



'The court process is slow but biology is fast':* Assessing the impact of the Family Court approval process on transgender children and their families

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Australian adolescents experiencing gender dysphoria must obtain Family Court approval before they can commence cross-sex hormone treatment that will enable them to develop the pubertal characteristics of their chosen sex. While the legal reasoning supporting this requirement has been widely criticised, much less attention has been given to the impact of the Family Court process on transgender adolescents and their families. This article presents the findings of a small, qualitative study with parents of transgender children who were either preparing for the Family Court process, actively engaged in it, or had recently completed it. It contends that the court approval process imposes a harmful and unnecessary burden on children and their families.

Introduction

A growing number of Australian children identify as transgender.¹ A person is transgender when they have a gender identity that differs from the sex they were assigned at birth. Gender dysphoria is the medical term that describes the distress a transgender person experiences when their anatomical body does not accord with their gender identity.² Medical treatment for children experiencing gender dysphoria, which is regulated by international consensus

* Quote from the mother of a child who was granted access to Stage 2 hormones by the Family Court, speaking to the federal Parliamentary Friendship Group for Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) Australians, 22 February 2016. Quoted in: S Medhora, 'Australian transgender children closer to accessing hormones without court permission', *The Guardian*, 22 February 2016, at <<http://www.theguardian.com/society/2016/feb/22/australian-transgender-children-closer-to-accessing-hormones-without-court-permission>> (accessed 16 September 2016).

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¹ Population based studies estimate that 1.2% of adolescents identify as transgender. As awareness of transgenderism increases and social acceptance increases a growing number of those adolescents will seek medical treatment. For example, the Royal Children's Hospital's Gender Service in Melbourne, the largest such clinic in Australia, has experienced an 18 fold increase in referrals in just the last 6 years. T C Clark et al, 'The health and well-being of transgender high school students: Results from the New Zealand adolescent health survey' (2014) 55 *Journal of Adolescent Health* 93 at 93–9; M Telfer, M Tollit and D Feldman, 'Transformation of health-care and legal systems for the transgender population: The need for change in Australia' (2015) 51 *Journal of Paediatrics and Child Health* 1051 at 1051–3.

² American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed, American Psychiatric, 2013. Previous editions of the DSM used the terminology 'gender identity disorder'. Earlier decisions of the Family Court use the old terminology.

guidelines,³ occurs in two stages. Stage 1 comprises the administration of puberty-suppressant hormones or ‘blockers’ which prevent the child from entering puberty. Stage 1 treatment commences just prior to the child entering puberty (usually around 11 or 12 years of age)⁴ and parents are able to consent to its administration. Stage 2 treatment, which occurs when the child is approximately 16 years of age, involves the administration of cross-sex hormones, which cause the child to develop the pubertal characteristics of the sex with which they identify. Before Stage 2 treatment can be recommended, a multidisciplinary team consisting of a paediatrician, two mental health professionals (one must be a psychiatrist), and a fertility expert, must agree that treatment is in the child’s best interests.⁵

In 2013, the Full Court of the Family Court held in *Re Jamie (Special medical procedure)* that parents cannot consent to Stage 2 treatment for their child.⁶ Rather, they must apply to the Family Court for authorisation for the treatment to proceed. The first stage in the process is for the court to determine if the child is competent to consent to the treatment. If the child is found to be competent, he or she can consent to the treatment. If the child is found not to be competent, the court will determine if treatment is in the child’s best interests. Every application for stage two treatment heard by the Family Court since *Re Jamie* has been approved, with the vast majority of the young people being found competent to consent.⁷

Australia is the only country in the world that requires Court approval for cross-sex hormone treatment for transgender children. In other jurisdictions, the child’s treating medical professionals, in conjunction with the parents and the child, make decisions about treatment. A growing number of health professionals,⁸ academics,⁹ and judges¹⁰ have questioned whether the Family Court *should* be involved in medical decision-making for transgender

3 World Professional Association of Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7*, 2012.

4 The consensus guidelines recommend Stage 1 treatment commence when the child has experienced puberty to at least Tanner Stage 2: *ibid*.

5 *Clinical Pathway for patients referred to the Royal Children’s Hospital Gender Service* (obtained from Lead Paediatrician at RCH Gender Service; on file with author). The RCH’s protocol follows the international consensus guidelines published by the World Professional Association for Transgender Health, above n 3. Similar protocols are followed in Western Australia, Tasmania, Queensland and South Australia (private correspondence with physician).

6 *Re Jamie (Special medical procedure)* (2013) 50 Fam LR 369; 278 FLR 155; [2013] FamCAFC 110; BC201350653 (*Re Jamie*).

7 Examples of cases where the young person was not found to be competent include *Re Sam and Terry (Gender Dysphoria)* (2013) 49 Fam LR 417; [2013] FamCA 563; BC201350635; *Re Shane (Gender Dysphoria)* [2013] FamCA 864; BC201350573; *Re Jordan* [2015] FamCA 175; BC201550030.

8 J Hewitt et al, ‘Hormone Treatment of Gender Identity Disorder in a Cohort of Children and Adolescents’ (2012) 196 *Med J of Aust* 578 at 580; Telfer et al, above n 1, at 1052.

