Authorisation for gender dysphoria treatment for transgender children in Australia

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This topic has been of controversy for some years. Prior to 2017 stage 2 treatment always had to be court approved. The court was then the subject of constant criticism about delays, costs and the imposition on the resources of treating psychiatrists, psychologists and paediatricians, who complained regularly about the burden imposed on them in having to write reports to the court, in addition to their practice requirements.

Matters came to a head in 2017. In 2017 a specially constituted five-member court of the Family Court of Australia determined the case of *Re Kelvin* [2017] FamCAFC 258[2]. It was a case arising from an application by the father concerning the administration of stage 2 medical treatment for gender dysphoria for his then 16-year-old child Kelvin. In essence, the question stated for the opinion of the Full Court concerned the effect of the Full Court's decision in *Re Jamie* [2013] FamCAFC 110 and the role of the Family Court more generally in relation to stage 2 medical treatment for gender dysphoria and the determination of Gillick competence.

The Court set out in its judgment as to what was gender dysphoria, as defined in DSM-5, treatment guidelines for the care of transgender diverse children at adolescence, in accordance with the WPATH Standards of Care, Version 7 (2011) and the Endocrine Society Treatment Guidelines (2009).

At the time of the judgment, it was expected that Australia's specific guidelines for the standards of care and treatment for transgender and gender diverse children at adolescence were expected to be available shortly, but they had not been published at the time of judgment. The Court went on to say:

> *"Best practice medical treatment for Gender Dysphoria is often following a comprehensive multidisciplinary assessment. The multidisciplinary treating team may include clinicians with the experience of the disciplines of child and adult psychiatry, paediatrics, adolescent medicine, paediatric endocrinology, clinical psychologist, gynaecology, andrology, fertility counselling and services, speech therapy, general*

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[2] http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/FamCAFC/2017/258.html

practice and nursing. These treating professionals need to agree on the proposed treatment plan before it can be implemented. Medical treatment is only commenced after physical examination and blood tests confirm that the adolescent has entered into puberty. Best medical practice is that the adolescent and their parents/guardians must provide informed consent.

The existing Medicare legal structure for stage 1, stage 2 and stage 3 treatment in Australia requires at least one psychiatrist or a clinical psychologist to confirm a diagnosis of Gender Dysphoria in Adolescence prior to medical intervention.

Stage 1 treatment is "puberty blocking treatment" and the effects of this treatment are reversible when used for a limited time for approximately three to four years. Gonadotrophin releasing hormone analogue (GnRHa) are used for stage 1 treatment and are administered via injection with the aim of reducing the psychological distress associated with development and progression of the unwanted, irreversible changes of the adolescent's endogenous (biological) puberty. It also allows the adolescent time to mature emotionally and cognitively such that they can achieve maturity sufficient to provide informed consent for stage 2 treatment. Stage 1 treatment is ideally commenced in the early stages of puberty (known as Tanner Stage 2) which can occur from the age of approximately nine to 12 years of age.

Stage 2 Treatment or "gender affirming hormone treatment" involves the use of either estrogen to feminise the body in those who have a female gender identity or use of testosterone to masculinise the body in those who are male gender identity. This treatment is ideally commenced at an age where the adolescent is sufficient mature to be able to provide informed consent given the irreversible nature of some of the effects of estrogen and testosterone.

The irreversible physiological effects of estrogen are breast growth and decreased sperm production, and partially irreversible effects are decreased testicular volume and decreased terminal hair growth. The irreversible physiological effects of testosterone are facial and body hair growth, scalp hair loss, clitoral enlargement, vaginal atrophy and deepening of voice.

Stage 2 treatment for Gender Dysphoria may, but does not necessarily, cause long term infertility. For individuals who are assigned male at birth, estrogen treatment may render the adolescent infertile over time. However, options are explored with the

adolescent regarding their future ability to have biological children prior to the commencement of estrogen use including preserving their fertility using sperm preservation procedures prior to the commencement of estrogen use.

So that it is clear, stage 2 treatment does not include stage 3 treatment which treatment involves surgical interventions. Those interventions include:

Chest reconstructive surgery	*Hysterectomy*
Phalloplasty	*Creation of a Neovagina*
Bilateral Salpingectomy	*Vaginoplasty*

Failure to provide gender affirming hormones results in the development of irreversible physical changes of one's biological sex during puberty or the development of changes that lead to the need for otherwise avoidable surgical intervention such as chest reconstruction in transgender males or facial feminisation surgery in transgender females.

The prolonged use of puberty blockers (stage 1 treatment) has long term complications for bone density (osteopenia) namely osteoporosis and bone fractures in adulthood. Best practice is to limit the time an adolescent is on puberty blockers and then commence estrogen or testosterone. Delaying stage 2 treatment for those on puberty blockers also results in psychological and social complications of going through secondary school in a pubertal state which is inconsistent with the child's peers.

