Transforming lives

ACCESS TO TREATMENT HAS IMPROVED FOR CHILDREN WHO SUFFER FROM GENDER DYSPHORIA, BUT THERE ARE STILL SOME UNNECESSARY HURDLES. BY ADELE KATZEW

SNAPSHOT

- The law in Australia currently requires that a court application is made when a transgendered child seeks access to cross hormone treatment for gender dysphoria.
- A review of recent cases demonstrates that there are inconsistencies between judgments, of which practitioners should be mindful.
- Law reform is needed to remove the requirement for judicial oversight in uncontroversial cases.

Many children who identify as transgender experience gender dysphoria, a condition that can be harmful to the child's wellbeing in the absence of proper care and support. The law in Australia has made positive steps toward improving access to treatment. However, a review of cases in the last 12 months highlights the need for legislative reform in order to remove some unnecessary hurdles.

A person with gender dysphoria experiences a marked and persistent incongruence between their biological sex and their identification with the gender of the opposite sex. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning. The diagnosis of gender dysphoria is governed by the *Diagnostic and Statistical Manual of Mental Disorders*. The number of Australian children who identify as transgender and seek medical treatment for gender dysphoria continues to rise.

There are two stages of hormone therapy for treatment of gender dysphoria in children. Stage 1 involves suppressing the onset of puberty and stage 2 treatment alters the physical characteristics of the child's sex. The need for straightforward access to support and treatment is significant. Young people with gender dysphoria are at high risk of depression, anxiety self-harm and suicide.[1]

Currently, in Australia, a transgendered child cannot access stage 2 treatment without an application first being made to the Family Court. The vast majority of gender dysphoria cases that come before the Family Court are uncontroversial – there is no disagreement between the child, the parents and medical practitioners in relation to diagnosis, treatment plan and the child's competency. This article will focus on these uncontroversial cases.

Since 2013, following the Full Court's decision in *Re Jamie*,[2] the law has developed in a positive direction. An application to the Court is no longer required in order to access stage 1 treatment unless there is a dispute. However, judicial involvement is still required to access stage 2 treatment, and there remains a crucial need to minimise delays for young people in accessing what is potentially life-saving treatment. Research suggests that the greatest risk of suicide for transgender individuals is the period between deciding to seek treatment and the time of accessing treatment.[3]

Gillick competence

Central to the discussion regarding access to treatment is the concept of *Gillick* competency.

The concept derives from the English case *Gillick v West Norfolk and Wisbech Area Health Authority*.[4] The House of Lords determined that a child is capable of independently consenting to medical treatment where the child is found to be of sufficient intelligence and maturity to fully understand what is involved.

The High Court of Australia endorsed this finding in *Marion's Case*.[5]

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Court authorisation of medical treatment: *Marion's Case*

In *Marion's Case*, the High Court established the principles concerning when court authorisation for medical treatment of a child is required.

The case concerned a 14 year old girl, "Marion", who suffered an intellectual disability as well as deafness, epilepsy and behavioural problems. It was proposed by her parents that Marion undergo surgery which would prevent menstruation and render her unable to have children. Due to her intellectual disability and age, Marion could not provide independent consent. Further, the procedures were not required to treat an underlying medical condition.

The High Court drew a distinction between medical treatment that is therapeutic (necessary to treat a malfunction or disease) and non-therapeutic, and held that the proposed sterilisation of Marion was a non-therapeutic intervention.

The majority held that Court authorisation of a medical procedure on a non-*Gillick* competent child is required where:

- the proposed procedure is non-therapeutic
- the proposed procedure is irreversible
- there is a significant risk of making the wrong decision as to a child's capacity to consent or as to the child's best interests
- the consequences of a wrong decision are particularly grave.

Hormone treatment for gender dysphoria

The treatment for gender dysphoria is usually administered in two stages. Stage 1 involves the administration of puberty blockers which suppress the onset of puberty. It is fully reversible.

Stage 2 treatment, which usually commences at approximately age 16, involves the administration of either testosterone or oestrogen. Some of the effects are not entirely reversible. There are also risks associated with hormone treatment, for example impaired liver function.

The changes brought about by hormone treatment in transition from male to female involve the development of breasts and testicular shrinkage. For transition from female to male, changes include the growth of facial hair, deepening of the voice and muscle growth.

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The Full Court: *Re Jamie*

Re Jamie involved an application by the parents of the child "Jamie" for stage 1 and stage 2 treatment.

