The commencement of hormone therapy for minors with gender dysphoria: a recent Queensland case

Health and Guardianship Law

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THE COMMENCEMENT OF HORMONE THERAPY FOR MINORS WITH GENDER DYSPHORIA: A RECENT QUEENSLAND CASE

Introduction

In the last 10 years the Family Court of Australia (Family Court) saw a rapid increase in the number of applications seeking approval for the commencement of Stage 1 and/or Stage 2 hormone treatment for children with Gender Dysphoria.[1] The number of applications each year decreased significantly due to the impact of the 2017 decision of the Full Court of the Family Court of Australia (Full Court) in *Re Kelvin*.[2] In this case, the Full Court determined that except in cases of "controversy", generally court approval is not required for the commencement of Stage 1 and/or Stage 2 treatment for Gender Dysphoria in minors, nor is an application necessary for the purpose to confirming the minor's capacity to make their own decision about treatment. Despite the outcome of this decision, there are some circumstances where court approval is still a requirement in such cases. Recent case law has considered the ongoing role of the court in relation to the decision to administer hormone treatment for Gender Dysphoria[3] and the post-*Kelvin* decisions in this field are relevant to clarifying when an application to court is required. An example of such a decision is the recent decision of the Supreme Court of Queensland concerning an application for approval to commence Stage 1 treatment for a minor with Gender Dysphoria.[4] This Queensland case is interesting because the significant body of case law that has developed in this field is Family Court jurisprudence rather than decisions of the State and Territory Supreme Courts. Recent case law considers the issue of when it is necessary to involve the court in decisions about hormone treatment for minors with Gender Dysphoria, despite the general approach adopted by the Full Court in *Re Kelvin*. A question also arises as to when an application to the Supreme Court may be appropriate rather than an application to the Family Court.

Gender Dysphoria is a serious condition where a child's subjectively felt identity and gender are not congruent with their biological sex, causing clinically significant distress or impairment in social functioning or other important areas of functioning. Treatment of Gender Dysphoria is typically given in two stages (stage three treatment may also be considered for some young persons). Stage 1 treatment involves the commencement of medication "which supresses the endogenous oestrogen and testosterone responsible for induction of secondary sexual characteristics".[5] In Australia gonadotrophin releasing hormone analogues (GnRHa) are typically administered to suppress puberty. Stage 1 treatment may be administered for the purpose of relieving distress "for trans adolescents by halting progression of physical changes such as breast growth in trans males and voice deepening in trans females" and is

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[1] For an overview of the number of cases and the purpose of the applications, see the comments made at [51] of the joint judgment of Thackray, Strickland and Murphy JJ in *Re Kelvin* (2017) 327 FLR 15; [2017] FamCAFC 258, who explain that between 31 July 2013 (the date that the Full Court handed down its decision in *Re Jamie* (2013) 278 FLR 155; [2013] FamCAFC 110) and 16 August 2017, the Family Court dealt with 63 applications concerning minors seeking authorisation for, or confirming the minor's competency to consent to stage two or three treatment for Gender Dysphoria (or gender identity disorder as previously termed): *Re Kelvin* (2017) 327 FLR 15, [51]; [2017] FamCAFC 258.

[2] *Re Kelvin* (2017) 327 FLR 15; [2017] FamCAFC 258.

[3] See, eg, *Re Imogen (No 6)* (2020) 61 Fam LR 344; [2020] FamCA 761.

[4] *Re A* [2020] QSC 389.

[5] Michelle Telfer et al, *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* (Version 1.3, The Royal Children's Hospital Melbourne, 2020) 15 <https://www.rch.org.au/uploadedFiles/Main/Content/adolescent-medicine/australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents.pdf>.

considered reversible in its effects.[6] Although other "linear growth and weight gain" continue while the young person is on these medications, a key purpose of Stage 1 treatment is to give the young person "time to develop emotionally and cognitively prior to making decisions on gender affirming hormone use which have some irreversible effects".[7] In relation to Stage 2 treatment, the *Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* explain:

> Gender affirming hormones oestrogen and testosterone are used to either feminise or masculinise a person's appearance by inducing onset of secondary sexual characteristics of the desired gender. Some of the effects of these medications are irreversible, whilst others have a degree of expected reversibility, that is likely, unlikely or unknown.[8]