The distress caused by Gender Dysphoria can lead to anxiety, depression, self-harm and attempted suicide.

Individuals with Gender Dysphoria who commence sex hormone therapy generally report improvements in psychological wellbeing. An affirmation of their gender identity coupled with improvements in mood and anxiety levels typically results in improved social outcomes in both personal and work lives.

For a transgender male, manifestations of increased body hair and deepening of the voice are generally considered by them as positive.

For transgender females if stage 2 is not administered another risk is linear growth beyond their expected final height.

Some patients receiving treatment for Gender Dysphoria have reported purchasing hormones over the internet or illegally obtaining hormones through prescriptions written for other people. They have also reported that estrogen and testosterone are cheap and freely available over the internet or through friends or acquaintances. Accessing hormones in this way is dangerous for several reasons including the risks of complications from blood born viruses such as Hepatitis B, Hepatitis C and HIV contractible with shared use of needles and syringes and the taking of inappropriate dosages of hormones which can be life threatening."

Kelvin had experienced all aspects of the DSM-5 diagnostic criteria for Gender Dysphoria since he was 9. In April 2014 when he was in year 8, Kelvin transitioned socially as a transgender person. Throughout 2015, Kelvin attended upon doctors for referrals for his general health and wellbeing. In April 2015, Kelvin commenced being named by his preferred name at school. In that same month he attended upon a psychologist and continued to do so for 10 sessions. In June 2015, Kelvin attended upon an endocrinologist. He attended a further appointment with his doctor in August 2016. In October 2015, Kelvin commenced attending upon an accredited counsellor mental health social worker. In July 2016, Kelvin attended upon a psychiatrist. In July and August 2016, Kelvin attended upon a psychologist.

Kelvin's history of Gender Dysphoria has resulted in significant problems with anxiety and depression including self-harming for which he has been prescribed medication. His mental health improved since taking steps towards a medical transition. Kelvin had not undergone stage 1 treatment and as a consequence has experienced female puberty which has caused him significant distress. Stage 2 treatment is necessary for his ongoing psychological health and wellbeing. Although they were separated, both Kelvin's parents supported him commencing stage 2. Kelvin was 17 and wished to commence stage 2.

The Court noted that between 2013 and 2017 it dealt with 63 cases involving applications of either stage 2 or stage 3 treatment. In 62 of those cases the outcome allowed treatment. The most common outcomes were:

(a) declaring a child Gillick competent to consent (26);

(b) finding that the child is Gillick competent to consent (22);

(c) finding Gillick competence and making a declaration (7).

In the one case where an application was dismissed the child was 17 years and 11 months at the time of the hearing. The application was not supported by evidence that would allow the Court to make a positive finding that the child was Gillick competent. Of course, within a month, the child would have achieved majority, and then had the ability to authorise treatment.

In 39 of the 63 cases the date of filing of the initiating application was recorded in the judgment and on average took 26 days.

A study undertaken in 2016 found the average delay for families was 8 months from the time the process commenced until the adolescent commenced treatment. The Court costs over 12 families varied between $8,000 and $30,000.

The Royal Children's Hospital Gender Service in Victoria had since its commencement in 2003 received 710 patient referrals including 126 between 1 January and 7 August 2017. 96% of all those patients received a diagnosis of Gender Dysphoria and continued to identify as transgender or gender diverse into late adolescence. No patient who had commenced stage 2 treatment had sought to transition back to their birth assigned sex. No longitudinal study is yet available.

The Court came to the conclusion that Court approval is not required for stage 2 treatment where the child is Gillick competent and there is no dispute.

The Court said:

> *"**We think it important to emphasise that the Court in this case is concerned to examine, within the confines of the questions stated, whether there is any role for the Family Court in cases where there is no dispute between parents of a child who has been diagnosed with Gender Dysphoria, and where there is also no dispute between the parents and the medical experts who propose the child undertake treatment for that dysphoria.** To paraphrase counsel for the Royal Children's Hospital, the question is why should the family of a child in one wing of the Hospital be forced to come to court before recommended medical treatment commences when the family of a child in another wing of the Hospital is not required to do so, in circumstances where both forms of treatment carry a significant risk of making the wrong decision as to a child's capacity to consent and with both forms of treatment the consequences of a wrong decision are particularly grave."*

What happens if there is a dispute between the parents or the child is determined not to be Gillick competent?