The appellant parents sought to distinguish Jamie's situation from *Marion's Case*. They argued that hormone therapy for gender dysphoria, unlike sterilisation, is therapeutic treatment of a medical condition. They further argued that Court approval should not be necessary where there is no controversy between the child, the parents and the health professionals.

The findings of the Full Court included:

- for stage 1 treatment Court authorisation is not required, save for situations where there is a dispute in relation to treatment
- although stage 2 treatment is therapeutic, judicial involvement is still required because there is a significant risk of making the wrong decision, and the consequences of a wrong decision are particularly grave
- where a child lacks *Gillick* competence to consent to stage 2 treatment, the Court rather than the parents, should give consent

It is difficult to justify the distress, delay and cost associated with court proceedings in situations where the necessary outcome is obvious, urgent and agreed upon . . .

- where a child is *Gillick* competent, the child can consent to stage 2 treatment without Court authorisation. However, the decision as to competency remains with the Court. In other words, it is for the Court to determine whether a child is *Gillick* competent, irrespective of whether the parents and medical professionals already agree.

Whether or not the Full Court appropriately applied the findings in *Marion's Case* has been questioned.[6] The High Court in *Marion's Case* held that therapeutic treatment of a medical condition does not require Court authorisation. The Full Court in *Re Jamie* concluded that stage 2 treatment for gender dysphoria is "administered for therapeutic purposes" (at [98]), yet judicial oversight is still necessary.

It is arguable that *Re Jamie* represents a missed opportunity to significantly improve access to stage 2 treatment.

Recent decisions

For the period 1 June 2015 to 30 June 2016 there were:

- 21 published cases of applications for cross sex hormone treatment where there was no dispute as to treatment and no issue as to the child's competency
- three published decisions where the child in question lacked competency, but there was no issue as to treatment (*Re Marley, Re Karsen, Re Cameron*)[7] – in all three cases, orders were made authorising the parents to consent to treatment on the child's behalf
- two cases that concerned stage 1 treatment where the applicant was the Minister for the relevant government department – in both cases the child in question was not in the primary care of a biological parent
- no published cases involving a dispute as to whether stage 2 treatment should occur.

Inconsistencies in recent judgments

An increasing number of applications are being listed within days of filing and are determined on a final basis at the first hearing date.

However, a review of the 21 cases involving applications for stage 2 treatment in the last 12 months, where there is no dispute as to competency or treatment, indicates that there are inconsistencies in relation to both procedural matters and the form of orders granted.

In most cases no Independent Children's Lawyer (ICL) was appointed or considered. However, in 35 per cent of cases an ICL was appointed, which presumably necessitated more than one court event and delayed the child's access to treatment. In *Re Lincoln*,[8] for example, the application was filed on 28 January 2016 but the final hearing was not until 18 April 2016. The evidence from the treating psychiatrist in that case was that without stage 2 treatment the child was at risk "of worsened depression and recurring deliberate self-harm" (at [26]).

Sometimes the requirement of service upon the relevant government authorities pursuant to 14.10 of the *Family Law Rules 2004* was either formally dispensed with (for example *Re Logan, Re Marco and Re Kate*)[9] or overlooked entirely. In some cases the relevant child welfare authority was served and appeared (in these situations there was often a delay of approximately six weeks between the application being filed and determined (for example *Re Darcey*).[10] In at least two cases the Court declined to dispense with service. In *Re Emery*,[11] Thornton J adjourned the matter for one week to enable service upon the relevant government authorities, and in *Re Gabrielle*[12] Stevenson J suspended the operation of an order authorising the child to consent to treatment for 14 days pending service of the relevant government department, which was granted liberty to apply.

In terms of outcomes, the relief granted in the majority of cases was in the form of a declaration that the child is competent to consent to stage 2 treatment. This accords with what was contemplated in *Re Jamie*. However some judges are unwilling to adopt this approach.[13]

In *Re Dale*,[14] Thornton J expressed reservations about whether declaratory relief was an appropriate remedy. Her Honour indicated it was controversial as to whether, in the absence of a statutory conferral of power, the Court has the authority to make a declaration that a child is *Gillick* competent (at [74]). Her Honour decided not to frame the order in terms of a declaration. Rather, a finding was made that the child is competent to consent to the proposed treatment and is authorised to make his own decision in relation to that treatment (at [76]).