9 F Bell, ‘Children with Gender Dysphoria and the Jurisdiction of the Family Court’ (2015) 38 *UNSWLJ* 426; L Young, ‘Gender Identity Dysphoria Update and Developments in Property Settlement Law’ (2014) *International Survey of Family Law* 1 at 5–7; F Kelly, ‘Australian Children living with Gender Dysphoria: Does the Family Court have a role to play?’ (2014) 22 *Journal of Law and Medicine* 105 at 105–20; K France, ‘Let me be me: Parental Responsibility, Gillick Competence, and Transgender Minors’ Access to Hormone Treatments’ (2014) 4 *FLR* 227.

children. The legal experts have focused their critique on the correctness of the reasoning of the Full Court in *Re Jamie*, questioning in particular the court's decision to apply the test from *Secretary, Department of Health and Community Services v JWB and SMB*¹¹ — a case addressing the capacity of parents to consent to a non-therapeutic medical procedure for an intellectually disabled child — to the therapeutic treatment provided to transgender children, as well as to the question of the child's competency to consent.¹² The second criticism of the status quo has been that the court process imposes on transgender youth and their families a substantial psychological and financial burden.¹³ However, in the absence of research analysing the impact of the process on families, assertions of this kind have been largely speculative or anecdotal. This paper reports on the findings of a qualitative study of the experiences of parents who have sought, or anticipate seeking, Family Court approval for their child's Stage 2 hormone treatment, with a view to testing these assertions, as well as gaining a greater understanding of the experiences of the families who engage in the Family Court process.

The article draws on 10 qualitative interviews with 12 parents from across Australia who were either preparing for the Family Court process, actively engaged in it, or had recently completed it. It contends that the court approval process, which has only ever resulted in the approval of treatment, imposes an unnecessary and harmful burden on parents and children. The article begins with a summary of the law and a brief overview of the various critiques of its correctness. Next, it introduces the study and reports on the three key themes to emerge from the interviews: (i) that the Family Court process causes significant psychological harm to young people and parents; (ii) that it can cause dangerous delays in the child's medical treatment; and (iii) that it presents significant cost barriers for families. In light of the study findings, the article concludes with a discussion of legislative reform that would remove the Family Court from the decision-making process where the parents (or the child, if competent) and treating medical professionals agree that treatment is in the child's best interests.

1 The law

While it is generally within the bounds of parental responsibility to consent to medical treatment for and on behalf of a child, it was held by the High Court in *Marion's case*¹⁴ that there are certain procedures that fall beyond that responsibility. Referred to in the case law as 'special medical procedures',¹⁵ they require the authorisation of the Family Court.¹⁶ To guide courts in

10 See Bennett J's critical judgment in the recent decision of *Re Martin* [2015] FamCA 1189; BC201551205.

11 (1992) 175 CLR 218; 106 ALR 385; 15 Fam LR 392 (*Marion's case*).

12 For the most comprehensive analysis of this kind see Bell, above n 9.

13 Bell, *ibid*, at 451; France, above n 9, at 245–6; Hewitt et al, above n 8, at 580.

14 *Marion's case* (1992) 175 CLR 218; 106 ALR 385; 15 Fam LR 392.

15 While the phrase 'special medical procedure' does not appear in the High Court's decision in *Marion's case*, the concept has its origins in the decision.

16 The procedure to be followed in such cases is found in r 4.09(1) of the Family Law Rules (Cth) 2004, which requires the applicant to provide evidence 'to satisfy the court that the proposed medical procedure is in the best interests of the child'.

identifying the types of procedures that might fall within the scope of *Marion's* case, the High Court distinguished between therapeutic and non-therapeutic treatment, stipulating that the focus of its judgment was on the latter and specifically on the sterilisation of intellectually disabled minors. As the court stated, '[i]t is necessary to make clear that, in speaking of sterilization in this context, *we are not referring to sterilization which is a byproduct of surgery appropriately carried out to treat some malfunction or disease*'.¹⁷ The court then went on to identify why non-therapeutic sterilisation amounted to a 'special case':

As a starting point, sterilization requires invasive, irreversible and major surgery. But so do, for example, an appendectomy and some cosmetic surgery, both of which, in our opinion, come within the ordinary scope of a parent to consent to. However, other factors exist which have the combined effect of marking out the decision to authorize sterilization as a special case. Court authorization is required, first, because of the significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave.¹⁸

In the case law that has followed, the Family Court has relied heavily on the passage above to determine whether a specific procedure is a special medical procedure. Judges first determine whether treatment is therapeutic or non-therapeutic and, if found to be non-therapeutic, judges then turn to the remaining constellation of factors to decide whether authorisation is required. Situations in which the Family Court has held that treatment amounts to a special medical procedure have included parents requesting surgical treatment for an intersex child,¹⁹ non-therapeutic sterilisation,²⁰ and the harvesting of bone marrow from a child to be donated to a family member.²¹

When the question of whether parents can consent to medical treatment for gender dysphoria first came before the Family Court in 2004 in *Re Alex (hormonal treatment for gender dysphoria)*,²² Nicholson CJ concluded that treatment for Stages 1 and 2, which he considered 'part of a single package',²³ required court authorisation. The decision turned on Nicholson CJ's assertion that the treatment was non-therapeutic and therefore fell within the ambit of *Marion's* case. Nicholson CJ's conclusion flowed from the distinction made by the High Court between treatment that is in response to a 'bodily malfunction or disease' (therapeutic) and all other forms of medical treatment (non-therapeutic). Not wishing to pathologise those experiencing gender dysphoria by labelling it a 'disease' or 'bodily malfunction', Nicholson CJ felt that the only option open to him was to conclude that the treatment was

17 *Marion's case* (1992) 175 CLR 218 at 250; 106 ALR 385 at 404; 15 Fam LR 392 at 409.

18 *Ibid.*, at CLR 253; ALR 404; Fam LR 410.

19 *Re Lesley (Special Medical Procedure)* [2008] FamCA 1226; BC200851339; *Re Sally (Special Medical Procedure)* [2010] FamCA 237; BC201050268.

20 *Re H* [2004] FamCA 496; *Re Katie* (1995) 128 FLR 294; FLC 92-659.

21 *GWV v CMW* [1997] FamCA 2; cf *Re Inaya (Special Medical Procedure)* (2007) 38 Fam LR 546; 213 FLR 278; [2007] FamCA 658.