Re Imogen (No 6) [2020]

In *Re Imogen (No 6)* [2020] FamCA 761, a decision from September last year, where at trial Imogen was 16 years and 8 months, the issues facing Watts J were these[3]:

> *"This case raises the following questions about the current law for children and adolescents presenting with Gender Dysphoria, when there is a dispute about consent or treatment:*
>
> - *Is an application to the Court mandatory?*
> - *Whether mandatory or not, once an application is made and if Imogen is found to be Gillick competent, can she make her own decisions about her treatment?*
> - *If so, what order, if any, should be made in respect of the issue of Gillick competence?*
> - *If Imogen's consent is not sufficient and the Court is required to make an order that is in Imogen's best interests, should that order grant Imogen "parental responsibility" to make her own decision or should an order authorising treatment be made?"*

It didn't help that the father, Independent Children's Lawyer and the Commonwealth on the one hand and the mother and the Australian Human Rights Commission on the other submitted diametrically opposed arguments as to the current state of the law.

Watts J stated[4]:

> *"Expert evidence was given about the efficacy of Imogen's proposed treatment. In what is currently the orthodox middle, Imogen's treating medical practitioners follow The Australian Standards of Care and Treatment Guidelines: For trans and gender diverse children and adolescents ("the Australian Standards") which adopts a multi-disciplinary approach to treatment using gender affirming hormones. Advocating a more conservative approach, Dr D'Angelo the mother's adversarial expert psychiatrist suggests that psychotherapy rather than medication should be the preferred method of treatment of Gender Dysphoria. Relevant to these competing approaches, a body of research was adduced in evidence and explored in cross examination. Adopting a less conservative approach, reference was made to the "Informed Consent Model" made available through general practitioners who are willing to prescribe gender affirming hormone treatment to 16- and 17-year-old adolescents without knowing whether their parents or legal guardians dispute whether that treatment should be prescribed.*
> *Whilst this case is heard in the context of an emerging debate about the diagnosis and treatment of Gender Dysphoria, the outcome is focused upon an assessment of Imogen's particular circumstances."*

The father sought that he alone could decide treatment, or that the court could authorise treatment. The mother initially opposed both stage 1 and 2 treatment, but at trial she neither consented nor opposed stage 2 treatment. It remained her case that she did not consent to

[3] At [2].
[4] At [4].

Imogen having stage 2 treatment for a condition which she asserted that Imogen did not have but no longer sought any mandatory injunction to stop and/or prevent that treatment.

Further[5]:

> *"At the commencement of the final hearing the mother sought an order that the father do all necessary things to facilitate Imogen attending appointments with a psychologist/ psychiatrist who specialises in treating adolescents with "Complex Post-Traumatic Stress Disorder" for the purposes of psychotherapy. The mother renewed this application at the commencement of final submissions and at no time withdrew this application. The ICL opposed that application.*
>
> *"At the commencement of final submissions, the mother also sought liberty to provide the L Centre Back to school program and any mental health professional Imogen consults with a copy of the mother's expert's report. During submissions the parents agreed what could be provided was all of the expert affidavits filed in the proceedings. That order was opposed by the ICL. All of the parties agreed that a copy of these reasons for judgment was to be provided."*

The Independent Children's Lawyer sought that the Court authorise stage 2 treatment.

Watts J then helpfully set out what is gender dysphoria and what the Australian Standards say[6]:

> *"Gender Dysphoria is a term that describes the distress experienced by a person due to incongruence between their gender identity and their gender assigned at birth. The description of Gender Dysphoria in the American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders: DSM-5 Fifth Edition ("DSM-5") at 302.85 is in two parts. Part A sets out six manifestations of marked incongruence, two of which must be present for at least six months. Part B requires the incongruence to be associated with clinically significant distress or impairment in social, occupational or other important areas of functioning (see also World Health Organization, ICD-10 Classification of Mental and Behavioural Disorders (ICD-10) at F64.2, a different diagnostic instrument).*
> *The Australian Standards provide (at page 11) that the optimal model of care for trans and gender diverse adolescents who present to services involves a coordinated, multidiscipline team approach. This may include clinicians with experience in the disciplines of child and adolescent psychiatry, paediatrics, adolescent medicine, paediatric endocrinology, clinical psychology, gynaecology, andrology, fertility services, speech therapy, general practice and nursing.*
>
> *The Australian Standards (at page 15) describe stage 1 treatment as 'puberty suppression' which typically relieves distress for trans adolescents by halting progression of physical changes such as breast growth in trans males and voice deepening in trans females. In Australia, gonadotrophin releasing hormone analogues (GnRHa) are available in subcutaneous and intramuscular injectable preparations. Citing a 2017 paper[2], the Australian Standards claim that the effects of puberty suppression is reversible whilst acknowledging both that the main concern*

[5] At [9] and [10].
[6] At [22]-[27].

relates to the impact upon bone mineral density and that the long term impact on bone mineralisation is currently unknown.

The Australian Standards (at page 16 and following) describe stage 2 treatment as gender affirming hormone treatment using oestrogen and testosterone and notes some of the effects of this medication are irreversible (such as breast growth), whilst others are unknown (such as decreased sperm production).

