The role of the Family Court in the treatment of gender dysphoric adolescents

By Stephen Tully

In *Re: Imogen (No 6)* [2020] FamCA 761, a single judge of the Family Court of Australia (Watts J) considered an application by the father of an adolescent, Imogen, who wished to pursue gender affirmation treatment. The proposed treatment was objected to by Imogen's mother.

Background

Imogen, aged 16 and formerly known as Thomas, was diagnosed with gender dysphoria, which caused clinically significant distress and impaired social functioning due to a marked incongruence between her expressed/experienced gender identity and her gender assigned at birth (at [22], [182]). Two issues arose. First, whether in circumstances where one parent objected it was necessary for the Court's approval to be obtained before Imogen could obtain gender affirmation treatment. Second, whether Imogen was '*Gillick competent*', which means a child who is capable of giving informed consent, and which occurs when that child achieves a sufficient intelligence to enable them to fully understand what is proposed: *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 237 per Mason CJ, Dawson, Toohey and Gaudron JJ, following *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] UKHL 7.

Imogen was taking puberty suppression medication (stage 1) and, with her father's support, wished to move to gender affirming hormone treatment (stage 2). However, Imogen's mother, who did not consent to stage 2 and proposed alternative treatment, disputed Imogen's diagnosis and whether she was *Gillick* competent.

In *Re Jamie* [2013] FamCAFC 110, a Full Court determined that (i) stage 1 treatment was therapeutic but stage 2 treatment was not, given a significant risk of a wrong decision and its grave consequences; (ii) a *Gillick* competent child could consent to stage 1 treatment and if not, then the child's parents could consent, without court intervention; and (iii) a Court had to determine *Gillick* competence or otherwise authorise stage 2 treatment.

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The first and third of these conclusions were reversed in *Re Kelvin* [2017] FamCAFC 258. There, a Full Court determined that (i) stage 2 treatment was therapeutic and consent for it no longer lay outside parental authority; (ii) in order to proceed to stage 2 treatment, a court need not determine *Gillick* competence if the child, the parents and the medical practitioners so agreed; (iii) if all agreed, a *Gillick* competent child could consent to stage 2 treatment; and (iv) if a child was not *Gillick* competent but the treating medical practitioners agreed, a child's parents could consent to stage 2 treatment without court approval.

Re: Imogen considered the situation where there was a disagreement between the parents as to whether or not stage 2 treatment should be administered. Both the Australian Human Rights Commission and the Attorney-General of the Commonwealth intervened in the proceedings. Proceedings were heard in open court, although participants were limited to the parties and their lawyers and the court was inaccessible to the public and media: *Re: Imogen (No. 5)* [2020] FamCA 760.

Judgment

Watts J concluded (at [35], [200]) that it was mandatory to make an application to the Family Court when a parent or medical practitioner disputed an adolescent's *Gillick* competence, gender dysphoria diagnosis or proposed treatment for gender dysphoria. His Honour concluded that if the only dispute was as to *Gillick* competence, a court should determine that issue by way of a declaration under s 34(1) of the *Family Law Act 1975* (Cth) (the Act) without regard to best interest considerations, and the adolescent could determine their own treatment. Where diagnosis or treatment was disputed, his Honour held that a Court should determine those issues having regard to the adolescent's best interests as the paramount consideration and if appropriate authorise treatment. Treatment disputes were appropriately dealt with under s 67ZC of the Act, which empowers the court to make orders relating to the welfare of children by reference to the paramount consideration of the best interests of the child, because it eliminated the uncertainty for medical practitioners when providing future healthcare (at [238]). His Honour held that if a parent did not consent to treatment, medical practitioners should not treat an adolescent who wished it without court authorisation.

As an adolescent of sophisticated intelligence, Imogen was found to be *Gillick* competent to consent to stage 2 treatment (at [198]-[199]). Administering oestrogen was authorised as being in Imogen's best interests notwithstanding her mother's objections (at [231]).

Observations

The Australian Professional Association for Trans Health (AusPATH), Australia's peak body for professionals involved in transgender health care, has since called for legislation to 'correct' the judgment of *Re: Imogen* (see https://auspath.org/advocacy/). In the case of

absent or unsupportive parents, AusPATH questioned the need for time-consuming, expensive and public court processes. It argued that medical practitioners are unfairly burdened by the need to seek court approval to administer stage 2 treatment when an adolescent's parent or legal guardian objects. Although Imogen was competent to make her own treatment decisions, her consent was insufficient if a parent or guardian objected. AusPATH submitted that mature trans youth face increased risks of anxiety, depression, self-harm or suicidality by reason of delayed treatment and could self-medicate. Whether such legislation will be introduced remains to be seen.

The judgment confirms that medical practitioners examining adolescents under 18 years cannot initiate medical treatment without first ascertaining whether or not there is parental consent. But absent any dispute, medical professional bodies regulate what standards should apply to the treatment (at [63]). The 'Informed Consent Model', which enables gender affirming hormone treatment to 16 and 17 year old adolescents without knowing whether their parents or legal guardians dispute the prescription of that treatment, was found to be the consensus medical approach whereas it was accepted that purely psychotherapeutic approaches could unnecessarily delay gender affirmation treatment (at [224], [226]).

The judge defined the boundaries of curial intervention by reference to current Australian standards and research on transgender healthcare (at [4], [21], [23]-[27], [146], [150], [154]). The case recognises the recent exponential rise in adolescent referral to gender clinics. His Honour did not accept that Imogen was affected by any possible contagion effects as a result of social media (at [140], [197]). The authority will propel further consideration of the extent and desirability of judicial intervention in the treatment of gender dysphoric children and adolescents. BN