22 (2004) 31 Fam LR 503; 180 FLR 89; [2004] FamCA 297 (*Re Alex*).

23 *Ibid.*, at [186].

non-therapeutic.²⁴ Subsequent case law adopted this conclusion.²⁵

In 2013, the Full Court of the Family Court was asked to revisit the question of whether treatment for gender dysphoria required court authorisation. The case was an appeal from the trial decision²⁶ of Dessau J. and included two interveners, the Australian Human Rights Commission (AHRC)²⁷ and a public authority (not named). In *Re Jamie*,²⁸ the Full Court accepted the submissions of the appellant and the AHRC²⁹ that the two stages of treatment be considered separately, stating that it would be inappropriate to determine at the point of commencing Stage 1 treatment if Stage 2 treatment, which would typically follow 4–5 years later, was in a child’s best interests.³⁰ Addressing Stage 1, the court held that there was no need to limit the concept of ‘therapeutic treatment’ to treatment for a physical disease. Rather, the term should be defined broadly, as Brennan J had suggested in *Marion’s* case,³¹ to include psychological disorders and mental illness.³² The court then noted that the ‘weight of professional opinion’ is that gender dysphoria represents such a disorder.³³ Stage 1 treatment was therefore therapeutic and could commence without court involvement.³⁴ However, Stage 2 treatment, *though also held to be therapeutic*, was considered to be beyond the bounds of parental responsibility. In coming to this conclusion, Bryant CJ applied the test in *Marion’s* case and, consistent with the submissions of the AHRC, accorded the irreversible nature of Stage 2 treatment particular importance.³⁵

The Full Court was also called upon to determine whether a child who was determined to be ‘Gillick competent’ could consent to Stage 2 treatment without needing the approval of the court. The notion of *Gillick* competency comes from the English case of *Gillick v West Norfolk and Wisbech Area Health Authority*,³⁶ in which the House of Lords held that a mature minor may

24 Ibid, at [195].

25 See, eg, *Re Bernadette (Special Medical Procedure)* (2010) 43 Fam LR 467; 244 FLR 242; [2010] FamCA 94; BC201050827; *Re Brodie (Special Medical Procedure)* [2008] FamCA 334; BC200851177.

26 *Re Jamie (Special medical procedure)* [2011] FamCA 248 (*Re Jamie*).

27 For a detailed discussion of the AHRC’s submissions in *Re Jamie*, *ibid*, see G Triggs and G Edgerton, ‘The Rights of the Child’ (2013) 51 *LSJ* 57 at 57–59.

28 *Re Jamie*, *ibid*.

29 *Ibid*, at [49].

30 *Ibid*, at [110]–[113].

31 *Marion’s* case (1992) 175 CLR 218 at 269; 106 ALR 385 at 421; 15 Fam LR 392 at 423 per Brennan J.

32 *Re Jamie* (2013) 50 Fam LR 369; 278 FLR 155; [2013] FamCAFC 110; BC201350653 at [91].

33 *Ibid*, at [69]. There has been some criticism of the characterisation of gender dysphoria as a ‘disorder’. While it may be of strategic advantage for litigants to accept the ‘disorder’ label, critics have suggested that it pathologises children living with gender dysphoria. In *Re Jamie*, *ibid*, at [69], Bryant CJ acknowledged the ‘discomfort’ created by labeling Jamie’s experience ‘a disorder’, but refused to draw any conclusions as to its correctness. The most recent edition of the DSM no longer refers to ‘gender identity disorder’ (the term used in *Re Jamie*), replacing it with ‘gender dysphoria’. The new term was designed to emphasise the distress or ‘dysphoria’ an individual might experience when their body is out of sync with their perceived gender identity.

34 *Ibid*, at [98].

35 *Ibid*, at [111].

36 [1986] AC 122; [1985] 3 All ER 402 (*Gillick*).

consent to his or her own medical treatment in the event that he or she ‘has achieved a sufficient understanding and intelligence to enable him or her to understand fully what is proposed’.³⁷ Given that most children seeking stage two treatment are approximately 16 years of age, it is possible they are mature enough to be declared *Gillick* competent. It was argued by the appellants in *Re Jamie* that where a child is determined by health professionals to be *Gillick* competent, he or she should be able to consent to Stage 2 treatment without court involvement. By contrast, the AHRC argued that while Australia’s international law obligations meant that children should have input into decisions that affect them in accordance with their evolving capacity, because Stage 2 treatment is still in its infancy, court attendance must remain mandatory.³⁸ The Full Court accepted the AHRC’s submissions, holding that while a *Gillick* competent child could consent to Stage 2 treatment, ‘the nature of the treatment at stage two requires that the court determine *Gillick* competence’.³⁹ Thus, a transgender child wishing to commence Stage 2 treatment must always appear before the Family Court, though he or she may ultimately be found to be capable of consenting to the treatment.

There has been a great deal of criticism of the reasoning underlying the Full Court’s judgment in *Re Jamie*, both in relation to the decision to define Stage 2 treatment as a special medical procedure, and the conclusion that competency should be determined by the court. The arguments have been well rehearsed elsewhere⁴⁰ and I do not intend to repeat them in detail. However, a brief overview of the key arguments is provided.

Critics such as Bell, Young and Smith have argued that the Full Court’s conclusion that parents cannot consent to Stage 2 treatment, despite it being therapeutic, appears to involve a misreading of *Marion’s* case.⁴¹ As noted above, the majority in *Marion’s* case was clearly focused on *non-therapeutic* procedures, distinguishing on several occasions between the sterilisation proposed for Marion and one that results from treatment designed to remedy a disease or illness.⁴² It has therefore been argued that in light of the Full Court’s finding that Stage 2 treatment is therapeutic, the additional issues raised by the High Court, such as the irreversibility of the treatment and gravity of the consequences of a wrong decision, were incorrectly considered.⁴³ As Smith argues:

If the treatment is deemed to be therapeutic, it could be stated that the court has no authority to narrow the boundaries of parental decision-making in the way that it did,

37 *Ibid.*, at AC 122 189; All ER 423. The notion of *Gillick* competency was adopted as part of Australia’s common law by the High Court in *Marion’s* case (1992) 175 CLR 218 at 237; 106 ALR 385 at 394; 15 Fam LR 392 at 400 in 1992.

