FAMILY LAW ACT 1975

IN THE FULL COURT
FAMILY COURT OF AUSTRALIA

BETWEEN

APPELLANT PARENTS

AND

A PUBLIC AUTHORITY
First intervener

AUSTRALIAN HUMAN RIGHTS COMMISSION
Second intervener

RE: JAMIE

SUMMARY OF ARGUMENT OF AUSTRALIAN HUMAN RIGHTS COMMISSION

Nature of the treatment sought

1. This proceeding commenced at first instance with an application for authorisation of a 'special medical procedure' for a child.[1]

2. The child, Jamie, was diagnosed with gender identity disorder of the transsexual type (**transsexualism**).[2] The applicant parents sought authorisation from the primary judge for two stages of medical treatment which her treating doctors considered necessary to treat her transsexualism.[3]

3. The proposed treatment involves:[4]

[In accordance with orders made in this proceeding, the names of the parties and other people involved in the proceeding, along with other material that may identify them, have been removed from these submissions.]

1 AB 68.
2 J[4], [45], [47], [48]; Appeal Book (**AB**) 28, 39, 40.
3 J[4]-[5] and [9], AB 28-30.
4 AB 23. Note that the form in which Stage 1 was ordered differed from the way in which it was described in the initial application and at J[4]. See T47.39-T49.17; AB 333-335; and J[56] AB 43.

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3.1. the administration of Zoladex (a GnRH agonist) and cyproterone acetate in such a dose, in such manner, and with such frequency as determined in consultation with Jamie's treating medical practitioners to achieve suppression of gonadotrophins and testosterone to pre-pubertal levels (**Stage 1**);

3.2. additional treatment with oestrogen once Jamie turns 16 years old (**Stage 2**).

4. On 28 March 2011, the primary judge made an order to permit Stage 1 treatment to start immediately.[5] No order was made in relation to Stage 2 and on 6 April 2011 the application was otherwise dismissed.[6] As a result, a further application would need to be made for Stage 2 treatment, closer to when Jamie will turn 16.

5. The appellants seek to raise a new argument on appeal, namely, that the treatment sought is not a special medical procedure and that court authorisation for Stage 1 and Stage 2 is not required.[7] Alternatively they submit that orders authorising Stage 2 should have been made at the same time as orders were made in relation to Stage 1.[8]

Basis for intervention and outline of submissions

6. The Australian Human Rights Commission was granted leave to intervene in this proceeding on 24 November 2011 pursuant to s 92(1) of the *Family Law Act 1975* (Cth) (the **Family Law Act**) and s 11(1)(o) of the *Australian Human Rights Commission Act 1986* (Cth) (**AHRC Act**).

7. Pursuant to s 11(1)(o) of the AHRC Act, the Commission has the function of intervening in proceedings that involve human rights issues, where the Commission considers it appropriate to do so and with the leave of the court hearing the proceedings, subject to any conditions imposed by the court.

8. The phrase 'human rights' is defined by s 3 of the AHRC Act to mean the rights and freedoms recognised in the International Covenant on Civil and Political Rights, declared by the three Declarations appearing at schedules 3 to 5 of the AHRC Act, or recognised or declared by any relevant international instrument.

9. A 'relevant international instrument' is one in respect of which a declaration under s 47 of the AHRC Act is in force. On 22 October 1992, the Attorney General made a declaration under s 47 that the Convention on the Rights of the Child (**CRC**)[9] is an international instrument relating to human rights and freedoms for the purposes of the AHRC Act.[10] On 20 April 2009, the Attorney General made a declaration under s 47 that the Convention on the Rights of

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5 AB 23, order 1.
6 AB 26, order 1.
7 AB 4, grounds 1 and 2.
8 AB 4, ground 3.
9 Done at New York on 20 November 1989, [1991] ATS 4.
10 *Human Rights and Equal Opportunity Commission Act 1986 - Declaration of the United Nations Convention on the Rights of the Child*, 22 October 1992.

Persons with Disabilities (**CRPD**)[11] is an international instrument relating to human rights and freedoms for the purposes of the AHRC Act.[12]

10. The Commission considers that this proceeding engages a number of rights under the CRC which are dealt with in more detail below. These include:

    10.1. in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration (Article 3(1));

    10.2. the rights of children to such protection and care as is necessary for their well-being, taking into account the rights and duties of their parents, legal guardians, or other individuals legally responsible for them (Article 3(2));

    10.3. respect for the responsibilities, rights and duties of parents, legal guardians or other persons legally responsible for children, to provide, in a manner consistent with the evolving capacities of the children, appropriate direction and guidance in the exercise by the children of their rights (Article 5);

    10.4. assurance to children who are capable of forming their own views the right to express those views freely in all matters affecting them, the views of children being given due weight in accordance with their age and maturity (Article 12(1));

    10.5. in particular, children shall be provided the opportunity to be heard in any judicial and administrative proceedings affecting them, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law (Article 12(2)); and

    10.6. recognition of the principle that parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child (Article 18(1)).

11. The Commission considers that this proceeding also engages a number of rights under the CRPD. These include:

    11.1. the principle of respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities (Article 3(h));

    11.2. in all actions concerning children with disabilities, the best interests of the child shall be a primary consideration (Article 7(2));

    11.3. children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realise that right (Article 7(3));

    11.4. persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life, and have the right to access to the support

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11 Done at New York on 13 December 2006, [2008] ATS 12.

12 *Convention on the Rights of Persons with Disabilities Declaration 2009*, 20 April 2009.

they may require in exercising their legal capacity (Article 12(2) and (3));

11.5. all measures that relate to the exercise of legal capacity shall provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests (Article 12(4)).

12. These submissions deal with:

12.1. the relevance of the CRC to the questions the Court has been asked to determine;

12.2. whether Stage 1 and Stage 2 treatment should be considered together;

12.3. the characteristics of 'special medical procedures' which distinguish them from procedures that do not require Court authorisation;

12.4. whether Stage 1 treatment requires Court authorisation;

12.5. whether Court authorisation is required for Stage 2 if a young person is competent to make a decision about treatment;

12.6. whether Court authorisation is required for Stage 2 if a young person is not sufficiently competent to make a decision about treatment.

13. The submissions that the Commission seeks to make in relation to the proposed treatment for transsexualism can be summarised as follows:

13.1. The CRC should be an interpretive aid when considering the meaning of the provisions of Part VII of the Family Law Act. The CRC makes clear that it is important for children to have input into decisions that affect them, including decisions about medical treatment, and that parents have a special responsibility for assisting their children in making these decisions. This position is also consistent with the provisions of the CRPD referred to above.

