would be unavailable otherwise, given the prohibition on prescribing puberty blockers to the general population of trans youth[265]. This exception, though, does not suffice to those who claim that such a prohibition is discriminatory towards trans persons, as other pediatric procedures, whose impact is not certain due to the difficulty of collecting long-term data, not unlike puberty blockers, can still be prescribed[266]. Cross sex hormones can instead still be prescribed, also outside of a research setting, in England and Wales for those aged 16 and over[267]. This distinction acknowledges the principle enshrined in article 12 of the Convention on the Rights of the Child that age is a factor that needs to be taken into consideration

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[259] Secretary, Department of Health and Community Services (NT) v JWB (Marion's Case) (1992) 175 CLR 218, 316 (McHugh J).
[260] Bell v The Tavistock & Portman NHS Foundation Trust [2021] EWCA Civ 1363, [76].
[261] Secretary, Department of Health and Community Services v JWB (1992) 175 CLR 237 (Mason CJ, Dawson, Toohey and Gaudron JJ).
[262] Pip Trowse, 'Refusal of Medical Treatment: A Child's Prerogative?' (2010) 10(2) Queensland University of Technology Law and Justice Journal 210-11.
[263] Aoife Daly, Children, Autonomy and the Courts: Beyond the Right to be Heard (Brill Nijhoff, 2018) 434.
[264] Hilary Cass, *The Cass Review: Independent Review of Gender Identity Services for Children and Young People – Final Report* (NHS England 2024) 228 para 19.39.
[265] Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report* (NHS England 2024) 32, para 84.
[266] Simona Giordano, Fae Garland and Soren Holm, 'Gender Dysphoria in Adolescents: Can Adolescents or Parents Give Valid Consent to Puberty Blockers?' (2021) 47(5) Journal of Medical Ethics 325; Michelle M Taylor-Sands and Georgina Dimopoulos, 'Judicial Discomfort over "Innovative" Treatment for Adolescents with Gender Dysphoria' (2022) 30(3) Medical Law Review 494.
[267] NHS England, *Clinical Commissioning Policy: Prescribing of Gender-Affirming Hormones (Masculinising or Feminising Hormones) as Part of the Children and Young People's Gender Service* (2021).

when determining the weight to give to children's views[268]. However, the CRC's General Comment 12 on article 12 makes clear that age is not the only factor that contributes to the development of a child's levels of understanding. This reinforces the importance of individualized assessments that take into account not only age but also cognitive, emotional, and social development A case by case assessment should always be made to determine competency in children according to the General Comment[269], which is also what English case law has long held[270].

CONCLUSIONS

Since its entry into force, the Convention on the Rights of the Child has provided states with a legal framework for incorporating high standards of children's rights into legislation and policies affecting children [271] . This study takes the position that the Convention can also serve as a guiding framework for the regulation of gender-affirming medical care for children. This medical field has in recent years been subject to much public debate, in part due to the significant increase in the number of adolescents[272], particularly adolescents who are female assigned at birth[273], seeking gender-affirming treatments. The controversy has been further fuelled by the limited number of studies on the safety and

[268] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 12.
[269] CRC Committee, *General Comment No 12: The Right of the Child to Be Heard* (1 July 2009) UN Doc CRC/C/GC/12, para 21.
[270] Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112, 188–9 (Lord Scarman).
[271] John Tobin, 'Increasingly Seen and Heard: The Constitutional Recognition of Children's Rights' (2005) 21 South African Journal on Human Rights 86; John Tobin, 'Judging the Judges: Are Judges Adopting the Rights Approach in Matters Involving Children' (2009) 33 Melbourne University Law Review 579; Helen Stalford and E Drywood, 'Using the CRC to Inform EU Law and Policy-Making' in Antonella Invernizzi and Jane Williams (eds), *The Human Rights of Children: From Visions to Implementation* (Ashgate 2011).
[272] Care Quality Commission, *The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report* (CQC 2021); Riittakerttu Kaltiala and others, 'Time Trends in Referrals to Child and Adolescent Gender Identity Services: A Study in Four Nordic Countries and in the UK' (2020) 74(1) *Nordic Journal of Psychiatry* 40 https://doi.org/10.1080/08039488.2019.1667429.
[273] Madison Aitken and others, 'Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria' (2015) 12(3) *The Journal of Sexual Medicine* 756 https://doi.org/10.1111/jsm.1281.; Nienke M de Graaf and others, 'Evidence for a Change in the Sex Ratio of Children Referred for Gender Dysphoria: Data from the Gender Identity Development Service in London (2000–2017)' (2018) 15(10) *The Journal of Sexual Medicine* 1381 https://doi.org/10.1016/j.jsxm.2018.08.002; Nienke M de Graaf and others, 'Sex Ratio in Children and Adolescents Referred to the Gender Identity Development Service in the UK (2009–2016)' (2018) 47(5) *Archives of Sexual Behavior* 1301 https://doi.org/10.1007/s10508-018-1204-9; Thomas D Steensma, P T Cohen-Kettenis and K J Zucker, 'Evidence for a Change in the Sex Ratio of Children Referred for Gender Dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam (1988–2016)' (2018) 44(7) *Journal of Sex & Marital Therapy* 713 https://doi.org/10.1080/0092623X.2018.1437580; Qing Zhang and others, 'Changes in Size and Demographic Composition of Transgender and Gender Nonbinary Population Receiving Care at Integrated Health Systems' (2021) 27(5) *Endocrine Practice* 390 https://doi.org/10.1016/j.eprac.2020.11.016.