Similarly, Berman J in *Re Flynn*[15] was not satisfied that an order by way of a declaration was necessary or that the power exists to make it. Stevenson J in *Re Lincoln* expressed doubt as to the jurisdictional basis for a declaration (at [37]).

These inconsistencies did not impinge on the effect of the outcomes (all judgments resulted in the child being able to commence stage 2 treatment). However, they do create uncertainty, delays and additional expense for applicants.

Practitioners who are advising applicants cannot give clear advice as to whether an ICL will be appointed, whether their application will involve more than one court date, whether service on the relevant government agency is required and if so, whether the government agency will wish to be involved.

Further, practitioners need to be cognisant of the differing preferences as to the nature and form of relief. This necessitates more time spent on drafting applications that encompass several alternative orders and preparing submissions.

Should the Court have a role?

The result of the decision in *Re Jamie* is that a court application must always be made where stage 2 treatment is sought to determine, at the very least, the issue of the child's competency.

In cases where the child, the parents and health professionals are united as to the treatment plan and the child's competency, it is questionable whether there should be any judicial involvement at all.

The uncontroversial gender dysphoria cases determined in the last year suggest that the Court will make orders enabling the child to access stage 2 treatment when sought.

It is difficult to justify the distress, delay and cost associated with court proceedings in situations where the necessary outcome is obvious, urgent and agreed upon by all concerned. Impediments to accessing treatment exacerbate risks to the physical and psychological wellbeing of children with gender dysphoria.

Concerns have been articulated by Bennett J in recent judgments. In *Re Martin*[16] her Honour pointed to the "contradiction and inconstancy" (at [34]) contained in *Re Jamie* and expressed the view that the question of *Gillick* competency in uncontroversial cases can be appropriately determined by the medical practitioners.

Her Honour stated at [35]-[36]:

"It is difficult to see, in reality, what the court will do other than to approve of the treatment explained and recommended to it by competent and qualified clinicians.

"In this entirely uncontroversial case, I have difficulty in identifying how the interests of the child are well served by compelling his parents to make the instant application."

In *Re Flynn* Berman J also queried the appropriateness of court involvement given the obstacle it arguably places in the way of young people seeking treatment (at [25]).

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Conclusion – the need for law reform

The Family Court continues to have an important role in determining applications in relation to transgender children where there is a dispute as to treatment or an absence of *Gillick* competence.

However, there is a need for law reform to remove the necessity for judicial oversight in uncontroversial cases

A review of the recent judgments in undisputed cases suggests that the Family Court is essentially "rubber stamping" a decision that has already been agreed.

It seems improbable that any appeals will be made to the Full Court in uncontroversial cases as it is unlikely that applications for stage 2 treatment in such cases will be refused by a single judge.

Therefore, legislative intervention is the more realistic option to hasten access to treatment for children with gender dysphoria. ■

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1. Telfer M, Tollit M, and Feldman D, "Transformation of health-care and legal systems for the transgender population: The need to change in Australia", *Journal of Paediatics and Child Health* 51 (2015).
2. *Re Jamie* [2013] FamCAFC 110.
3. Bauer GR, Pyne J, Francino MC, Hammond R, "Suicidality among trans people in Ontario: implications for social work and social justice", *Service Social* 59 (2013).
4. *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.
5. *Secretary, Department of Health and Community Services v JWB and SMB* [1992] HCA 15; (1992) 175 CLR 218 ("*Marion's case*").
6. See Kelly F, "Treating the transgendered child: The Full Court's decision in Re Jamie", *Australian Journal of Family Law* 28 (2014).
7. *Re Marley* [2016] FamCA 878; *Re Karsen* [2015] FamCA 733; *Re: Cameron* [2015] FamCA 1113.
8. *Re Lincoln* [2016] FamCA 267.
9. *Re Logan* [2016] FamCA; *Re Marco* [2016] FamCA 187; *Re Kate* [2015] FamCA 705.
10. *Re Darcey* [2015] FamCA 409.
11. *Re Emery* [2016] FamCA 240.
12. *Re Gabrielle* [2016] FamCA 470.
13. For example *Re Emery, Re Gabrielle, Re Dale.* In the unreported decision of *Re Conrad* [2016], Cronin J adopted a different approach and granted the child sole parental responsibility for medical decisions.
14. *Re Dale* [2015] FamCA 473.
15. *Re Flynn* [2015] FamCA 629.
16. *Re Martin* [2015] FamCA 1189.