13.2. If there is a dispute about the proposed course of treatment, for example between the views of the child, his or her parents or guardians and his or her treating medical practitioners, then it is appropriate for the matter to be determined by the Court pursuant to an application under s 67ZC.

13.3. It is open to the Court to consider separately whether authorisation is required for each of Stage 1 and Stage 2.

13.4. Once a child has been diagnosed with transsexualism by appropriately qualified medical practitioners, Court authorisation should not be required for Stage 1 treatment administered in accordance with accepted treatment guidelines because:

13.4.1. the treatment is reversible;

13.4.2. there are no alternative treatments available;

13.4.3. withholding (or significantly delaying) treatment is likely to have significant adverse psychological and physical effects.

13.5. It is appropriate for an application to be made to the Court for authorisation of Stage 2 treatment when a young person is approaching 16 years of age. Treatment guidelines for transsexualism recommend that Stage 2 commence at age 16 because at this age it is expected that the young person will be able to make informed mature decisions and engage in the therapy, while at the same time developing along with his or her peers.

13.6. The first question to be determined by a Court when considering an application for authorisation of Stage 2 treatment is whether the young person is "*Gillick* competent". That is, a Court should assess whether the young person is capable of consenting to medical treatment on his or her own behalf. The threshold applied by the High Court in *Marion's case* for this assessment is whether the young person is able to "understand fully what is proposed". If so, and the young person requests Stage 2 treatment, then the Court should find that authorisation for this treatment is not required. The question of whether a young person has capacity to authorise treatment for transsexualism can only be determined in the circumstances of a particular case as it requires a careful assessment of matters that are personal to the young person in question, such as their level of maturity and their ability to understand the nature of the treatment, the risks, benefits and any alternatives to that treatment.[13]

13.7. The test applies equally to all children, including those with a disability.

13.8. If the Court finds that the young person is not *Gillick* competent, then in accordance with s 67ZC(2) it should make an assessment about whether to authorise Stage 2, having regard to the best interests of the young person as the paramount consideration. In making this assessment, the Court should give significant weight to views of the young person in accordance with his or her age and maturity.

Convention on the Rights of the Child

14. The Parliament has recognised that the CRC should be an interpretive aid when considering the meaning of the provisions of Part VII of the Family Law Act (dealing with children). On 7 December 2011, the Family Law Legislation Amendment (Family Violence and Other Measures) Bill 2011 received royal assent. As a result, from 7 June 2012, s 60B will be amended to incorporate a new object of Part VII. From that date, s 60B(4) will provide:

> *An additional object of this Part is to give effect to the Convention on the Rights of the Child done at New York on 20 November 1989.*

[13] See Burney, L, "The Capacity of Competent Minors to Consent to and Refuse Medical Treatment", (1997) 5 *Journal of Law and Medicine* 52 at 59-60.

15. The Explanatory Memorandum states that the purpose of this amendment is to:[14]

> *confirm, in cases of ambiguity, the obligation on decision makers to interpret Part VII of the Act, to the extent its language permits, consistently with Australia's obligations under the Convention. The Convention may be considered an interpretive aid to Part VII of the Act. To the extent that the Act departs from the Convention, the Act would prevail.*

16. The Explanatory Memorandum also provided that this provision is not equivalent to incorporating the CRC into domestic law.[15]

17. The explicit reference to the CRC in s 60B(4) will also mean that consideration may be given to the CRC to confirm that the meaning of provisions of Part VII of the Family Law Act is the ordinary meaning conveyed by the text of the provisions taking into account their context in the Act and the purpose or object underlying the Act.[16]

Best interests of the child

18. In dealing with actions involving children, the Family Law Act and the CRC share a common underlying purpose or object, namely, a concern that decisions are made that are in children's best interests. Art 3(1) of the CRC provides that:

> *In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.*

Section 67ZC of the Family Law Act applies in circumstances such as the present where an application is made for orders pursuant to the Court's welfare jurisdiction. Section 67ZC provides that:

> *(1) In addition to the jurisdiction that a court has under this Part in relation to children, the court also has jurisdiction to make orders relating to the welfare of children.*
>
> *(2) In deciding whether to make an order under subsection (1) in relation to a child, a court must regard the best interests of the child as the paramount consideration.*

19. There is support for the view that, even prior to the amendment to s 60B referred to above coming into effect, s 67ZC implements relevant parts of Australia's obligations under the CRC.[17] Where a provision of an international

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14 Family Law Legislation Amendment (Family Violence and Other Measures) Bill 2011, Replacement Explanatory Memorandum at [24].

15 Replacement Explanatory Memorandum at [24].

16 *Acts Interpretation Act 1901* (Cth) s 15AB.

17 *In the Marriage of B* (1997) 140 FLR 11 at 76-85 (Nicholson CJ, Fogarty and Lindenmayer JJ); *KN v SD* (2003) 176 FLR 73 at [68] (Nicholson CJ and O'Ryan J), cf [148]-[151] (Ellis J); *B and B v Minister for Immigration and Multicultural and Indigenous Affairs* (2003) 173 FLR 360 at [288] (Nicholson CJ and O'Ryan J), cf [424] (Ellis J). Although the decision of the Full Court in the last mentioned of these cases was overturned on appeal (*MIMIA v B* (2004) 219 CLR 365) this was done on the basis of a construction of the scope of Part VII of the Family Law Act. The only Justice to explicitly consider the conclusion drawn by Nicholson CJ and O'Ryan J about the implementation of the CRC was Callinan J at [220]-[222], who disagreed with their Honours'

instrument such as the CRC is transposed into a statute, the *prima facie* legislative intention is that the transposed text should bear the same meaning in the domestic statute as it bears in the international instrument.[18] Similarly, where a provision of a domestic statute follows quite closely the language of an international instrument, it may be possible to infer an intention that the words used in the statute should attract the same meaning as would be given by international law to the words of the international instrument.[19]

20. Section 43(c) of the Family Law Act provides that in exercising its jurisdiction under the Act, the Court shall have regard to the need to protect the rights of children and to promote their welfare. It is likely that when s 43(c) was enacted, Parliament had in mind the rights of children under the "predecessor" of the CRC: the United Nations Declaration of the Rights of the Child done at New York, proclaimed by General Assembly Resolution 1386 (XIV) on 20 November 1959.[20]

21. Further, even where an international instrument has not been implemented in domestic law, it is well settled that legislative provisions that are ambiguous are to be interpreted by reference to the presumption that Parliament did not intend to violate Australia's international obligations.[21]

22. The requirement of ambiguity has been interpreted broadly; as Mason CJ and Deane J observed in *Teoh*:[22]

> *there are strong reasons for rejecting a narrow conception of ambiguity. If the language of the legislation is susceptible of a construction which is consistent with the terms of the international instrument and the obligations which it imposes on Australia, then that construction should prevail.*

23. The principle that legislation is to be construed so as to give effect to, and not to breach, Australia's international obligations assists in minimising the risk of legislation inadvertently causing Australia to breach international law. Any breach of international law occasioned by an Act of Parliament ought to be the

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conclusion. To the extent that the issue was referred to by the other Justices, they considered that it was unnecessary to comment: at [108]-[110] per Gummow, Hayne and Heydon JJ, at [134]-[135] per Kirby J.