efficacy of these treatments on children with gender dysphoria[274], and by the fact that many of these studies are of law quality, due to ethical constraints related to research involving children[275]. As a consequence, some Western jurisdictions have changed their law on gender-affirming care for adolescents. Since this area of law was already evolving prior to these changes, the result is an increased difference in how this care is regulated across countries. Thus, access of trans children to the care they seek largely depends on the jurisdiction in which they reside, inevitably raising important questions about the protection of their rights. In this context, the principles enshrined in the Convention on the Rights of the Child appear to be the ideal foundation for the establishment of a common children's rights-centered approach. The analysis of the laws regulating access to gender-affirming treatments for children in three different jurisdictions, all of whom adopt very different approaches, applied these principles to assess which, if any, of them centers children's rights.

The categorical prohibition on gender-affirming medical treatments passed by the Arkansas state legislature appears to be inconsistent with multiple principles of the children's rights legal framework. Article 24 of the Convention, which ensures access to the highest attainable standard of health, is one of them. Indeed, by categorically denying trans adolescents access to gender-affirming medical procedures, without exception, in the interest of public health, Arkansas expressed a position on the appropriateness of this care that is at odds with those held by major medical associations in the United States. The Academy of Paediatrics and the American Medical Association, among others, have endorsed it as the standard of care[276] and, unlike some major medical associations in England and Wales[277], have not withdrawn this support. Moreover, following a trial on the merits of the case, a district judge that was called to determine the constitutionality of the Arkansas ban, concluded that

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[274] Hilary Cass, Independent Review of Gender Identity Services for Children and Young People: Interim Report (Report, February 2022) 19, 39. <https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim Report-Final-Web-Accessible.pdf> ; Eli Coleman and others, 'Standards of Care for the Health of Transgender and Gender Diverse People: Version 8' (2022) 23(sup1) International Journal of Transgender Health 46 <https://doi.org/10.1080/26895269.2022.2100644>. Socialstyrelsen, The National Board of Health and Welfare, Care of Children andAdolescents with Gender Dysphoria: Summary ofNational Guidelines (Report, December 2022) 3 <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf>.

[275] Hilary Cass, *The Cass Review: Independent Review of Gender Identity Services for Children and Young People – Final Report* (NHS England 2024) 228 para 19.39.

[276] American Medical Association, 'Clarification of Evidence-Based Gender-Affirming Care H-185.927' (AMA Policy, 2023) https://policysearch.ama-assn.org/policyfinder/detail/H-185.927; Jason Rafferty and others, 'Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents' (2018) 142 *Pediatrics* e20182162.

[277] Royal College of General Practitioners, Position Statement on the Care of Trans and Gender Questioning Adults and Young People (26 April 2024).

gender-affirming care is safe for children[278]. Among the evidence he used to justify this conclusion are the testimonies of clinicians working with adolescents with gender dysphoria in the jurisdiction, whose years of clinical experience in the field informed their support for this model of care[279]. Furthermore, the Committee on the Rights of the Child, in its General Comment on the right of the child to the enjoyment of the highest attainable standard of health, has explained that states have an obligation to ensure that children's health is not undermined by discrimination based on gender identity[280]. Given this, Arkansas ban appears to be inconsistent with the CRC because, as it explicitly prohibits the prescription of certain treatments only when they are used for gender-affirming purposes, discriminating against trans individuals, the only ones who need them for these purposes. In this context, it is important to note that the UN Independent Expert on sexual orientation and gender identity has concluded, following a visit to the United States, that bans such as the Arkansas one are part of a broader effort by legislatures in many US federal states to roll back the human rights of LGBT individuals[281]. The law also fails to give due consideration to children's right under Article 12 of the Convention to express their views on matters affecting them and to have those views accorded appropriate weight in accordance with their age and maturity. Indeed, the ban applies without distinction, disregarding the principle of the evolving capacities that has taken an increasingly significant role for the interpretation of the treaty as a whole, thanks to its development by the Committee on the Rights of the Child[282], and that stems from article 5 of the CRC. There is also another reason why the Arkansas ban fails to align with this provision. Article 5, indeed, obliges states to respect the right and responsibility of parents to guide their children in the exercise of their rights. The state's forced involvement in a child's medical decision undermines not only the right of parents recognized under the Convention, but also the parental right recognized by the US Constitution in the Due Process Clause to make decisions for one's children, as established by the district court's judgment which blocked the law from taking effect[283]. Finally, since the best interests of the child must be a