38 *Re Jamie* (2013) 50 Fam LR 369; 278 FLR 155; [2013] FamCAFC 110; BC201350653 at [120]-[122].

39 *Ibid.*, at [137].

40 Bell, above n 9; Young, above n 9; Kelly, above n 9; France, above n 9; M Smith, ‘The Boundaries of Parental Decision-Making and the Requirement to Obtain Court Approval for “Special Medical Procedures”: The Recent Decision of *Re Jamie* [2013] FAMCAFC 110’ (2013) 33 *Queensland Lawyer* 182 at 186.

41 Bell, above n 9; Young, above n 9; Kelly, above n 9; Smith, *ibid.*

42 *Marion’s* case (1992) 175 CLR 218 at 250; 106 ALR 385 at 404; 15 Fam LR 392 at 409.

43 See, eg, Young, above n 9, at 5–6; Bell, above n 9, at 339–442; Kelly, above n 9, at 114–16.

as the classification of the treatment as therapeutic was itself a critical factor in distinguishing [*Marion's Case*] from previous jurisprudence on special medical procedures.⁴⁴

Therapeutic treatment may involve some of the factors the High Court identifies in *Marion's* case (for example, an appendectomy requires major surgery that is invasive and irreversible), but the presence of those concerns does not bring the decision back within the ambit of *Marion's* case. Bryant CJ herself seems to acknowledge the crucial distinction made in *Marion's* case between therapeutic and non-therapeutic treatment when she concludes that Stage 1 treatment is within the scope of parental authority for the *sole reason* that it is therapeutic:

If the treatment is in response to a disorder, even a psychological or psychiatric one, it is administered for therapeutic purposes. *For that reason alone*, in my view, the treatment at stage one . . . would not fall within the category of cases which the High Court was considering in *Marion's case*.⁴⁵

It therefore stands to reason that if the therapeutic nature of treatment for gender dysphoria can be cited as the *sole reason* that Stage 1 treatment falls outside the ambit of *Marion's* case, then this conclusion should apply equally to Stage 2.

The second common criticism of *Re Jamie* is that in deciding that the court must determine *Gillick* competency the majority again misapplies the decision in *Marion's* case. Bryant CJ holds that it is the particular 'nature' of Stage 2 treatment — its irreversibility and the seriousness of the consequences of an incorrect decision — that makes it inappropriate for medical professionals to make the decision without judicial oversight.⁴⁶ However, in reaching this conclusion Bryant CJ again appears to overlook the differences between the facts in *Marion's* case and the situation of a transgender child. The majority in *Marion's* case was concerned about the risk of wrongly assessing capacity in a situation of *intellectual disability*, where the child was at risk of having her autonomy overridden by medical professionals who might assume that a child's intellectual disability will always inhibit his or her competency. As the High Court explained, medical professionals may have 'misconceptions' about the capacity of persons with intellectual disabilities,⁴⁷ and those misconceptions are likely to be heightened when it comes to issues involving sexuality and sexual identity.⁴⁸ Thus, as Bell argues:

It is the presence of intellectual disability as well as the context of the decision to be made that creates the 'significant risk of making the wrong decision' as to competency. *Marion's case* does not *mandate* a finding that such a risk is automatically present in cases involving children with gender dysphoria nor the asserted consequence that it is for a court alone to make the assessment of competence.⁴⁹

44 Smith, above n 40, at 186.

45 *Re Jamie* (2013) 278 FLR 155; 50 Fam LR 369; [2013] FamCAFC 110; BC201350653 at [98].

46 *Ibid*, at [136]–[137].

47 *Marion's case* (1992) 175 CLR 218 at 238; 106 ALR 385 at 395; 15 Fam LR 392 at 401.

48 *Ibid*, at CLR 239; ALR 396; FamLR 401.

49 Bell, above n 9, at 447.

Put simply, medical professionals determining the competency of a transgender child does not raise any of the risk factors identified in *Marion's* case. In fact, a transgender child's medical team, which has often treated the child for over 5 years, is in an ideal position to determine competency. This fact is reflected in the deference Family Court judges give to the medical experts who appear in court. Whether they support a finding of competency or not, the Family Court has deferred to the medical experts in every Stage 2 treatment case it has heard.

2 The study

While the court's conclusions in *Re Jamie* are open to considerable criticism, until such time as the Full Court reconsiders the matter, it remains the case that adolescents who wish to commence Stage 2 hormone treatment must apply to the Family Court. This study was designed to explore the impact of this requirement on the young people and their parents who have undergone this process. The study comprised qualitative interviews with parents of transgender children who had completed the court process, as well as those who were currently engaged in it, or would be required to apply in the future. Though they had not yet made an application to the court, the last group was included in the sample to explore the impact, if any, of knowing that an appearance before the Family Court would be necessary in the future. While it is small in size, it is the first study of its kind in Australia.

Study participants were recruited via a number of online Facebook groups and forums for Australian parents of transgender children. Parents were eligible to participate in the study if they had a transgender child who had completed the Family Court process or anticipated applying in the future. Given the relatively small number of possible participants, and the challenge of finding parents willing to talk about such a personal and emotional issue,⁵⁰ convenience sampling was relied upon. However, as noted below, there were no notable thematic differences across the sample, suggesting that thematic saturation was achieved.