The Australian Standards (at page 25) provide guidelines for surgical interventions for trans and gender diverse adolescents (also referred as stage 3 treatment).

In its guidelines to health professionals, the Australian Standards make an incorrect assertion about the current state of the law. At page 7, the Australian Standards state, "current law allows adolescent's clinicians to determine their capacity to provide informed consent for treatment. Court authorisation prior to commencement of hormone treatment is no longer required". Again, whilst the guidelines say that informed consent from parents/legal guardians should be obtained in relation to puberty suppression (at page 23) and surgical interventions (at page 25), in relation to the commencement of gender affirming hormone treatment the Australian Standards say (at page 24) "…although obtaining consent from parents/guardians for commencement of hormone treatment is ideal, parental consent is not required when the adolescent is considered to be competent to provide informed consent". The effect of the submissions of the Attorney General (and the applications of the ICL and the father) is that the Australian Standards incorrectly state the current law in relation to the need for the consent of parents/guardians to stage 2 treatment. As I shall discuss, the statements in the Australian Standards do not accurately reflect current Full Court authority which binds me, in circumstances where there is a dispute about treatment."

Watts J then set out the current state of the law[7]:

"I conclude:

a. If a parent or a medical practitioner of an adolescent disputes;

i. The Gillick competence of an adolescent; or

ii. A diagnosis of gender dysphoria; and

iii. Proposed treatment for gender dysphoria.

an application to this Court is mandatory.

*b. Whether mandatory or not, once an application is made, the court should make a finding about Gillick competence of an adolescent. If the **only** dispute is as to Gillick competence, the court should determine that dispute by way of a declaration, pursuant to s 34(1) of the Act, as to whether or not the adolescent is Gillick competent, without the need to make a determination based upon best*

[7] At [35].

interest considerations. If a declaration of Gillick competence is made, then that is determinative of the only dispute before the court and the adolescent is left to determine their treatment without court authorisation;

c. *Notwithstanding a finding of Gillick competence, if there is a dispute about diagnosis or treatment, the court should;*

   i. *Determine the diagnosis;*

   ii. *Determine whether treatment is appropriate, having regard to the adolescent's best interests as the paramount consideration; and*

   iii. *Make an order authorising or not authorising treatment pursuant to s 67ZC of the Act on best interest considerations.*

d. *If a parent or legal guardian does not consent to an adolescent's treatment for gender dysphoria, a medical practitioner, who is willing to do so, should not administer treatment to an adolescent who wishes it, without court authorisation."*

His Honour accepted the Commonwealth's position, based on medical practice:

"As the Attorney-General points out, there is a basis in proper medical practice for requiring an application to the court if a dispute cannot otherwise be resolved:

a. *Without such a determination, a medical practitioner may run the risk of being criminally or civilly liable in the event that, notwithstanding the practitioner's assessment that the child is Gillick competent, that is not in fact the case. That risk may be heightened in circumstances where there is a dispute between the parents as to the appropriate treatment, and one of the parents does not consent to the treatment.*

b. *Without such a determination, a medical practitioner may run the risk of effectively giving preference to one parent's view over that of the other in circumstances where, if the child is not Gillick competent, each parent with parental responsibility has power to consent (or not consent) on behalf of the child (s 61C of the Act). If parents disagree, it is invidious for medical practitioners to be required to give preference to the views of one parent rather than the other."*

How should a dispute only about Gillick competence be determined?

His Honour stated[8]:

"That determination is based upon factual findings and can be undertaken without recourse to the *parents patriae* jurisdiction and without regard to best interest principles if a declaration is made …. In the context of this contested case, had a finding of *Gillick* competence been sufficient for me to put my pen down, I would have made that declaration without reference to best interest principles."

[8] At [43].

Why is the finding of Gillick competence of an adolescent not determinative, if parents do not agree about treatment?

His Honour concluded that when there is a dispute about treatment when the child is Gillick competent, the Court should determine treatment and[9]:

> *"In doing so the court should have regard to the best interests of the child as the paramount consideration and give significant weight to Imogen's views in accordance with her maturity and level of understanding."*

Should a medical practitioner administer stage 2 treatment without parental consent or alternatively court authorisation?