18 *Applicant A v Minister for Immigration and Ethnic Affairs* (1997) 190 CLR 225 at 230-31 (Brennan CJ).

19 *De L v Director General, NSW Department of Community Services* (1996) 187 CLR 640 at 675 (Kirby J).

20 *B and B v Minister for Immigration and Multicultural and Indigenous Affairs* (2003) 173 FLR 360 at [274] (Nicholson CJ and O'Ryan J). See comments in footnote 17 above.

21 This principle was first stated in the Commonwealth context in *Jumbunna Coal Mine No Liability v Victorian Coal Miners' Association* (1908) 6 CLR 309 at 363. It has since been reaffirmed by the High Court on many occasions: see, eg, *Zachariassen v Commonwealth* (1917) 24 CLR 166 at 181 (Barton, Isaacs and Rich JJ); *Polites v Commonwealth* (1945) 70 CLR 60 at 68-69 (Latham CJ), 77 (Dixon J), 80-81 (Williams J); *Chu Kheng Lim v Minister for Immigration* (1992) 176 CLR 1 at 38 (***Chu Kheng Lim***) (Brennan, Deane and Dawson JJ); *Dietrich v R* (1992) 177 CLR 292 at 306 (Mason CJ and McHugh J); *Minister for Immigration & Ethnic Affairs v Teoh* (1995) 183 CLR 273 at 287 (Mason CJ and Deane J) (***Teoh***); *Kartinyeri v Commonwealth* (1998) 195 CLR 337 at 384 (Gummow and Hayne JJ); *Re Minister for Immigration and Multicultural and Indigenous Affairs; Ex parte Lam* (2003) 214 CLR 1 at 33 (McHugh and Gummow JJ); *Al-Kateb v Godwin* (2004) 219 CLR 562 (***Al-Kateb***); *Coleman v Power* (2004) 220 CLR 1 at 91 (Kirby J). Despite his stringent criticism of the rule, in *Al-Kateb* at [63]-[65] McHugh J acknowledged that "it is too well established to be repealed now by judicial decision".

22 (1995) 183 CLR 273 at 287-8.

result of a deliberate decision by Parliament. To this end, where a construction that is consistent with international law is open, that construction is to be preferred over a construction that is inconsistent with international law.[23]

24. In interpreting the CRC, the international principles relevant for the purposes of the present proceeding are that:

    24.1. the treaty should be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose;[24]

    24.2. there shall be taken into account, together with the context, any subsequent practice in the application of the treaty which establishes the agreement of the parties regarding its interpretation.[25]

25. It is therefore appropriate for the Court to have regard to relevant provisions of the CRC in providing context to the "best interests" principle and its application to matters falling within the terms of s 67ZC. It is also appropriate for the Court to have regard to General Comments published by the Committee on the Rights of the Child.[26]

26. The CRC makes clear that it is important for children to have input into decisions that affect them, and that parents have a special responsibility for assisting their children in making these decisions. Children are rights bearers and not merely objects of protection.[27] Further, there is a strong presumption that the realisation of children's rights will occur in the context of the family unit in a manner which accommodates a child's evolving capacities.[28] These requirements are considered in more detail below in the discussion about Stage 2 treatment.

Whether Stage 1 and Stage 2 treatments should be considered together

27. The applicant parents contended that Stage 1 and Stage 2 should be viewed as the one treatment program and approved at the same time.[29] The main arguments put forward in favour of this approach are that it would save the expense of the family making two applications to the Court, and that it would provide certainty for Jamie that Stage 2 treatment would be available to her once she turned 16, if considered appropriate by her treating doctors at that time.

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23 *Teoh* (1995) 183 CLR 273 at 362 (Mason CJ and Deane J); *Chu Kheng Lim* (1992) 176 CLR 1 at 38 (Brennan, Deane and Dawson JJ).

24 Vienna Convention on the Law of Treaties, Article 31(1).

25 Vienna Convention on the Law of Treaties, Article 31(3)(b).

26 The Committee is established under Article 43 of the CRC and has functions including making general recommendations based on information received from parties to the Convention (Article 45(d)).

27 *Juridical Condition and Human Rights of the Child (Advisory Opinion)* [2002] Inter-American Court of Human Rights (Ser A) No 17, p 79 at [1].

28 *Juridical Condition and Human Rights of the Child (Advisory Opinion)* [2002] Inter-American Court of Human Rights (Ser A) No 17, p 79 at [4]; John Tobin, "Judging the Judges: Are They Adopting the Rights Approach in Matters involving Children?" 33 *Melbourne University Law Review* 579 at 587.

29 J[9], AB 30.

28. In previous decisions involving applications for authorisation of similar treatment, the Court has asked two questions when considering whether Stage 1 and Stage 2 should be considered together:[30]

    28.1. is authorisation required for both stages (for example because they amount to a single 'course of treatment')?

    28.2. if Court authorisation is required for both stages, should they be considered together for the purpose of making orders for both Stage 1 and Stage 2 at the same time?

29. The issue in paragraph 28.1 is an element of Ground 1 in the appeal: is authorisation required (for either or both stages)? The issue in paragraph 28.2 above is central to Ground 3 in the appeal: should authorisation for Stage 2 have been granted at the same time as Stage 1 was authorised?

Is authorisation required for each stage?

30. In relation to the first issue, the Commission submits that it is open to the Court to consider separately whether authorisation is required for each of Stage 1 and Stage 2. Although they are part of the same treatment regime, Stage 1 and Stage 2 treatment involve different medication administered at different times. Further, they have different consequences, particularly in relation to the reversibility of their effects. The fact that a young person has undergone Stage 1, does not mean that he or she will necessarily undergo Stage 2. Stage 1 treatment has been described as being, at least in part, diagnostic in the sense that it serves to confirm the diagnosis of transsexualism.[31]

31. For the reasons set out in paragraphs 55 to 75 below, the Commission submits that Court authorisation should not be required for Stage 1 treatment where transsexualism has been diagnosed by appropriately qualified medical practitioners and treatment is prescribed in accordance with accepted treatment guidelines.

Should authorisation be given for both stages?

32. In relation to the second issue, different approaches have been taken in previous cases as to whether Stage 1 and Stage 2 should be authorised at the same time.