The study comprised 10 interviews with 12 parents of transgender children ranging in age from 6 to 18, with an average age of 14. Five of the families had completed the Stage 2 court process, three were preparing for or engaged in the process, and in two families the children were not yet old enough to apply. All of the families who had applied for court approval were successful and in all five cases the child was found to be *Gillick* competent. Families lived in Victoria, Tasmania, New South Wales, and Queensland. The interviews were conducted in late 2015, either in person or over the phone, and were approximately one hour in length. The interviews were semi-structured in format, with the majority of the interview focused on encouraging parents to tell their child's 'story'. Specific questions focused on how they found out about the court approval requirement, the impact (or anticipated impact) of the court process on the family and child, and whether they had legal assistance. The interview transcripts were coded thematically,

⁵⁰ Several parents responded to the advertisement but decided not to go ahead with the interview as they found even the initial discussion about whether they would like to participate in the study too upsetting.

and analysed using inductive methods. Inductive analysis was relied upon because while families who had told their stories to the media had been uniformly negative about the process, it was not assumed their experiences were universal.

While the sample size for the study is relatively small, this is not surprising given the deeply personal nature of the subject matter and the fact that the number of parents in this situation, though certainly increasing, remains fairly low.⁵¹ For example, only 17 families sought Family Court approval for Stage 2 treatment in 2015, five of whom were interviewed for this study. By contrast, only four families sought approval in 2014. Three of the families interviewed anticipated having their cases heard in 2016. The study therefore includes a significant percentage of the total cohort of parents currently or recently involved in the Family Court process. While participation in the study was also open to parents who anticipated engaging in the Family Court process in the future, based on the circumstances of those who participated, it is likely that the study was of more interest to parents who were currently engaged with or had recently completed the court process, than those for whom it was still a fairly distant prospect.

Though the small sample size makes it difficult to draw definitive conclusions about the impact of the court process on families, there were no notable thematic differences across the sample. While those who had not yet completed the court process obviously had less to say about its impact on their child, it was evident that even the *prospect* of the process in the future was causing the children distress. In fact, the remarkable uniformity of the participants' responses suggests that the study offers an accurate picture of current experiences. It is also notable that the study findings reflect many of the critical assertions made by individual parents to the media and politicians in recent months.⁵² Thus, while one should be cautious about drawing definitive conclusions, there is no reason to believe that the experiences of

51 Statistics from Melbourne's Royal Children's Hospital indicate that the surge in referrals to the Gender Service commenced in 2014. In the decade prior to 2014, there were an average of fewer than five referrals a year. In 2014, referrals surged to 104 and in 2015 they reached just under 200. The average age of referral to the service was 12.6 years. Statistics for other Australian clinics are not available. Based on the Victorian statistics, it is likely that the Family Court will experience a dramatic increase in applications in 2017, when a significant number of the 2014 cohort reach the age of 15. Telfer et al, above n 1, at 1052.

52 See, eg, S Medhora, 'Australian transgender children closer to accessing hormones without court permission', *The Guardian*, 22 February 2016, at <<http://www.theguardian.com/society/2016/feb/22/australian-transgender-children-closer-to-accessing-hormones-without-court-permission>> (accessed 16 September 2016); M Perkins, 'Push to end court control of treatment for transgender young people', *The Age*, 4 February 2016, at <<http://www.theage.com.au/victoria/push-to-end-court-control-of-treatment-for-transgender-young-people-20160204-gmlrj4.html>> (accessed 16 September 2016); L Sainty, "'Someone Is Going To Die': Meet The Trans Kids Fighting For The Right To Transition", *Buzzfeed*, 6 March 2016, at <<http://www.buzzfeed.com/lanesainty/meet-the-kids-fighting-for-the-right-to-transition#.ngyVgy1V4>> (accessed 16 September 2016); J Ireland, 'Young transgender people go to Canberra to lobby for change', *Sydney Morning Herald*, 22 February 2016, at <<http://www.smh.com.au/federal-politics/political-news/young-transgender-people-go-to-canberra-to-lobby-for-change-20160221-gmzikd.html>> (accessed 16 September 2016).

those interviewed are not reasonably representative of the overall cohort of families seeking court approval.

3 Findings

There was universal agreement among the parents interviewed that the court process was unnecessary, as well as deeply harmful to their family and their child. The harms identified were multiple. However, three key themes emerged. First, that the process had a damaging psychological impact on the child, as well as on the wellbeing of other family members. Second, that the court process caused delay in the child's treatment, often jeopardising their mental health and even compromising the efficacy of their medical care. Finally, parents indicated that the cost of the court process had placed an enormous financial burden on them.

A Psychological impact

Concerns about the psychological impact of the court process on the children dominated the interviews. This is not surprising given the high rates of depression, anxiety, self-harm, and suicide among transgender youth.⁵³ Just over 50% of Australia's transgender young people will have self-harmed, and 28% will have attempted suicide, by their twenty-first birthday.⁵⁴ Recent research indicates that the greatest risk of attempted suicide occurs between the time that a transgender individual decides to seek medical care and the time that he or she is able to access that care.⁵⁵ Dr Michelle Telfer, the Lead Paediatrician at the Gender Service at Melbourne's Royal Children's Hospital, has argued that the barrier to accessing timely treatment posed by the Family Court approval process can be expected to result in 'an ongoing rise in morbidity and mortality amongst transgender youth'.⁵⁶ The evidence provided in the interviews supports Dr Telfer's assertion. Parents indicated that the court process, and its associated delays, added an additional high stakes stressor to their child's life, increasing their anxiety, depression and dysphoria. The court process also took a significant emotional toll on parents making it difficult for them to meet the increasing demands of the child's deteriorating mental health.

In all instances, the court process took between 8 and 12 months to complete and parents reported that the mental health of the child deteriorated as time went on. Jasmine, the mother of a 17-year-old, recounted how her daughter developed depression as they waited for their case to be heard:

I always said to her, look it's the system. It's not you. You know? It's nothing to do with you. But as it wore on and on, and it was just this long timeline, and she's dealing with other teenage stuff, and she became depressed. To the point where I was actually concerned about her wellbeing and had to take her to hospital.