Watts J concluded[10]:

> *"This judgment confirms the existing law is that any treating medical practitioner seeing an adolescent under the age of 18 is not at liberty to initiate stage 1, 2 or 3 treatment without first ascertaining whether or not a child's parents or legal guardians consent to the proposed treatment. Absent any dispute by the child, the parents and the medical practitioner, it is a matter of the medical professional bodies to regulate what standards should apply to medical treatment. If there is a dispute about consent or treatment, a doctor should not administer stage 1, 2 or 3 treatment without court authorisation."*

Watts J helpfully then set out the current research into the diagnosis and treatment of gender dysphoria:

"

137. *Relevant to the issues raised by the experts in this case, are their different views about the state of the current research into the diagnosis and treatment of Gender Dysphoria.*

138. *As indicated, a significant volume of recent research was adduced in evidence and additionally many publications and writings were referred to in footnotes to the written evidence given by Dr D'Angelo and Associate Professor Winter. Research literature in transgender health has expanded rapidly in the last decade and particularly since Re Kelvin was decided. For example, Associate Professor Winter states that his search for "transgender" and "health" yielded 5,681 results with 1,135 of them being published in 2019 compared to 94 in 2009.*

139. *Some of the issues raised by a review of the research by Dr D'Angelo and Associate Professor Winter are:*

    - *Why has there been an exponential rise in gender dysphoria cases in the past decade?*

[9] At [59].
[10] At [63].

- *Why has there been a surge in adolescent transgender identification without a reported history of childhood gender-nonconforming behaviours?*
- *What is the research base for the gender-affirmative care model?*
- *What is the state of the research in respect of later regret and de-transitioning?*

Rise in cases

140. *The experts in this case agree that there has been an exponential rise in adolescent referral to gender clinics in the last decade.*

141. *Dr D'Angelo opines there is "concern that the current surge in adolescent transgender identification represents a new manifestation of maladaptive coping with various developmental issues, exacerbated by underlying mental health comorbidities" and a "degree [of] social contagion".*

142. *Associate Professor Winter opines that the rise in referrals may be largely due to developments in society and in medicine, leading to greater awareness and understanding, and lessening of stigma associated with gender issues and of trans identity. An additional factor of note in his view is the increased availability of appropriate and accessible services. Furthermore, he believes adolescents may be able to exert greater agency than children in securing a referral and this may go some way to accounting for the more dramatic rise in referral numbers for adolescents.*

143. *Associate Professor Winter also opines that there is a co-occurrence in several gender dysphoria cases with Autism Spectrum Disorder which itself is an increasingly prevalent diagnosis, consequently providing a pathway to gender clinic referral.*

Lack of reported childhood history

144. *Dr D'Angelo identifies a recent study by Littman[3] which claimed to identify "Rapid Onset Gender Dysphoria" ("ROGD"):*

A recent study suggests that transgender ideation in this new cohort can manifest after intense online exposure to transgender topics, and that often groups of friends come out as trans simultaneously.[4]

145. *Dr D'Angelo says that this descriptive study raises the concern that the sudden surge in adolescent transgender identification represents a new manifestation of maladaptive coping with various developmental issues, exacerbated by underlying mental health comorbidity and that some have also raised concerns about the degree to which social contagion is involved. Dr D'Angelo asserts that the study concludes that much additional research is needed.*

146. *Associate Professor Winter comments upon the Littman study and refers to a paper by Restar (2020)[5] which makes a number of criticisms of the Littman study. Associate Professor Winter finds the most compelling criticisms to be firstly*

the way parents were recruited for the study, namely, through websites prominent for their critical stance towards contemporary transition health care, as practised with adolescents; secondly the failure of the author to share potentially important findings and thirdly, the fact that there is no attempt whatsoever to collect any data from the adolescents themselves. Associate Professor Winter cautions against interpreting Littman's results and opines that puberty (and the physical transformations it brings), changes in gender demands of school and home, increased knowledge, understanding and self-reflection and other factors more commonly play a part in promoting late onset trans youth to access services. Both the World Professional Association for Transgender Health ("WPATH") and the Australian Professional Association for Trans Health ("AusPATH") have released statements urging caution regarding the research on ROGD.

147. *Associate Professor Winter opines that what Littman refers to as "rapid onset gender dysphoria" is not actually all that rapid. He opines that "the absence of a documented history does not inevitably mean absence of earlier gender incongruence or dysphoria". He then extracts the following statement from WPATH SOC-7[6]:*

    ... many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender-nonconforming behaviours [sic]...Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

148. *Associate Professor Winter also observes:*

The gender issues may indeed develop with the approach or arrival of adolescence. But in some cases, a sense of gender unease or uncertainty, a feeling of not fitting in, or indeed discomfort and distress, may have been present for some time. The young person may have lacked an awareness or language to enable them to pinpoint what they face. They may have been hiding their emerging sense of self for years, for fear of negative reaction from others, including peer and family rejection, bullying, harassment and stigmatisation. They may have even overcompensated, throwing themselves into activities that are stereotypically masculine or feminine, in each case in line with the sex assigned at birth. They may even come into contact with health professionals on account of other issues, such as poor peer relationships, social anxiety or difficult behaviour. The professionals concerned may fail to ascertain the role gender issues might play in the young person's circumstances.