The legal basis in the earlier case law for the requirement to refer decisions about hormone treatment for childhood Gender Dysphoria to the Family Court was underpinned by legal principles relevant to special medical procedures as set out by the High Court in *Secretary, Department of Health & Community Services v B* (*Marion's Case*).[9] An overview of these principles and how they were applied to some of the earlier case law relevant to Gender Dysphoria is outlined in my previous health and guardianship law column which examined the decision in *Re Jamie*.[10] In summary, *Re Jamie* decided in 2013 by the Full Court determined that court approval for the commencement of Stage 1 treatment was not necessary as this was a decision that fell within the parental power to consent. However, the Full Court also determined that decisions about Stage 2 treatment and/or whether a minor has the capacity to make their own decision about treatment should be referred to the Family Court. This position changed in 2017 when the Full Court decided *Re Kelvin*,[11] which established that court oversight is not generally required for either Stage 1 or Stage 2 treatment, except in cases of "controversy". A controversy might include where there is disagreement between the decision-makers and/or clinical team about whether treatment should commence, or dispute about the capacity of the minor to make the decision. Despite these legal developments, uncertainties remain about the legal basis for the Family Court's oversight of such cases, particularly as the majority judgment of the Full Court in *Re Kelvin* did not go as far as saying that the Full Court's earlier decision in *Re Jamie* was "plainly wrong" (although the minority judgment did form this view). Because of this, subsequent decisions have noted that elements of the Full Court's decision in *Re Jamie* remain as binding precedent.[12] The state of the current law raises a number of questions, including issues about how the underlying legal principles relevant to "special medical procedures" set out in *Marion's Case* continue to apply to decisions about commencing hormone treatment for Gender Dysphoria in children.[13]

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[6] Telfer et al, n 5, 15.

[7] Telfer et al, n 5, 15.

[8] Telfer et al, n 5, 16.

[9] *Secretary, Department of Health & Community Services v B* (1992) 175 CLR 218 (*Marion's Case*). See *Re Alex* (2004) 180 FLR 89; [2004] FamCA 297, which was the first key decision in this field where the principles from *Marion's Case* were applied in the context of the commencement of hormone treatment for a minor with Gender Dysphoria (or gender identity disorder as it was then named under the DSM-IV), and the two stages of treatment were regarded as a "special medical procedure".

[10] *Re Jamie* (2013) 278 FLR 155; [2013] FamCAFC 110, cited in M Smith, "Health and Guardianship Law. The Boundaries of Parental Decision-making and the Requirement to Obtain Court Approval for 'Special Medical Procedure': The Recent Decision of Re Jamie [2013] FamCAFC 110" (2013) 33(3) Qld Lawyer 182.

[11] *Re Kelvin* (2017) 327 FLR 15; [2017] FamCAFC 258.

[12] See the comments of Watts J in *Re Imogen (No 6)* (2020) 61 Fam LR 344; [2020] FamCA 761.

[13] Note that the history of the legal developments in the key cases relevant to Gender Dysphoria and the principles relevant to special medical procedures that determine whether court oversight is, or is not warranted, is not considered here. Explanation of the underlying legal principles and the inconsistencies in legal reasoning that have occurred in this body of case law would require significant discussion of key, underlying legal reasoning in the cases, which is beyond the remit of this column. For an overview of such issues, see the judgment of Ainslie-Wallace and Ryan JJ in *Re Kelvin* (2017) 327 FLR 15; [2017] FamCAFC 258, as well as: Felicity Bell, "Children with Gender Dysphoria and the Jurisdiction of the Family Court" (2015) 38(2) *UNSW Law Journal* 426.

A Recent Queensland Decision

In December 2020, the Supreme Court of Queensland determined an application relating to the commencement of Stage 1 treatment for Gender Dysphoria in respect of a 12-year-old child, "A".[14] The case is interesting in that it is a rare instance where an application has been made to the Supreme Court for a determination about commencing hormone treatment for Gender Dysphoria, rather than the Family Court.

Background to the Matter

The factual background to the application outlines that A, who was born male, was diagnosed with Autism Spectrum Disorder and that from the age of four she had declared "she was something other than her male gender and … she was a girl and not a boy, and had been born in the wrong body".[15] It is also explained that A had socially transitioned to female clothing and uses her chosen female name at school. Multidisciplinary care (from specialists in psychology, psychiatry and endocrinology) was provided to A and the treating team recommended Stage 1 treatment in the form of puberty blocking treatment. The application was brought to the Supreme Court because although A's mother supported A and agreed that the commencement of Stage 1 treatment was in her best interests, she had been estranged from A's father for a number of years and did not know his whereabouts. It was therefore the case that consent for the commencement of Stage 1 treatment could not be consented to by both of A's parents. A's mother moved to regional Queensland to escape A's father, who had a background of "illicit drug use and emotional, verbal and physical abuse towards both 'A' and the applicant" (A's mother) – at one stage A's father was the subject of a domestic violence order and had a criminal history including drugs and weapons offences.[16]

The Court was asked to exercise its power under the parens patriae jurisdiction for the purpose of making a declaration "that the applicant may consent to the proposed treatment and those treating 'A' may act on that consent", on the basis that such a course was in A's best interests.[17]