[278] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para III.
[279] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para II.
[280] Committee on the Rights of the Child, *General Comment No 15: The right of the child to the enjoyment of the highest attainable standard of health (art 24)* (17 April 2013) UN Doc CRC/C/GC/15, para 8.
[281] UN Human Rights Council, *Visit to the United States of America: Report of the Independent Expert on Protection against Violence and Discrimination Based on Sexual Orientation and Gender Identity, Victor Madrigal-Borloz* (17 June 2022) UN Doc A/HRC/50/26/Add.1.
[282] Jaap Doek, 'The CRC General Principles' in *18 Candles: The Convention on the Rights of the Child Reaches Majority* (Institut international des droits de l'enfant 2007) 31; John Tobin, 'Understanding a Human Rights Based Approach to Matters Involving Children: Conceptual Foundations and Strategic Considerations' in A Invernizzi and J Williams (eds), *Human Rights of Children: From Visions to Implementation* (Ashgate 2011) 61, 71–72; Karl Hanson and Laura Lundy, 'Does Exactly What it Says on the Tin? A Critical Analysis and Alternative Conceptualisation of the So-called "General Principles" of the Convention on the Rights of the Child', 2017 (25) The International Journal of Children's Rights 285.
[283] *Brandt v Rutledge*, No 4:21-CV-00450-JM (ED Ark, *Findings of Fact and Conclusions of Law*, 20 June 2023) para III.

primary consideration in all decisions affecting them, according to article 3, and since this principle cannot be applied in a context where other CRC rights are undermined, the ban as a whole is in conflict with the Convention's fundamental principles. This conclusion is supported by two reports, one by the UN Independent Expert on sexual orientation and gender identity[284] and one by Human Rights Watch[285].

In England and Wales, children, regardless of age, have the right, reinforced by the Court of Appeal in the Bell judgment, to make medical decisions for themselves, including consenting to a gender-affirming treatment, when they are deemed competent to do so by their treating clinicians[286]. This policy is in line with the principles of the evolving capacities of the child and of giving due weight to children's views in accordance with their age and maturity, respectively enshrined in article 5 and 12 of the Convention on the Rights of the Child. However, the clinical policy by the National Health Service that prohibits the routine prescription of puberty blockers[287], the inclusion of such medicines among those that can not be prescribed through the public system[288] and the order banning private prescribers from selling them appears to significantly limit the exercise of this right[289]. At the same time, such actions would also restrict the right of parents, recognized by article 5 of the Convention, to make medical decisions on behalf of their children, when these are not assessed to be competent to do so themselves. Nonetheless, the restrictions on gender-affirming treatments in England and Wales are not categorical. Although they are broad, they are based on specific recommendations made following an independent review of this model of care. That is why, in theory, it is still possible for adolescents to to receive puberty blockers through the National Health Service, either in a research setting[290] or via an application under the Individual Funding Request process[291]. Therefore, children with gender dysphoria

[284] UN Human Rights Council, *Visit to the United States of America: Report of the Independent Expert on Protection against Violence and Discrimination Based on Sexual Orientation and Gender Identity, Victor Madrigal-Borloz* (17 June 2022) UN Doc A/HRC/50/26/Add.1.
[285] Human Rights Watch, *"They're Ruining People's Lives": Bans on Gender-Affirming Care for Transgender Youth in the US* (HRW, 3 June 2025).
[286] Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, 1 All ER 416, [48] (Lord Burnett CJ for the Court).
[287] NHS England, *Clinical Policy: Puberty Suppressing Hormones (PSH) for Children and Young People Who Have Gender Incongruence/Gender Dysphoria* [1927] (2024).
[288] The National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) (Amendment) Regulations 2024, SI 2024/728.
[289] The Medicines (Gonadotrophin-Releasing Hormone Analogues) (Restrictions on Private Sales and Supplies) Order 2024, SI 2024/1319.
[290] NHS England, *Clinical Policy: Puberty Suppressing Hormones (PSH) for Children and Young People Who Have Gender Incongruence/Gender Dysphoria* [1927] (2024).
[291] NHS England, '*Consultation Report for the Clinical Policy on Puberty Suppressing Hormones for Children and Adolescents Who Have Gender Incongruence/Gender Dysphoria'* (2024).