Research base for gender-affirmative care model

149. *Imogen seeks to embrace the gender-affirmative care model. This is a model promoted both in Australia and worldwide.*

150. *Associate Professor Winter records that in Australia, AusPATH is the peak national organisation actively promoting communication and collaboration amongst professionals across all disciplines engaged in health care, rights and wellbeing of trans people. He opines that its membership represents a substantial*

percentage of those working on a daily basis in health care with trans individuals in Australia. AusPATH has published the Australian Standards, Worldwide, the corresponding organisation is WPATH. WPATH publishes the Standards of Care for the Health of Transexual, Transgender and Gender-Nonconforming People, now in version 7 (Soc-7),[7] enclosed as annexure H to Associate Professor Winter's affidavit. Both offer detailed guidelines for clinicians; the former runs to 51 pages; the latter to 67 pages. The organisations are independent of one another.

151. *Dr D'Angelo asserts that the gender affirming treatment model is based on the "Dutch protocol" described in de Vries et al.[8]. Dr D'Angelo criticises the small sample size, the strict inclusion criteria limit, the lack of assessment of physical health outcomes, the lack of any longitudinal aspect to the study and the lack of a control group. Associate Professor Winter concedes that the current Australian model supports social transition to an extent that was not a feature of the 'Dutch protocol'.[9]*

152. *Dr D'Angelo expresses concern about the lack of adequate study into the physical and psychological long-term effects of hormonal and surgical interventions. Dr D'Angelo points to one 2019 study[10] showing more than three times the incidence of venous thromboembolism for biological males.*

153. *Whilst Associate Professor Winter acknowledges that the research base is small, he notes a growing body of evidence on the effects of transition healthcare. He refers to a report by Cornell University in which 55 individual studies were reviewed with 51 reporting "gender transition improves overall well-being of transgender people"[11]. The report concluded that "the greater the availability of medical and social support for gender transition contributes to better quality of life for those who identify as transgender".*

154. *Both the Australian Standards and Associate Professor Winter acknowledge that further research is warranted into the long-term outcomes of current treatments under the gender affirmative model. Whilst the Australian standards assert that they are based upon available empirical evidence and clinical consensus there is also an acknowledgement on page 1 that not only is future research warranted, but it is also likely to influence future recommendations.*

155. *Dr D'Angelo challenged the notion, promoted by those who have developed the Australian Standards, that suicidality was reduced by treatment. Dr D'Angelo claimed that a Swedish study[12] showed that compared with aged-matched controls, there was a 19 times higher hazard rate of completed suicide after transgender surgery. Dr D'Angelo was challenged in relation to that claim during cross examination by the AHRC. I was satisfied that Dr D'Angelo had not properly analysed the table in the report upon which he based his claim.*

156. *Dr D'Angelo also raises the spectre of there being vested interests at play in the development of the WPATH standard of care, claiming that there are ties between the guideline authors (including paid consultancies) and pharmaceutical companies producing hormones. I am unable to place any weight on that speculation.*

Regret and de-transitioning

157. *Dr D'Angelo claims in his report at paragraph 80:*

It is generally asserted that the rate of regret following medical and surgical transition is extremely low, in the order of 2-3%. I have argued in a previous publication that this figure may in fact be substantially larger. Most adult follow-up studies have very large lost-to-follow up rates, in the order of 30% or more. This is very large when compared to the usual lost-to-follow up rates in most studies. Many have expressed concern that this 30% of patients may consist of people who regret their transition or who have had an adverse outcome.

158. *I accept Associate Professor Winter's evidence that there are many reasons why trans patients are lost to follow up including patients change their documentation, move locations, start a new life, and lose contact with social groups and family and that "one should be cautious in drawing conclusions about de-transitions from looking at lost-to-follow up figures".*

159. *The AHRC challenged Dr D'Angelo's **30%** lost to follow up claim. I reject Dr D'Angelo's original claim that the 30% loss to follow up may consist of people who regret their transition. Dr D'Angelo subsequently modified that claim to say that the studies with such a loss to follow up rate cannot be regarded as statistically valid.*

160. *Associate Professor Winter states that he is familiar with research on children who desist. There is a small group of studies which have suggested "desistance is the most common outcome for young trans children, and that it is a minority whose gender incongruence...goes beyond a phase persisting into adolescence or adulthood". Most of this research is through "follow up" methodology.*

The Royal Australian College of Physicians' letter of 5 March 2020

161. *In August 2019 the Federal Minister for Health wrote to The Royal Australian College of Physicians (RACP) seeking advice on the treatment of Gender Dysphoria in children and adolescents in Australia. The RACP responded on 5 March 2020.*