33. As noted above, in *Re Brodie* (heard in 2007) authorisation was only sought for Stage 1 treatment. The Commission understands that in November 2011 Dessau J heard a separate application in relation to Stage 2 treatment for the same young person.

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30 In these submissions, the terms Stage 1 and Stage 2 are used broadly. While the particular treatments ordered in previous cases have differed in some respects (particularly as between affirmed males and affirmed females) there are similarities which mean that it is appropriate to consider each of them as a class. In general terms Stage 1 involves reversible treatment to arrest the onset of puberty, while Stage 2 treatment involves the administration of hormones (testosterone or oestrogen) in order to develop secondary sexual characteristics of the affirmed sex.

31 US Guidelines p 3139 (section *1.3 Remarks*), AB 170; p 3140 (section *2.1-2.2 Evidence*), AB 171.

34. In *Re Alex*,[32] Nicholson CJ considered that it was appropriate to authorise both stages at the same time given the *"deep and long held desire"* of Alex for this treatment. Alex was 13 years old at the time.

35. Similarly in *Re O*,[33] both stages were authorised together given that *"the evidence did not suggest that a change of heart was likely"* nor *"that there should be any undue delay between stages"*. O was 16 years old at the time.

36. In *Re Rosie*,[34] Dessau J ordered Stage 2 treatment without the preliminary step of ordering Stage 1 treatment given that Rosie was almost 17 years old.

37. If the Court considers that authorisation is required for both stages, it appears that the question of whether to authorise both stages at the same time will turn on an assessment of whether Stage 2 treatment will be in the child's best interests at the time the child is old enough for it to be administered. It appears that courts have been more comfortable making this finding when the time until Stage 2 treatment is shorter.

38. If the Court accepts the Commission's submission that authorisation for Stage 1 treatment is not required, then the issue of whether both Stages are authorised at the same time does not arise. We deal below with the question of whether authorisation for each Stage is required.

'Special medical procedures'

39. There is no statutory definition of 'special medical procedure'. The Family Court Rules 2004 (Cth) provide for Medical Procedure Applications to be made to the Court. These applications are made pursuant to the Court's welfare jurisdiction under s 67ZC. 'Medical Procedure Application' is defined in the dictionary to the Rules as follows:

> ***Medical Procedure Application*** *means an Initiating Application (Family Law) seeking an order authorising a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease.*
>
> *Example*
>
> *An example of a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease is a procedure for sterilising or removing the child's reproductive organs.*

40. *Marion's case* involved the proposed sterilization of a girl with an intellectual disability. The necessary criteria identified in *Marion's case* that led to a requirement for Court authorisation were:[35]

    40.1. a procedure that is irreversible;

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32 *Re Alex* (2004) 180 FLR 89 at [188].

33 *Re O* [2010] FamCA 1153 at [54].

34 *Re: Rosie (Special Medical Procedure)* [2011] FamCA 63 at [55].

35 *Secretary, Department of Health and Community Services v JWB and SMR* (1992) 175 CLR 218 (***Marion's Case***) at 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).

40.2. significant risk that a wrong decision might be made (either as to the minor's present or future capacity to consent, or about what are the best interests of a child who cannot consent);

40.3. grave consequences flowing from making a wrong decision.

41. Since that case, the criteria developed by the High Court for assessing whether authorisation was required for that procedure have been applied to other medical situations.

42. It is clear that it is not sufficient for a procedure to be a 'special medical procedure', such as to require Court authorisation, that the procedure is irreversible.[36] Similarly, it is not sufficient that the consequences of carrying out or not carrying out the procedure may be grave. In *Re Baby D (No 2)*,[37] Young J considered an application for authorisation of a procedure which involved removing and not replacing a breathing tube from an infant and possibly thereafter providing palliative care and not providing treatment to artificially prolong the life of the infant. Although this was treatment which had very grave consequences, it was held to be within the scope of parental power.

43. It seems that an essential element for a procedure that requires court authorisation is that there is a significant risk that a wrong decision might be made, either as to the minor's present or future capacity to consent, or about what are the best interests of a child who cannot consent.[38]

44. The High Court in *Marion's case* referred to three factors which contributed to the significant risk of a wrong decision in that case.[39]

(a) The complexity of the question of consent

45. The Court was concerned that in the case of sterilization procedures for children with intellectual disabilities, *"some sterilization operations have been performed too readily and that the capacity of the child to give consent … has been wrongly assessed"*.[40] This was particularly problematic in circumstances where sterilization was not *"clearly for the benefit of the child"*.[41]

46. Cases involving children with transsexualism but without intellectual disabilities seem to have different considerations. These issues are considered in more detail in paragraphs 103 to 112 below.

(b) The role played by the medical profession

47. The High Court expressed two concerns about the role played by the medical profession:[42]

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36 *Marion's case* at 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).
37 *Re Baby D (No 2)* [2011] FamCA 176.
38 *Marion's case* at 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).
39 *Marion's case* at 250-253 (Mason CJ, Dawson, Toohey and Gaudron JJ).
40 *Marion's case* at 250-251 (Mason CJ, Dawson, Toohey and Gaudron JJ).
41 *Marion's case* at 250-251 (Mason CJ, Dawson, Toohey and Gaudron JJ).
42 *Marion's case* at 251 (Mason CJ, Dawson, Toohey and Gaudron JJ).

47.1. First, that as with all professions, there are medical practitioners *"who act with impropriety as well as those who act bona fide but within a limited frame of reference"*.

47.2. Secondly, that sterilization is not merely a medical issue, but also a social and psychological issue.

48. Taking these two concerns together, the issue appears to be that where a procedure with significant consequences is not merely a medical issue but also involves social and psychological issues, the decision should not be left to medical practitioners who may only view the issue from a limited perspective. It may also be that there are some types of procedures where there are higher risks of incorrect assessments being made.

49. Again, it is worth considering whether treatment for a child with transsexualism is of the same nature as sterilization of a child with intellectual disabilities. In the present case, it will be relevant to consider:

49.1. whether the condition is a recognised medical condition;

49.2. whether it has been appropriately diagnosed;

49.3. whether there are alternative treatments available; and

49.4. the impact on the child of withholding treatment.

50. These factors are considered below in relation to the treatment proposed in this case.

(c) Conflicting interests of others

51. The High Court noted that questions of whether a child with an intellectual disability should be sterilized may involve independent and possibly conflicting (though legitimate) interests of the parents and other family members.[43]

52. The context for this statement appears to be the possibility that parents or carers may seek sterilization for a child, for reasons that may include reducing the burden of care, but that may not be in the child's best interests.[44] Again, this seems to be a different situation to the case of medical treatment for a child with transsexualism. There is no suggestion in the particular factual circumstances of this case that the treatment proposed would be of independent benefit to Jamie's parents (other than as a result of the benefit to Jamie). Nor is there any suggestion in this case that such treatment would be sought by Jamie's parents if it was not ardently sought by her.