53 Telfer et al, above n 1, at 1051.

54 L Hillier et al, *Writing Themselves in 3: The Third National Study on the Sexually Health and Wellbeing of Same Sex Attracted and Gender Questioning Young People*, Australian Research Centre in Sex, Health and Society, La Trobe University, 2010, p 100.

55 G Bauer et al, 'Suicidality Among Trans People in Ontario: Implications for Social Work and Social Justice' (2013) 59 *Social Service* 35 at 43.

56 Telfer, above n 1, at 1052.

Helen's son, Nick, experienced heightened anxiety as a result of the legal proceedings. The preparation of his case required Nick to meet with three mental health experts. Two were his treating psychiatrists, but because the hospital was nervous that the court would not let treatment proceed without the inclusion of a report from a third 'independent' expert, Nick was asked to attend an appointment with an additional psychologist who had little experience in the field. Helen reported that the psychologist 'crushed' Nick with his questioning, leaving the boy in tears. Helen, who was not permitted to sit in on the appointment, was furious that the psychologist seemed to have little insight into the fragile mental health of transgender youth. Nick was also required to attend several meetings with his legal team, which Helen thought he found extremely distressing. As Helen explained, '[f]rom Nick's perspective it was scary to walk into a lawyer's office and the big board room, and have these people across the desk from him asking questions'. Following the meetings, Helen reported that Nick became worried about who might read the documents being prepared for his case, which included intimate details about his body and its development. As Helen explained:

He asked me a couple of times, you know, who's going to see these papers and who types them up . . . His brain was even going to the secretaries reading it and who were they. So he got really stressed that this might be on public record and I actually had to organise for the lawyers to assure him that it wouldn't be.

A number of the parents noted that even the *prospect* of the court process in the future was taking a psychological toll on their children. Tessa and Neil, for example, had a 14-year-old daughter who was planning to apply for Stage 2 treatment in the next few months. Tessa recalled a recent conversation in which her daughter expressed significant anxiety about the upcoming process:

This is what she said to me the other day. She said, "I don't think my body actually belongs to me anymore." And that was pretty heartbreaking. Just through this whole process, that's where she's at right now. You know, her only mental image of a court case is *To Kill a Mockingbird*. I keep saying it's not *To Kill a Mockingbird*. But there's that sense that it's her own body on trial.

The anticipatory stress of the process was also taking a toll on Suzie's son, Calvin, who was 12 years old. Suzie was separated from Calvin's father, who had expressed some opposition to his son's treatment. Calvin had become concerned that something might happen to his mother, leaving it up to his father to bring the court application for Stage 2 treatment. This possibility was causing Calvin considerable anxiety. As Suzie explained:

The other night he came out of his bed crying and said, 'Mum, what happens if you die before I go to Court? How will I get this? What happens if something happens to you?' You know, he's aware that steps needs to be taken and it costs money and I guess he's aware that I'm his advocate. And what happens if I'm not there?

Parents reported that the court process also took a significant psychological toll on them. Several parents described feelings of having their privacy invaded, as they were required to repeatedly recount their child's story to different professionals, most of whom had no familiarity with gender dysphoria. Jasmine related her experience of doing an intake interview with a pro bono legal service:

I got a volunteer. I can't remember exactly what she asked me, but I did need to divulge the nature of our case. So already it felt like this process of being exposed to strangers. And it's like, what the hell, you're not a counsellor, you're not a doctor. I was just feeling this burning sense of injustice already. It was daunting and difficult and unfair.

Parents also experienced distress while attending the hearing. While most, though not all, found the judge to be compassionate, simply being in a courtroom intimidated them. They perceived the Family Court as an adversarial institution where their parenting decisions might be challenged. Hannah recounted her experience:

[It was] terrifying. I'd never been in a courtroom in my life before. It was really . . . it was really intimidating, very frightening. And also that sense that your child's life is in someone else's hands, or their mental health anyway. It was very intimidating.

Similar feelings were identified by Pauline, who described a sense of 'utter powerlessness as a parent' as she listened to 'someone who's got nothing to do with your child or your life tell you what you already know'. The distress created by the court process sometimes made it difficult for parents to fully support their children, many of whom required additional medical care due to declining mental health.

B Delay

Delay was another significant concern for the families. All of the parents who had completed the process or were currently engaged in it, indicated that their child experienced what the parents felt was damaging delay. On average, it took 8 months from the time the process was initiated until the child received treatment. What this meant in practice was that the child was determined by a medical team of six professionals to be ready to commence Stage 2 treatment but, due to the court approval requirement, treatment did not commence for at least another 8 months. This delay, and the uncertainty that it created for the child, was perceived by the parents to be harmful. Hannah explained the impact of her family's 9-month court process on her son:

He was really worried that he wouldn't get permission and that he wouldn't be able to do it. He was also very angry. He viewed the legal process as holding up what he wanted to get done and that the doctors had said he was ready for . . . He viewed the legal process as an obstacle in his way and got very angry with the bureaucracy and the doctors and us because he just wanted something done about this and [there were] all these things standing in his way.