Evidence of the Treating Clinical Team

Evidence provided was given by the clinical team in support of the proposed Stage 1 treatment. The evidence of A's treating psychiatrist noted that A had reported a history of self-mutilation and distress in relation to her genitalia, as well as suicidal ideation in relation to her gender identity and being born in the wrong body.[18] It was also noted that A was increasingly distressed and dysphoric about her body and wanted to stop puberty as early signs of puberty had been reported. Satisfied that A met the diagnostic criteria for Gender Dysphoria under the DSM-V (as well as the diagnostic criteria for Autism Spectrum Disorder), the psychiatrist's evidence was that it was in A's best interests to commence Stage 1 treatment as there was no other treatment available to A. Additionally, it was noted that the psychiatrist's evidence was that "treatment with puberty blockers will reduce the risk of future mental health problems and maximise the best medical transition to a female identity" and also reduce "well-documented risks of deliberate self-harm and suicide" for an untreated transgender adolescent.[19] The psychiatrist's evidence expressed the view that A had the capacity to make her own decision in line with the concept of *Gillick* competence, as she was able to "understand the nature and intention of the use of reversible puberty blockers for the prevention of the advancement of her male puberty" and that she was "well-aware of the treatment risks and complications" and had realistic expectations about the treatment.[20] However,

[14] *Re A* [2020] QSC 389.

[15] *Re A* [2020] QSC 389, [7].

[16] *Re A* [2020] QSC 389, [9]–[10].

[17] *Re A* [2020] QSC 389, [11].

[18] *Re A* [2020] QSC 389, [13]–[14].

[19] *Re A* [2020] QSC 389, [17].

[20] *Re A* [2020] QSC 389, [19].

although evidence provided by a different medical practitioner supported the commencement of Stage 1 treatment, with respect to A's capacity, the evidence of the second doctor was that "whilst she believes 'A' has the capacity to understand the information provided around the proposed treatment, she does not believe that 'A' fully understands what is proposed and is not persuaded that she is currently *Gillick* competent".[21]

The Decision of the Supreme Court

Lyons SJA noted that although parents generally have the power to consent to treatment on behalf of their children and that minors can give informed consent to treatment when they "achieve sufficient understanding and intelligence to enable them to understand fully what is proposed" (ie in line with the definition of *Gillick* competency), the parens patriae jurisdiction permits the Court to make orders in respect of children where it is in the child's best interests to do so. This is so even when the court's decision is contrary to the wishes of a child's parents.[22]

The main concern of the treating team in this case was that the views and consent of A's father had not been obtained in respect of the proposed Stage 1 treatment.[23] In fact, the history of the father's conduct towards both A and A's mother was noted as abusive, with A's father having said threatening and demeaning things towards both A and A's mother concerning A's desire to be female. As there was not consent from both parents for the proposed treatment, an application to court was considered necessary. Thus, while the 2017 decision of the Full Court in *Re Kelvin* established that court involvement is not generally required for decisions about the commencement of hormone therapy for children with Gender Dysphoria, this is the case only where a diagnosis of Gender Dysphoria results from a proper assessment and is in line with the relevant best practice guidelines (eg requiring a co-ordinated, multidisciplinary team approach to the child's treatment), and the child's parents and treating clinicians are all in agreement.

Her Honour noted that recent Family Court authority had considered this reasoning further to establish that treatment should only commence without a court order, where there is consent from both parents. Thus, it was stated:

> In the recent decision of *Re Imogen*, it was held 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 the child's parents or legal guardians consent to the proposed treatment. Absent any dispute between the child, the parents and the medical practitioner, it is a matter for 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.[24]

Her Honour also noted that in *Re Imogen (No 6)*, Watts J outlined that the optimal model of care for trans and gender diverse adolescents who present to specialist health centres and services involves a co-ordinated, multidisciplinary team approach in line with the Australian guidelines[25] (which should include the involvement of clinicians with experience in child and adolescent psychiatry, paediatrics, adolescent medicine and paediatric endocrinology). Despite the decision of the Full Court in *Re Kelvin*, Watts J in *Re Imogen (No 6)* concluded that court approval is required where the young person is not considered *Gillick* competent by their treating medical practitioner(s), where there is disagreement between the treating team such that a medical practitioner does not think it appropriate to commence treatment, and/or where one or both of the parents object to treatment. In A's circumstances, although there was no known objection from A's father, this was because he had not been contacted and therefore consent was not provided by both of A's parents. Additionally, although the treating medical practitioners

[21] *Re A* [2020] QSC 389, [25].

[22] *Re A* [2020] QSC 389, [28]. In this respect, her Honour cited the Queensland Supreme Court decision of *Queensland v Nolan* [2002] 1 Qd R 454; [2001] QSC 174 for authority that the parens patriae jurisdiction allows the Court to make a decision in the best interests of a child, contrary to the parents' wishes.

[23] *Re A* [2020] QSC 389, [29].