53. If there is a dispute about whether treatment should be provided, and what form any treatment should take, it is appropriate for this to be determined by the Court. This is the position taken by the appellants in the present proceeding.[45] A dispute could arise between the views of the child, his or her

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43 *Marion's case* at 251 (Mason CJ, Dawson, Toohey and Gaudron JJ).

44 *Marion's case* at 251-252 (Mason CJ, Dawson, Toohey and Gaudron JJ).

45 Appellant Parents' Summary of Argument in Support of the Appeal (**Appellant's Submissions**) at [11]-[12].

parents or guardians and his or her treating medical practitioners. For example, in *Re Brodie*, Brodie's father opposed the application for authorisation of treatment.[46]

54. The Court has jurisdiction under s 67ZC to hear and determine applications for authorisation of medical procedures, even where the procedure in question is ultimately determined not to be a special medical procedure.[47] Therefore, it is still appropriate for applications to be made where:

    54.1. there is disagreement about the proposed course of treatment between two or more of the child, his or her parents or guardians and his or her treating medical practitioners;

    54.2. there is a real and genuine issue or concern in relation to a medical treatment or procedure that is to be performed on a child.[48]

Stage 1 treatment

Treatment that is reversible

55. *Re Alex* was the first reported decision of this Court dealing with medical treatment for children with transsexualism. The case involved an affirmed male aged 13, and the proposed Stage 1 treatment was the administration of *"a combination of oestrogen and progestogen on a continuous basis until the child turns 16"*. Chief Justice Nicholson noted that this treatment had been *"uniformly identified as a reversible medical treatment"*.[49] On that basis, his Honour queried at an early stage of the proceeding whether Court authorisation was required at all. Ultimately, his Honour was persuaded that authorisation was necessary on the basis that Stage 1 and Stage 2 treatment should be considered together.[50]

56. *Re Brodie* related to an affirmed male aged 12.[51] In that case, authorisation was only sought for Stage 1 treatment. Justice Carter noted that the application concerned treatment which *"is completely reversible according to the expert evidence"*, and raised the same question as Nicholson CJ in *Re Alex*, namely, whether such treatment was a 'special medical procedure'.[52] However, the Court accepted the submission of the Independent Children's Lawyer that the treatment should be considered as part of an overall treatment plan. Even though a further application would need to be made for Stage 2 treatment, the Court considered that the nature of Stage 2 treatment meant that it was necessary for Stage 1 to be authorised.

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46 *Re Brodie* [2008] FamCA 334 at [15].
47 *Re Baby D (No 2)* [2011] FamCA 176 at [224].
48 *Re Baby D (No 2)* [2011] FamCA 176 at [234].
49 *Re Alex* (2004) 180 FLR 89 at [184].
50 *Re Alex* (2004) 180 FLR 89 at [185]-[188].
51 *Re Brodie* [2008] FamCA 334.
52 *Re Brodie* [2008] FamCA 334 at [37]-[38].

57. The present case involves an affirmed female, aged 11. The Stage 1 treatment proposed in this case is recognised by the experts in this case as being reversible.[53]

58. It appears that if the Court is able to consider Stage 1 treatment in isolation, then it would not satisfy the first requirement of the test for a 'special medical procedure' in *Marion's case*, namely, a procedure that is irreversible (see paragraph 40 above).

59. The Commission submits that it is open to the Court to consider each Stage separately, and that it is appropriate to do so. Further, it would be appropriate to allow parents to authorise Stage 1 treatment. In making these submissions, the Commission notes that:

    59.1. Stage 1 and Stage 2 treatment involve different medication administered at different times.

    59.2. Stage 1 and Stage 2 treatment have different consequences. The evidence is that Stage 1 is reversible.

    59.3. Although they are part of the same treatment regime, and it could reasonably be expected that a young person who commences Stage 1 treatment would also undergo Stage 2 treatment, this is not inevitable. A separate decision needs to be made to commence Stage 2 treatment, based on a further assessment by treating doctors. Stage 1 treatment has been described as being, at least in part, diagnostic in the sense that it serves to confirm the diagnosis of transsexualism.[54]

Appropriately diagnosed medical treatment

60. Although not necessary to the test in Marion's case, it is also useful to consider the questions set out in paragraph 49 above, to assess whether this is a medical issue or something else, for example a social or psychological issue.

Whether the condition is a recognised medical condition

61. As noted in paragraph 2 above, Jamie was diagnosed with gender identity disorder of the transsexual type. Diagnostic criteria for gender identity disorder are set out in DSM IV.[55]

62. The appellants describe this condition as being a psychiatric or psychological condition, rather than a physical condition.[56] Submissions of the ICL[57] are to similar effect. The basis for this appears to be the diagnostic criteria set out in DSM IV and the requirement for child psychiatrists to be involved in the diagnosis. Evidence from the medical experts was that the cause of

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53 J[58], [71], [82]; AB 43, 47, 50. See also US Guidelines p 3141 (section *2.3 Evidence*), AB 172.

54 US Guidelines p 3139 (section *1.3 Remarks*), AB 170; p 3140 (section *2.1-2.2 Evidence*), AB 171.

55 Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, published by the American Psychiatric Association.

56 Appellant's Submissions at [15](c) and (d), [17] and [19].

57 ICL's Summary of Argument at [7].

transsexualism is unknown,[58] and that it may include a biological component.[59] Regardless of the ultimate cause, there is no dispute on the evidence that it is a recognised medical condition that is able to be diagnosed.

63. [Dr G] has given evidence that there are now international consensus guidelines for the treatment of transsexualism published by the US Endocrine Society, which have been endorsed in Australia (**US Guidelines**).[60] A copy of those guidelines appears as an annexure to the affidavit of [Dr C].[61]

64. The Commission submits that it is not necessary to identify the cause of transsexualism in order for the court to find that it is a recognised medical condition with agreed procedures for treatment.[62]

Whether the condition has been appropriately diagnosed

65. The Court was provided with expert evidence from two child psychiatrists and a paediatric endocrinologist. Each of them confirmed the diagnosis, and the trial judge noted that no-one took issue with the diagnosis.[63]

66. The US Guidelines suggest that adolescents are eligible and ready for Stage 1 treatment if they:[64]

    66.1. fulfil DSM IV-TR or ICD-10 criteria for gender identity disorder or transsexualism;[65]

    66.2. have experienced puberty to at least Tanner stage 2;

    66.3. have (early) pubertal changes that have resulted in an increase of their gender dysphoria;

    66.4. do not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment;

    66.5. have adequate psychological and social support during treatment; and

    66.6. demonstrate knowledge and understanding of the expected outcomes of GnRH analog treatment, cross-sex hormone treatment, and sex

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58 Second report of [Dr C] p 4, AB 280; [Dr C] XXN T28.5-8 AB 315.