One of the young people experienced a failure of her puberty blockers, making Stage 2 treatment urgent. If a transgender child enters puberty and begins to develop secondary sex characteristics, he or she is considerably more likely to have poor mental health outcomes in adulthood.⁵⁷ As Shield notes, the young person 'will forever see the mark of this delay on [his or her]

⁵⁷ In children experiencing gender dysphoria, the development of secondary sex characteristics may increase 'comorbid' symptoms such as body dysmorphia and other obsessional disorders, as well as depression, anxiety, self-harm, suicidality, substance use and high risk sexual behaviors. J Olson, C Forbes and M Belzer, 'Management of the Transgender Adolescent' (2011) 165 *Archives of Pediatrics and Adolescent Medicine* 171.

body'.⁵⁸ For the young woman who experienced the failure of her blockers, the delay was unbearable. As her mother, Pauline, explained:

Her medication failed and she went into full blown male puberty in a very short space of time. I mean it was just horrific and ironic that after four years of consistent treatment we were back in danger of her voice breaking again. [My daughter] went into this terrible dysphoria that she'd never experienced before. I'd never seen her that bad. Her voice is very important to her and she told me that if her voice broke she would kill herself.

Desperate to get an immediate court date, Pauline contacted her lawyers:

It seems it takes a crisis to get people moving and with [my daughter's] elevated testosterone levels and her dysphoria, my head was about to blow off my shoulders with worry. I got on the phone first thing in the morning and, I'm not usually given to this, but I just wept. I wept and wept and I walked around the house in this howling state and waited for people to call back.

Pauline's lawyers were able to get a directions hearing the following week at which the judge, recognising the potentially catastrophic implications of further delay, made an order enabling immediate access to treatment.

While there was an expectation that the court process would be lengthy, several of the families commented that the inexperienced nature of their lawyers meant that it took even longer. All but one of the families who had commenced or completed the court process were represented by pro bono lawyers, primarily because they could not afford to pay for private legal representation. None of the lawyers had experience with previous Stage 2 cases and most had little familiarity with gender dysphoria. While the parents were extremely appreciative of their lawyer's willingness to act pro bono, their lack of experience was perceived to have increased the time it took for cases to be heard. For example, Jasmine, whose case was run by a lawyer who had no experience in the field, noted that she often had to explain things to her lawyer, who did not seem to be aware of how the case was likely to proceed. Jasmine also indicated that because she was not paying for her lawyer's services, she felt that she was not entitled to be 'too demanding'. Two other parents noted this same issue and concluded that it created additional delay. Jasmine recounted her experience:

Look, don't get me wrong. I was very grateful. We were incredibly grateful to get pro bono help, but I also felt a sense of don't bother them, they're doing it for free. I didn't want to be a bother and so sometimes I would hang back. In fact, it got to the stage where we were left hanging. This was when [my daughter] was very depressed and it was obviously affecting her wellbeing. I spoke to [the doctor] and she said, 'Do you know what's happening?' And I said, 'I don't'. Because [the doctor] was very confident that once [my daughter] was on oestrogen it would help enormously and that's proven to be the case. I said, 'Look it's pro bono.' And [the doctor] said 'It's their job and they're doing it for you'.

⁵⁸ S Shield, 'The Doctor Won't See You Now: Rights to Transgender Adolescents to Sex Reassignment Treatment' (2007) 31 *NYU Rev L & Soc Change* 361 at 362–3.

A number of the parents also mentioned that the under-resourcing of the medical system meant that it could take several months for a psychologist's report to be written. This further delayed the court process as cases required at least two such reports to proceed.

C Cost

The final harm identified by the families was the cost of obtaining Family Court approval. Those who had completed the court process estimated its cost to be between \$8000 (where a family had a pro bono lawyer) and \$30,000 (when costs were paid by the family). Families with pro bono lawyers still had to cover the cost of at least two reports from mental health professionals (typically several thousand dollars per report), as well as various court fees. A number of the parents also lost income during the lengthy court process because they had to take time off work, or decline offers of work where they were casually employed, due to the many appointments they needed to attend, as well as to manage the deteriorating mental health of their children.

Suzie, whose son was 12, was already concerned about how she would pay for the court process, particularly as she was separated from her son's father and anticipated that he might not be supportive. As she stated:

The cost has been a cause of concern for me. I'm a sole parent and I've seen in media reports it can cost up to \$30,000. So I'm looking at having to find that money in the next year or two. And it's just impossible.

For some families, the court costs may be insurmountable. Pauline, who ran a support group for parents of transgender children, indicated that she knew several families who were unable to meet the costs associated with the process and so had told their children they would have to wait until they turned 18 to receive treatment. Pauline's anecdotal evidence is supported by the research of Hewitt et al, whose study of 39 children being treated for gender dysphoria at the Royal Children's Hospital identified the 'complicated and costly legal process' as one of the reasons some families had elected not to pursue stage two treatment.⁵⁹ As Hewitt et al state, '[t]hese do not seem equitable or just reasons for restricting a young person's access to medical care'.⁶⁰

4 A streamlined decision-making process?

In light of the negative impact of the court process on their children and themselves, the parents were in unanimous agreement that the Family Court should not be involved in decision-making for Stage 2 treatment. All of the parents were confident that whether a young person should commence Stage 2 treatment was a decision best made by the child (or parents if the child was not yet competent) in conjunction with his or her treating health professionals. A number of the parents noted that the Royal Children's Hospital in Melbourne had already established a rigorous review system for Stage 1 decision-making that could be easily extended to include Stage 2.

⁵⁹ Hewitt et al, above n 8, at 580.

⁶⁰ Ibid.

In early 2016, the possibility of removing the Family Court approval requirement via legislative reform appeared to garner tentative cross-party support. Members of the bipartisan Parliamentary Friendship Group for Lesbian, Gay, Bisexual, Transgender, Intersex and Queer Australians convened a meeting in February 2016 to discuss the Family Court's role in Stage 2 decision-making. Speaking at the meeting were parents and children affected by the court process, as well as medical and legal experts.⁶¹ Also in attendance were members of each of the major parties, several independents, and a representative of the federal Attorney-General. At the meeting, legislative reform was discussed as a decisive way in which to end the current controversy. However, momentum was quickly lost due to the announcement of an early election, as well as controversy over the Safe Schools program,⁶² a voluntary curriculum schools can utilise to support gay, lesbian, and transgender students. The extreme attacks made against the Safe Schools program, particularly by conservative elements within the Liberal and National parties,⁶³ suggest that any reforms supportive of transgender young people are likely to be too controversial for the current government.