162. *In that response, the RACP noted that trans and gender diverse children and adolescents are a very vulnerable population, experiencing stigma and extremely high rates of depression, self-harm, attempted suicide and completed suicide. Importantly, the RACP described treatment for Gender Dysphoria as an emerging area of healthcare where existing evidence on health and wellbeing outcomes of clinical care is limited due to the relatively small number of studies, the small size of study populations, the absence of long-term follow up and the ethical challenges of robust evaluation when control (no treatment) is not acceptable. The College relevantly observes that similar limitations on the existing evidence of healthcare apply to other conditions which affect small segments of the population, such as rare cancers. The College expressed the view that addressing gaps in the evidence base is important, although notes that further scientific evidence may take a considerable period of time to produce.*

163. *In the meantime, the College supported the principles underlying the Australian Guidelines, and specifically the emphasis on the multidisciplinary approach to providing person-centred care which priorities the best interests, preferences and goals of the child or adolescent. The College recommends that treatment should be holistic, developmentally informed, child centred and individualised. In order to facilitate a higher level of informed consent, the College recommends that patients and families must be provided with information about the limitations of the available evidence regarding Gender Dysphoria and there should be informed discussion of the burdens and benefits of treatment and options in a way each child or adolescent can understand. The College points to differences across Australia in the access, funding and delivery of care and treatment for Gender Dysphoria. It recommends the development of a national framework for service provision and outcomes monitoring and believes that that is the best way to ensure consistency in the outcome of data collection across jurisdictions.*

164. *The College strongly advised the Australian Government against a suggestion that a national inquiry be undertaken into Gender Dysphoria on the basis that it would not increase scientific evidence available regarding Gender Dysphoria but would further harm vulnerable patients and their families through increased media and public attention."*

Was Imogen Gillick competent?

There was a dispute among the experts. Her treating psychiatrist considered that she was Gillick competent[11]:

"In Dr C's report of 16 December 2019, he assesses Imogen's Gillick competence under the following eight headings:

1. *Able to comprehend and retain both existing and new information regarding the proposed treatment;*

2. *Able to provide a full explanation, in terms appropriate to her level of maturity and education, of the nature of phase 2 treatment;*

3. *Able to describe the advantages of phase 2 treatment;*

4. *Able to describe the disadvantages of phase 2 treatment;*

5. *Able to weigh the advantages and disadvantages in the balance, and arrive at an informed decision about whether and when she should proceed with phase 2 treatment;*

6. *Able to understand that the decision to proceed with phase 2 treatment could have consequences that cannot be entirely foreseen at the time of the decision;*

[11] At [184].

7. *Able to understand that phase 2 treatment will not necessarily address all or any of the psychological and social difficulties that she had before the commencement of treatment; and*

8. *Being free to the greatest extent possible from temporary factors that could impair judgment in providing consent to the procedure."*

Grounds 1 to 7 were in accordance with Family Court authority. Ground 8 was additional.

The expert psychiatrist engaged by the mother formed the view that Imogen was not Gillick competent, stating[12]:

> *"There is an ongoing controversy about whether young people are able to fully understand the implications of the choices they are making, when they have not yet experienced adult relationships, sexuality and have been sheltered in the relatively protected world of home and school. Can a young person who has not had any sexual experiences consent to a procedure that will likely impair his capacity to experience sexual pleasure? Can a young person who has had no experiences of dating, intimacy or sexuality consent to a treatment that will forever alter the way he/she forms intimate relationships? Can young people, often in a state of distress, really understand what it will mean to be a trans person in our current community, with ongoing discrimination and negative public reaction? And can a young teen really know that having a child will always be of no importance to them even if it seems that way at the age of 14? Many young people present with a sense of urgency to undergo gender-affirming treatments because they are in such distress that they desperately want the treatment they believe will bring relief. Is this the appropriate state of mind for someone to calmly weigh all of the evidence and make a decision about what is best for them?"*

Watts J concluded that Imogen was Gillick competent[13]:

> *"Imogen is an adolescent of intelligence and maturity and has demonstrated a sophisticated ability to recognise that gender issues impact on all of the areas in which she is feeling distress, whilst recognising there are other issues also impacting upon her. She has demonstrated an ability to understand the information that she has been given in relation to proposed stage 2 treatment and to provide a full explanation of that understanding to her level of maturity and education. She has been able to describe the advantages and disadvantages of the treatment and I am satisfied has been able to weigh those in the balance. The decision that she herself has reached is an informed one. I am also satisfied that she understands that there are possible consequences that cannot be entirely foreseen. Further, Imogen understands that the proposed treatment is not a magic bullet for all her psychological and social difficulties. Her hope is that treatment will reduce her Gender Dysphoria to manageable levels. Finally, I am satisfied that Imogen is fully alert and orientated and not in physical pain or severe anxiety when expressing her opinions. She was not suffering from any hallucinations or delusional thoughts. There is no evidence she was using intoxicants.*

[12] At [189].
[13] At [198]-[199].