who are assessed as in need of this medical procedure have some available options left to access it. This recognition that some adolescents who may still need puberty blockers for their mental health should access them, despite the fact that one of the conclusions of the Cass review was that puberty blockers carry significant risks to children[292], suggests that England and Wales' actions may still comply with the standard of the highest attainable standard of care enshrined in article 24 of the CRC. In addition, cross sex hormones are still available[293], both through the National Health Service and private prescribers. Given this, then, the regulatory approach appears less likely to have been driven by discriminatory intent, forbidden by article 2 of the Convention, as it differentiates between treatments regardless of the fact that they are used for the same gender-affirming purpose. However, the National Health Service's clinical policy that only allows adolescents aged 16 and over to be prescribed gender-affirming care imposes an age threshold that may conflict with the CRC's principle of the evolving capacities of the child and with domestic case law on children's autonomy.

By contrast, the Australian approach always relies on individual assessments, in line with the Convention as interpreted by the Committee on the Rights of the Child[294]. When a clinician determines that a child is competent and in need of gender-affirming care, the competent child is allowed to exercise their right to make medical decisions, with parental assent. This regulatory framework upholds the child's best interests, which need to be taken as a primary consideration in all decisions affecting children according to article 3 of the CRC, by providing them with the medical information they need to understand the risks and implications associated with the procedure they are seeking. At the same time, it recognizes that the parents and the child themselves are in the best position to decide what serves their best interests. The endorsement of this principle is reflected in the absence of restrictions on adolescents' access to gender-affirming treatments beyond the ones already inherent in the model of care itself. Further restrictions could raise concerns about whether they undermine the child's right to the best available standard of health, protected by article 24 of the Convention on the Rights of the Child. Moreover, such limitations could result in medical decisions made by competent children or their parents being overridden by one made by the state, which is instead bound by article 5 and 12 of the Convention to respect parental rights and the views of mature children. Finally, this regulatory

[292] Hilary Cass (chair), '*Independent Review of Gender Identity Services for Children and Young People: Final Report*' (NHS England 2024) 32, para 84.
[293] NHS England, '*Clinical Commissioning Policy: Prescribing of Gender-Affirming Hormones (Masculinising or Feminising Hormones) as Part of the Children and Young People's Gender Service'* (2021).
[294] CRC Committee, '*General Comment No 12: The Right of the Child to Be Heard'* (1 July 2009) UN Doc CRC/C/GC/12, para 21.

approach, as it does not consider these treatments differently from similar procedures due to their purpose of affirming the gender identity of trans adolescents, allows the state to comply with the CRC's obligation that healthcare be provided to all individuals without discrimination on the basis of gender identity. However, the Full Court of the Family Court should provide greater clarity to trans children and their families on one aspect of the law on gender-affirming care for children. It should state whether court involvement is necessary when competent children and their parents disagree on the child's capacity or treatment. Indeed, this is a requirement that was established in the decision Re Imogen, which, due to being taken by a single judge as opposed to the Full Court, is non-binding[295]. Such a requirement appears inconsistent with article 5 of the Convention, since it would allow parents to override decisions made by an adolescent who has been assessed as competent to make medical decisions.

The analysis of the three regulatory approaches leads to the following conclusions. Arkansas' law, which imposes a categorical ban, does not appear to be in line with the standards of the Convention on the Rights of the Child. Similarly, the actions taken by England and Wales appear to contradict, to some extent, the principles of the Convention. On the other hand, Australia's regulation of gender-affirming medical care for children appears consistent with the provisions of the CRC.

Indeed, while many issues related to childrens' rights have emerged in the discussion of the different approaches to the regulation of gender-affirming medical care, like protection against discrimination based on gender identity and the right to health, the question of who should making decisions regarding access to these treatments remains key to identify the common principles that should guide the development of this relatively new field of law. Australia's answer is that competent children, preferably with the assent of their parents and following the recommendations of healthcare professionals, are the actors that are best positioned to take an autonomous decision in a matter that greatly affects them and their health. Such a model, which recognizes children as bearers of rights and as individuals capable of pursuing their best interests, while acknowledging the essential role of parents and clinicians in safeguarding children's well-being, centers the rights of the child in the regulation of gender-affirming medical care for children.

[295] *Re Imogen* [No 6] (2020) 61 Fam LR 351–52 [35], [38], 357 [63] (Watts J).

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