In light of the existing political climate, it is necessary to consider whether there might be alternatives to legislative reform that can alleviate the burden of the court process on families. In an interview in 2014, the Chief Justice of the Family Court, Diana Bryant, indicated support for a streamlined application process, stating she was '... confident that we can put in place a process which will be easily manageable'.⁶⁴ However, no such process eventuated. The issue was revisited in an interview in July 2016 in which the Chief Justice accepted that the existing process was 'difficult and stressful and we need to try and find some more simple solution'.⁶⁵ She went on to state that she had asked 'the [Attorney General's] Department if we could organise a roundtable involving the major hospitals ... and just see if we can sort out a simpler and consistent method of dealing with these matters'. While the exact details of any new process have not yet been determined, the Chief Justice envisaged one where an application 'could be made relatively simply by consent, with sufficient material but not as much as you would need for [a

61 Ireland, above n 52; Medhora, above n 52.

62 See <<http://www.safeschoolscoalition.org.au/>> (accessed 16 September 2016).

63 See, eg, A Gartrell, 'Malcolm Turnbull under pressure after George Christensen likens Safe Schools program to paedophile grooming' *Sydney Morning Herald*, 26 February 2016, at <<http://www.smh.com.au/federal-politics/political-news/malcolm-turnbull-under-pressure-after-george-christensen-likens-safe-schools-program-to-pedophile-grooming-20160225-gn42jk.html>> (16 September 2016); J Norman, 'George Christensen and Cory Bernardi push for 'full' inquiry into Safe Schools program', *ABC News* (online), 16 March 2016, at <<http://www.abc.net.au/news/2016-03-16/governments-safe-schools-review-labelled-joke-by-mps/7250974>> (16 September 2016).

64 Interview with Bryant CJ for 'Being Me', *Four Corners*, ABC TV, 17 November 2014.

65 J Taylor, 'Chief Justice demands change to "traumatic" court process for transgender children', *ABC News* (online), 5 July 2016, at <<http://www.abc.net.au/news/2016-07-05/court-process-for-transgender-children-set-to-be-overhauled/7546884>> (16 September 2016).

court] application; and in a form that the parties could do it without the assistance of lawyers'.⁶⁶

Without knowing exactly how the proposed process might work, it is difficult to comment in detail on the extent to which it would alleviate the harms identified by the study. However, some tentative assertions can be made. Not requiring families to attend a hearing would certainly be an improvement on the current situation. Removing the formal requirement would make the process less intimidating and daunting for both parents and children. However, it may still take an emotional toll on young people, knowing that the approval of their treatment continues to lie in the hands of a judge who has never met them or had any involvement in their care. A consent-based approval process is also likely to be quicker for families, reducing the period of delay between the decision that the child was ready for Stage 2 treatment and the actual receipt of that treatment. However, whether the delay is significantly reduced is going to depend on exactly what Bryant CJ meant when she said that the new system would involve 'sufficient material but not as much as you would need for [a court] application'. The process of obtaining detailed medical reports was a significant contributor to the delays involved in the current system. There are a small number of experts capable of preparing such reports and they are already inundated with both clinical and report-writing duties due to the increase in referrals. If formal medical reports are still required under the new system, significant delays are likely to continue.

A consent-based approval process is also likely to reduce costs for parties, particularly if lawyers are not needed. However, the full extent of the savings will depend on the role medical professionals play in the process. If formal medical reports are still required, families will continue to need several thousand dollars to bring an application. If medical reports can be limited or streamlined, then costs will be greatly reduced. The possibility of requiring less medical evidence, however, raises the question of the precise role of court involvement.

Conclusion

While drawing on a small sample of parents, this study provides the first qualitative evidence to confirm what health professionals,⁶⁷ academics,⁶⁸ and even some judges⁶⁹ have been arguing for some time: that the Family Court approval process for Stage 2 treatment has a damaging impact on transgender youth and their families. The unanimous support for change amongst the parents — echoed by comments of Australia's senior family law judge — suggests that reform is urgently needed. If action is not taken, another generation of children will likely be traumatised by the Family Court process.

⁶⁶ *Lateline*, ABC TV, 5 July 2016, at <<http://www.abc.net.au/lateline/content/2016/s4495200.htm>> (16 September 2016).

⁶⁷ Telfer et al, above n 1, at 1052; Hewitt et al, above n 8, at 580.

⁶⁸ Bell, above n 9, at 451; France, above n 9, at 245–6.

⁶⁹ In a recent stage two case, Bennett J was extremely critical of the existing protocol stating that 'in this entirely uncontroversial case, I have difficulty in identifying how the interests of the child are well served by compelling his parents to make the instant application'. *Re Martin* [2015] FamCA 1189 at 36; BC201551205 at [36].

The parents of the youngest children in the study could not help but speculate about the harm a Family Court application might do to a child who has had a positive experience of social transition and been able to access services in a timely and supportive manner. For example, Bronwyn was concerned that her efforts to normalise her 7-year-old son's gender identity would be undermined by having to go to court. As she explained:

The thing that really worries me is that I've got this child who's been told he's perfectly normal. His doctors see him as perfectly normal and he's been told that if he needs help at puberty he'll get it. So what's going to happen when at 16 he finds out that he has to go to Court to access what is supposed to be normal and accepting? How is that supposed to make him feel? Apart from the trauma of an anxious child and having his puberty exposed to the whole world, what . . . kind of message does that give him about being normal?

However reform is achieved, it is clear that removing barriers to accessing Stage 2 treatment will enhance the emotional and physical wellbeing of Australia's transgender youth and support their families through what is already a challenging process.