59 "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline", *Journal of Clinical Endocrinology & Metabolism*, September 2009, 94(9), p 3135; AB 166.

60 [Dr G] XN T34.3-7, AB 321. First report of [Dr G] p 2, AB 128. J[59] and [82], AB 43 and 50. See also Australasian Paediatric Endocrine Group, *Gender Identity Disorder Guidelines*, available at: http://www.apeg.org.au/Portals/0/guidelines.pdf. The pseudonym 'Dr G' is the same as is used in the judgment at first instance: *Re: Jamie (Special Medical Procedure)* [2011] FamCA 248.

61 "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline", *Journal of Clinical Endocrinology & Metabolism*, September 2009, 94(9), AB 163-185. The pseudonym 'Dr C' is the same as is used in the judgment at first instance.

62 Cf *Re Alex* (2004) 180 FLR 89 at [195] and *Re Bernadette (Special Medical Procedure)* [2010] FamCA 94 at [123] and [125].

63 J[49] AB 40.

64 US Guidelines p 3138, Table 5, AB 169.

65 This diagnosis is to be made by a mental health professional with training in child and adolescent developmental psychopathology: US Guidelines p 3138 AB 169.

reassignment surgery, as well as the medical and the social risks and benefits of sex reassignment.

Whether there are alternative treatments available

67. In *Re Bernadette*, heard in 2007, a divergence of views was expressed about whether treatment should commence before or after puberty.[66] This caused Collier J to conclude that:[67]

> *I am satisfied that there still remains grave dispute within the medical community as to the best treatment that can be offered. I am satisfied that until there is a clear cut line of authority within the medical profession, it would be difficult for parents to reach an informed conclusion in every case.*

68. Since that time, the US Guidelines have been published.

69. In the present case, the primary judge observed:[68]

> *In a balanced assessment, Dr C reported that previously some clinicians felt it was important for children to experience pubertal development of their own biological sex, so that they knew what it was really like to be for example "a boy", before any changes were made. He noted however that at the major centres now treating such children, it was no longer considered necessary or appropriate in circumstances where a child has a strong and persistent conviction that they are of the opposite gender.*

70. In three recent cases heard by the primary judge, her Honour considered that there were no alternative less invasive treatments available in the circumstances of those cases.[69] In the present case, her Honour considered that the only alternative was to withhold treatment.[70]

The impact on the child of withholding treatment

71. The evidence is that withholding treatment is likely to have significant adverse psychological and physical effects.

72. The primary judge referred to expert evidence that withholding treatment may lead to an increased likelihood of major mental disorder and behavioural difficulties including severe depression and anxiety disorders and risk of self-harm.[71] Studies cited by the same expert suggested that self-harm was common among young people with severe gender dysphoria.[72]

73. Further, if treatment was withheld it would have resulted in Jamie undergoing bodily changes that were opposite to her affirmed sex and which would be

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66 *Re Bernadette* [2010] FamCA 94 at [48]-[54] and [95].
67 *Re Bernadette* [2010] FamCA 94 at [124].
68 J[68] AB 46; see also AB 282.
69 *Re O* [2010] FamCA 1153 at [55], *Re Rosie* [2011] FamCA 63 at [72], J[85]-[89] AB 51-52.
70 J[86] AB 51.
71 J[63] AB 45.
72 J[64] AB 45; second report of [Dr C] p 5, AB 281.

irreversible without surgery.[73] Jamie would be likely to find such changes psychologically distressing.[74]

Conclusion about the nature of Stage 1 treatment

74. On the basis of the above analysis, it appears that Stage 1 treatment may also not satisfy the second or third criteria in *Marion's case*. That is, provided that the condition of transsexualism is appropriately diagnosed and administered in accordance with accepted guidelines, it seems that the risk of making a wrong decision is low and that the consequences of making a wrong decision are not grave (particularly because the treatment is reversible). The much more significant risk appears to be that young people in Jamie's position are not able to access treatment in a timely way.

75. It is consistent with the responsibilities of parents recognised under s 61C of the Family Law Act and Article 5 of the CRC for them to be responsible for making decisions about medical treatment of this nature, guided by the best interests principle. These provisions are considered in paragraphs 99 to 101 below.

Stage 2 treatment

76. The nature of Stage 2 treatment requires separate consideration.

77. Chief Justice Nicholson was the first judge of this Court to consider whether medical treatment of a child with transsexualism was a 'special medical procedure'. In *Re Alex*, decided in 2004, his Honour described the proposed treatment as 'novel'.[75] His Honour came to the view that the treatment (particularly Stage 2)[76] required Court authorisation because:

    77.1. the aetiology of the condition has not been definitively established, with the result that his Honour felt unable to make a finding that the treatment would clearly be for a 'malfunction' or 'disease';[77] and

    77.2. *"there are significant risks attendant to embarking on a process that will alter a child or young person who presents as physically of one sex in the direction of the opposite sex, even where the Court is not asked to authorise surgery"*.[78]

78. As noted in paragraphs 61 to 64 above, although there is still uncertainty about the aetiology of the condition of transsexualism, this does not prevent it from being a recognised medical condition with agreed procedures for treatment.

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73 J[5], [54]; AB 29, 42.
74 J[54] AB 42.
75 *Re Alex* (2004) 180 FLR 89 at [180].
76 *Re Alex* (2004) 180 FLR 89 at [184]-[189].
77 *Re Alex* (2004) 180 FLR 89 at [192]-[195].
78 *Re Alex* (2004) 180 FLR 89 at [196].

79. Previous disputes about appropriate treatment appear to have been limited to the timing of Stage 1.[79]

80. While [Dr G] has given evidence that the US Guidelines have now been adopted in Australia, it appears that this is a recent development. Further, the US Guidelines appropriately note the limitations to their recommendations based on availability of evidence. The recommendation relating to Stage 2 appears at [2.4] and is in the following terms:[80]

> *We suggest that pubertal development of the desired opposite sex be initiated at about the age of 16 yr, using a gradually increasing dose schedule of cross-sex steroids.*

81. Although this is the recommended treatment for Stage 2, it is described as a "weak recommendation" for which the evidence is "very low quality". The guidelines describe the implications of strong and weak recommendations as follows:[81]

> *The Task Force has confidence that persons who receive care according to the strong recommendations will derive, on average, more good than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action.*

82. Given the qualified nature of the recommended treatment, the necessity for a young person's individual circumstances to be considered carefully, and the significant risks described by Nicholson CJ in *Re Alex* set out in paragraph 77.2 above, the Commission submits that it remains appropriate for an application to be made to the Court for authorisation of Stage 2 treatment when a young person is approaching 16 years of age. It may be that further experience with this treatment will mean that such applications are not necessary in the future. On the basis of the evidence before the Court on this appeal, the Commission submits that such applications are still appropriate.