[24] *Re A* [2020] QSC 389, [29], citing *Re Imogen (No 6)* (2020) 61 Fam LR 344; [2020] FamCA 761.

[25] Telfer et al, n 5.

in the case were supportive of the decision to commence Stage 1 treatment, they did not both conclude that A was *Gillick* competent. It was for these reasons that the medical practitioners involved in A's care had concerns about the commencement of Stage 1 treatment and the need for court involvement. In reaching her decision to make the orders sought by the applicant, her Honour was satisfied that:

- A had a confirmed diagnosis of Gender Dysphoria as determined by a specialist psychiatrist in the field, and the diagnosis was supported by the multidisciplinary team;
- Stage 1 treatment was proposed as a therapeutic and reversible form of treatment;
- A and her mother were both willing to consent to the treatment;
- The treatment proposed is in accordance with national and international best practice, as set out in the current Guidelines;
- The applicant and the expert treating team all consider that it is in A's best interests that treatment should occur without delay;
- There is uncertainty as to whether the entire treating team can endorse that they consider A to be *Gillick* competent;
- Contact details for A's father are not known and he had not been in contact with the family since May 2017;
- To ascertain the views of A's father in relation to the proposed treatment would cause considerable delay; and,
- To delay treatment for the purpose of seeking and obtaining the consent of A's father is not in the best interests of A.[26]

Discussion

This Queensland Supreme Court decision demonstrates that despite the key legal developments in Australia relevant to decisions about the commencement of hormone therapy for children with Gender Dysphoria, there is continued court oversight in some circumstances and an awareness of such circumstances is particularly important for medical practitioners working in this field. This position was discussed in some depth in the Family Court decision of *Re Imogen (No 6)*.[27] Unfortunately, the majority in the Full Court decision of *Re Kelvin* were reluctant to conclude that the earlier Full Court decision in *Re Jamie* was "plainly wrong", which has arguably contributed to the current state of the law being complex.

Despite these recent decisions, there are more complex issues that will require clarification in the future. For example, in relation to the issue of *Gillick* competency, it was recognised in *Marion's Case* (and Watts J acknowledged this in *Re Imogen*[28]) that once the minor is regarded as competent to make their own decisions about treatment, the parental power to consent comes to an end. Given that the question of whether the minor is competent is typically a matter determined by the treating health professional, what then is the position in law if the minor's capacity is confirmed by the treating health professional but disputed by the parent? As the High Court confirmed in *Marion's Case* that the parental right to decide in these circumstances is extinguished once the child is *Gillick* competent, where a dispute is raised by a parent about their child's capacity thereby necessitating court involvement (where capacity is confirmed by a health professional), a question arises as to how this position sits with the High Court's reasoning in *Marion's Case*. Finally, as the Full Court in *Re Kelvin* confirmed that both Stage 1 and 2 treatment are indeed regarded as therapeutic and as the majority did not determine that the earlier decision in *Re Jamie* was plainly wrong, a question remains about the underlying legal basis for requiring ongoing involvement of the Family Court (and/or the State and Territory Supreme Courts). Arguably, the principles in *Marion's Case* can no longer be considered as the basis to require court oversight given that the authority of *Marion's Case* applies to *non*-therapeutic interventions and treatments.[29] If the

[26] *Re A* [2020] QSC 389, [37].

[27] *Re Imogen (No 6)* (2020) 61 Fam LR 344; [2020] FamCA 761.

[28] *Re Imogen (No 6)* (2020) 61 Fam LR 344, [28]; [2020] FamCA 761.

[29] For an overview of these issues, see the joint judgment of Ainslie-Wallace and Ryan JJ in *Re Kelvin* (2017) 327 FLR 15; [2017] FamCAFC 258. See also Felicity Bell, "Children with Gender Dysphoria and the Jurisdiction of the Family Court" (2015) 38(2) *UNSW Law Journal* 426.

requirement for court oversight is no longer based on the principles in *Marion's Case*, then the legal basis for these requirements should be clearly outlined.

Lastly, it should also be mentioned that the decision to make the originating application in the Supreme Court in *Re A* was not in line with the established body of case law relevant to Gender Dysphoria, which has developed in the Family Court. Lyons SJA noted the significant expertise and body of jurisprudence in this field, perhaps suggesting that because of such experience and expertise, applications should be commenced in the Family Court rather than the Supreme Court.[30] It appears that in the circumstances surrounding A's case, there was an urgency in terms of the need to start Stage 1 treatment to avoid deterioration in A's mental health and thereby also her physical health. Given that an application under the Family Court's jurisdiction relevant to seeking approval for a medical procedure would require the consent of both parents of the child, one advantage of an application to the Supreme Court is that a decision could be made urgently under the parens patriae jurisdiction which is a much broader jurisdiction that allows the court to make orders necessary to prioritise the best interests of the child.

[30] *Re A* [2020] QSC 389, [30].