I conclude that Imogen was free to the greatest extent possible from any temporary factors that could impair her judgment when she provided her consent to stage 2 treatment. I find that she was Gillick competent to provide that consent."

Watts J then set out the views of the three psychiatric experts, the treating psychiatrist, Dr C, the mother's expert Dr D'Angelo and the Independent Children's Lawyer's expert, Professor Winter:

"Conclusions in relation to recommendations

224. Dr C's views are consistent with the current approach to treatment for Gender Dysphoria, currently accepted by most of the medical profession.

225. Dr C disagrees with Dr D'Angelo's approach that primarily addressing recollections and effects of past trauma or other conditions will resolve any or all of Imogen's conditions and problems, including Gender Dysphoria.

226. Associate Professor Winter opined, and I accept, that it is a risky and unproven strategy to opt for an approach of exclusively using psychotherapy to treat a patient for Gender Dysphoria (for say up to 12 months as proposed in this case by Dr D'Angelo) whilst suspending the administration of any gender affirming hormonal treatment.

227. I have some reservations about the basis and practicality of Dr D'Angelo's recommendations.

228. Firstly, they are based upon a diagnosis that Imogen does not have Gender Dysphoria which I have not accepted.

229. Secondly, it is based upon his opinion about the superficiality of Imogen's responses during interviews with him which in his view, indicated an absence of self-reflection. I do not accept all of Dr D'Angelo's conclusions about how Imogen presented to him.

230. Thirdly, Dr D'Angelo presents as an advocate for an alternative approach to the treatment of adolescents presenting with Gender Dysphoria. Consistently with that advocacy, Dr D'Angelo believes Imogen's lack of self-reflection is likely to be due to the fact that she has been treated within a gender-affirming paradigm, which has an explicit agenda to affirm the person's experienced gender identity. His general opinion is that deeper psychological exploration is not part of this paradigm."

His Honour concluded that treatment was in Imogen's best interests and then made an order authorising treatment.

When a parent has not consented

In *Re Declaration regarding medical treatment for "A"* [2020] QSC 389, a decision of the Supreme Court of Queensland, Lyons SJA had to consider on the last day of the year an urgent application in which there was no dispute about treatment (where the doctors all

agreed that stage 1 treatment was required) but that the consent of the father had not been obtained. His whereabouts were unknown.

His views were, however, known[14]:

> *"A" and her mother, the applicant, have been estranged from "A"'s father since May 2017, against a background of his illicit drug use and emotional, verbal and physical abuse towards both "A" and the applicant. He was at one stage forcibly removed from the family home by police and was previously the subject of a domestic violence order. He has an interstate criminal history including drugs and weapons offences. Since April 2017, the applicant has not spoken to "A"'s father or received any support from him or his family.*
>
> *The applicant and "A" moved to regional Queensland to escape "A"'s father and lived first in a shelter, then with friends and then subsequently in a rented home and currently in a housing commission unit. "A"'s father does not know their current whereabouts, and it would seem they do not know his. The evidence indicates "A"'s father was unsupportive of "A"'s desire to be female and has said threatening and demeaning things to both "A" and her mother in this regard."*

As is common in such cases, "A" had a diagnosis of autism spectrum disorder. Despite some disruption at school was a B student who was being home schooled.

Her Honour stated[15]:

> *"Accordingly, medical practitioners have concerns as to whether they can commence treatment which is urgently required without the specific consent of "A"'s father – hence this application to the court."*

Her Honour authorised treatment, finding[16]:

(a) "A" has a confirmed diagnosis of gender dysphoria. Dr B, a specialist psychiatrist in this area, has considered that "A" meets the criteria for that diagnosis under DMSV as does Dr C.
(b) What is proposed is Stage 1 treatment which is puberty blocking treatment which is therapeutic and reversible.
(c) "A" and her mother both consent to the treatment. "A"'s experienced multi-disciplinary team support the diagnosis of gender dysphoria.
(d) The proposed treatment is the national and international best practice and is in accordance with the current Guidelines.
(e) The applicant and the expert treating team all consider that it is in "A"'s best interests that treatment should occur without delay.
(f) Whilst Dr B considers "A" is Gillick competent, there is uncertainty as to whether that is endorsed by the entire treatment team.
(g) Contact details of the father are not known and he has not been in contact with the family since May 2017.

[14] At [9] and [10].
[15] At [36].
[16] At [37].

(h) There will be considerable delay in ascertaining the views of the father in relation to the proposed treatment; and
(i) Delaying treatment to seek and obtain "A"'s father's consent is not in the best interests of "A".

Her Honour opined that any further application for stage 2 treatment should be before the Family Court, which had the expertise, when the application would not be so urgent.

Stephen Page
20 January 2021