Competence of a young person to make a decision in relation to Stage 2

83. The first question to be determined by a Court when considering an application for authorisation of Stage 2 treatment is whether the young person is '*Gillick* competent'. That is, a Court should assess whether the young person is capable of consenting to medical treatment on his or her own behalf. The threshold applied by the High Court in *Marion's case* for this assessment is whether the young person is able to *"understand fully what is proposed"*. The test applies equally to all children, including those with a disability. If the young person has this level of understanding, and the young person requests Stage 2 treatment, then the Court should find that authorisation for this treatment is not required.[82]

84. By virtue of legislation, the age of majority in all States and Territories of Australia is 18 years. In South Australia, a person who is 16 years old may

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79 See paragraphs 67 to 70 above.
80 US Guidelines p 3133 AB 164.
81 US Guidelines p 3135 AB 166.
82 *Re Alex* [2009] FamCA 1292 at [137].

make decisions about his or her own medical treatment as validly and effectively as an adult.[83]

85. The High Court in *Marion's case* adopted the test set out in *Gillick v West Norfolk AHA* [1986] AC 112 in determining whether a child is capable of giving informed consent to medical treatment at common law. The court held that a child is capable of giving informed consent when he or she *"achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed"*.[84]

86. While Nicholson CJ doubted that a 13 year old child could have sufficient competence to make decisions about medical treatment for transsexualism,[85] a young person approaching 16 may be in a different situation. In *Re Rosie*, Dessau J held that the young person of almost 17 was capable of making an informed decision about Stage 2 treatment.[86] However, her Honour authorised the proposed treatment rather than considering the question of whether or not such authorisation was necessary. Similarly, in *Re Alex (No 2)*, Bryant CJ considered that Alex was likely to be *Gillick* competent and able to consent to a double mastectomy at age 17 while undergoing Stage 2 treatment, however, no submissions were addressed to this issue and her Honour therefore found it unnecessary to determine.[87]

87. The US Guidelines recommend that Stage 2 be initiated at the age of 16. The rationale for selecting this age is said to be to *"start this process at a time when the individual will be able to make informed mature decisions and engage in the therapy, while at the same time developing along with his or her peers"*.[88]

88. In the present case, Jamie's treating psychiatrist [Dr C] and the family report writer have given their opinion of Jamie's expected competence at age 16.[89]

89. Allowing children who are competent to make decisions about their own medical treatment to make those decisions is consistent with the CRC. Australia has agreed that it will assure to children the right to express their own views in matters that affect them, and that those views will be given due weight in accordance with the age and maturity of the child.[90] This does not mean that the wishes of the child will always be determinative. However, in making decisions involving the rights of children, the starting point must be to determine the child's own views, and to give them as much weight as the maturity of the child dictates.

90. This principle is reflected in s 60CC(3)(a) of the Family Law Act, which provides that considerations in determining the child's best interests include any views expressed by the child and any factors (such as the child's maturity

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83 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6.

84 *Marion's case* at 237 (Mason CJ, Dawson, Toohey and Gaudron JJ), citing *Gillick* at 189.

85 *Re Alex* (2004) 180 FLR 89 at [173].

86 *Re Rosie* [2011] FamCA 63 at [100].

87 *Re Alex* [2009] FamCA 1292 at [147].

88 US Guidelines p 3142 (section *2.4 Values and Preferences*), AB 173.

89 First report of [Dr C] p 11, AB 153. See also [Dr C] XN T22.5-22, AB 309. Report by [family report writer] at [25], AB 256.

90 CRC Article 12(1).

or level of understanding) that the court thinks are relevant to the weight it should give to the child's views.

91. Giving substantive consideration in decision making to a child's own views is relevant when considering proposed medical treatment.

92. The Committee of the Rights of the Child has published a General Comment about adolescent health and development. This Comment notes:[91]

> *The right to express views freely and have them duly taken into account (art. 12) is also fundamental in realizing adolescents' right to heath and development. … In order for adolescents to be able safely and properly to exercise this right, public authorities, parents and other adults working with or for children need to create an environment based on trust, information-sharing, the capacity to listen and sound guidance that is conducive for adolescents' participation equally including in decision-making processes.*

93. The Committee has also published a General Comment about the right of children under article 12 to have their views heard. This Comment makes the following observations in relation to the application of this right in health care:[92]

> *The Committee welcomes the introduction in some countries of a fixed age at which the right to consent transfers to the child, and encourages States parties to give consideration to the introduction of such legislation. Thus, children above that age have an entitlement to give consent without the requirement for any individual professional assessment of capacity after consultation with an independent and competent expert. However, the Committee strongly recommends that States parties ensure that, where a younger child can demonstrate capacity to express an informed view on her or his treatment, this view is given due weight.*

94. Great weight should be given to a child's views where a Court determines that he or she is able to understand fully what is proposed. If a child has this level of understanding, then he or she should ordinarily be able to consent to medical treatment for a recognised condition that is provided in accordance with treatment guidelines recommended by a relevant treatment authority.

95. If a young person satisfies the *Gillick* test for competence, requests Stage 2 medical treatment for transsexualism, and the treatment is supported by his or her parents and treating medical practitioners, then the Court should find that authorisation by the Court for this treatment is not required.

Whether authorisation for Stage 2 is otherwise required

96. The Commission submits that, based on the evidence available in this appeal, the Court should not depart from the view in previous cases that Stage 2

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91 Committee on the Rights of the Child, *General Comment No. 4 (2003)*, "Adolescent health and development in the context of the Convention on the Rights of the Child", CRC/GC/2003/4 at [8].

92 Committee on the Rights of the Child, *General Comment No. 12 (2009)*, "The right of the child to be heard", CRC/GC/12 at [102].

treatment for transsexualism is a special medical procedure which it is beyond the power of parents to authorise.

97. An application for authorisation should be made to the Court in each case to confirm whether the young person is able to understand fully what is proposed.

98. If the Court finds that the young person is not *Gillick* competent, then in accordance with s 67ZC(2) it should make an assessment about whether to authorise Stage 2, having regard to the best interests of the young person as the paramount consideration. In making this assessment, the Court should give significant weight to views of the young person in accordance with his or her age and maturity.

99. Section 61C of the Family Law Act recognises that each of the parents of a child who is not 18 has parental responsibility for the child, meaning all the duties, powers, responsibilities and authority which, by law, parents have in relation to children. An issue raised in 'special medical procedure' cases is the extent to which the decision to authorise a medical procedure falls within the scope of parental authority. In making this assessment, the Commission submits that it is important to bear in mind the responsibilities of parents recognised in the CRC.

100. In ratifying the CRC, Australia has agreed that it will respect the responsibilities, rights and duties of parents to provide appropriate direction and guidance to their children in the exercise by the children of their rights, in a manner consistent with the evolving capacities of the child.[93] Parents have the primary responsibility for the upbringing and development of children, and in exercising this responsibility the best interests of their children will be their basic concern.[94] Where children are unable to make decisions about particular issues themselves, parents have a special responsibility to provide direction and guidance to assist them so that their rights are exercised in a way that promotes their best interests.

101. The role of parents is not absolute, and it is conditional on the exercise of parental responsibility being carried out in a manner that promotes the child's best interests. The overriding criterion of the child's best interests is a limit on parental power.[95] Further, the responsibility of parents will give way to the rights of the child to express his or her own views and have those views given due weight as the child gains maturity with age.[96]

102. Some aspects of Stage 2 treatment are irreversible, and making an incorrect decision about whether or not to administer this treatment involves grave consequences. Under the test in *Marion's case*, for children who are not *Gillick* competent, authorisation will therefore be required if there is significant risk of making the wrong decision, either as to the child's present or future capacity to consent or about the best interests of a child who cannot consent.

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93 CRC Article 5. The language used in the CRC is not limited to parents, and recognises that in some circumstances these responsibilities will also fall on other legal guardians.

94 CRC Article 18(1).

95 *Marion's case* at 240 (Mason CJ, Dawson, Toohey and Gaudron JJ).

96 CRC Articles 14(2) and 12(1).

Future capacity to consent

103. The first part of this test is whether there is a significant risk of making the wrong decision about the future capacity of a child who is not *Gillick* competent to consent to treatment. Essentially, this requires consideration of whether there is a significant risk that a child currently requesting Stage 2 treatment would not do so in the future when he or she became *Gillick* competent.

104. This situation is different from circumstances where sterilization is proposed for an intellectually disabled child. In those circumstances, there are strong grounds for considering that if a child is currently unable to make a decision about sterilization, but may acquire that capacity in the future, then sterilization should not be performed. In any event, all alternatives to sterilization should be fully explored.

105. In cases such as the present, the initial impetus for treatment for transsexualism is likely to have come from the child him or herself.

106. Some young people involved in reported cases involving treatment for transsexualism have conducted extensive research into their condition. For example in *Re O* one expert referred to *"the enormous amount of research O has done in respect of what options are available to him"*.[97] In *Re Rosie* the Court noted that *"Rosie not only agrees to the treatment, but she has researched it and is ardently seeking it"*.[98]

107. It appears that a concern may be that the child may not be fully informed and may later change his or her mind. In the present proceeding, Dr C a child psychiatrist was asked about the chances of a child changing his or her mind between Phase 1 and Phase 2 treatment. The primary judge's reasons note:[99]

> *Dr C emphasised that the cause of a typical gender identity disorder is not known. He said it is understood that many of the children who present early in childhood with atypical gender identity development do not progress in adulthood to an ongoing transsexual identity. He continued, however, that there is increasing research indicating that those children with early-onset gender identity disorder, whose cross-gender identity remains "fixed and persistent" through early childhood, puberty, and into adolescence, are more likely to progress to becoming on-going adult transsexuals.*

108. The trial judge referred to expert evidence to the effect that there was no research evidence to demonstrate that behavioural and psychological therapies cause a child to change their experience of their own gender identity.[100]

109. In cross-examination, [Dr C] and [Dr G] gave evidence that while a minority of pre-pubertal children with gender identity disorder go on to become adult transsexuals, when gender identity disorder has persisted from a young age

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97 *Re O* [2010] FamCA 1153 at [81].

98 *Re: Rosie (Special Medical Procedure)* [2011] FamCA 63 at [93].

99 J[125], AB 64. See second report of [Dr C] p 4, AB 280.

100 J[87], AB 52.

until puberty there is a very low rate of people changing their mind about treatment.[101]

110. This view is supported by some of the medical literature annexed to the affidavit of [Dr C] sworn 23 December 2010.[102]

111. However, the kind of treatment proposed in this case is still relatively new. It is difficult to draw general conclusions about future regret rates in the absence of larger studies over a longer period of time. Perhaps unsurprisingly given the way in which this case was conducted at first instance, there do not appear to be any such studies in evidence.

112. Although the material currently before the Court shows that in a number of particular examples the risk of future regret was assessed as being low, this may not be generally representative and may in any event still be a "significant risk". It does not appear to be sufficient to avoid the requirement for a case by case assessment of the individual circumstances of each young person seeking treatment.

Other issues relevant to a 'best interests' analysis

113. The second part of the test from *Marion's case* referred to above is whether there is a significant risk of making the wrong decision about the best interests of a child who cannot consent to treatment.

114. An assessment about the best interests of a child would need to take into account the future risks involved if the treatment is carried out, along with the risks if the treatment is not carried out.

115. In *Re Bernadette*, the Commission considered that Stage 2 treatment may require authorisation given that there were a number of uncertainties about the long term effects of the proposed treatment and there was limited professional experience in Australia in providing treatment. Those submissions were made in January 2008.

116. There is now some increased professional experience in Australia in providing treatment to children with transsexualism, as is apparent from the decided cases since then. Since the decision in *Re Bernadette*, the US Endocrine Society has published guidelines for the treatment of transsexualism which are now used by medical professionals in Australia.

117. Although it appears that there is now a consensus opinion on the proper course of treatment for children diagnosed with transsexualism, it is a recent consensus. There are still uncertainties about the long term effects of treatment. It is possible that the recommended course of treatment may change once more evidence is available. In the absence of evidence such as longitudinal studies of the effects of this treatment, the Commission considers

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101 [Dr C] XXN T27.21-44, AB 314; [Dr G] XXN T36.11-28, AB 323.

102 Delmarre-van de Waal and Cohen-Kettenis, "Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects" (2006) 155 *European Journal of Endocrinology* S131 at S135 ("At present, 54 patients are being treated according to this protocol") AB 160, and S136 ("However, until now, none of the patients who were selected for pubertal suppression has decided to stop taking GnRHa") AB 161. See also US Guidelines p 3138 (section *1.2 Evidence*) AB 169.

that it is too soon to say that Court authorisation for this kind of treatment is not required.

Date: 22 February 2012

Australian Human Rights Commission