CASE SUMMARY

Re: Imogen (No. 6) [2020] FamCA 761 (10 September 2020)

FACTS AND BACKGROUND

This case before the Family Court of Australia ('the Court') concerned Imogen, aged 16 and 8 months, who was assigned male at birth but identifies as female. Imogen was diagnosed with gender dysphoria by her treating doctors and was medically assessed to be capable of giving informed consent. Imogen had been receiving Stage 1 (puberty suppression) therapy since 2018, when she was 15 years of age. She expressed a consistent wish to proceed to Stage 2 (hormonal) therapy to affirm her gender.

The proceedings involved a dispute between Imogen's father and mother as to whether Imogen should commence Stage 2 therapy. Imogen's father supported her wish to undergo gender affirming therapy. He served an application to grant Imogen 'parental responsibility' under s 65D of the *Family Law Act 1975* (Cth) ('the Act') to make her own decision or, in the alternative, to seek a court order authorising the therapy.

Imogen's mother disputed the diagnosis of gender dysphoria and believed that Imogen was not '*Gillick* competent', a legal principle which recognises the increasing capacity of minors to make informed decisions in matters affecting them. In the present case, Imogen's mother did not consider her competent to make a fully informed decision about accessing Stage 2 therapy. The mother did not consent to Imogen receiving Stage 2 therapy, but in her final submissions she did not seek a mandatory injunction to stop the treatment. The mother expressed her wish that Imogen should undergo psychotherapy instead.

With respect to Imogen's particular circumstances, the questions before the Court were:

1. Where there is a dispute about consent for a child presenting with gender dysphoria, is it mandatory to make an application to the court to resolve that dispute?
2. If Imogen is found to be *Gillick* competent, can she make her own decisions without her parents' consent?
3. If Imogen's consent is not sufficient on its own, is it preferable to grant her 'parental responsibility' to make her own decisions, or make an order to authorise treatment on the basis of her 'best interests'?[1]

REASONING

Applicable legal principles

The Court, constituted by Watts J, began by clarifying the applicable legal principles and by restating the current state of the law as it applies to the treatment of trans and gender diverse children. His Honour did so because the Australian Standards of Care and Treatment Guidelines ('the Australian Standards') for trans and gender diverse children incorrectly asserted that medical practitioners do not need to obtain parental consent for Stage 2 therapy. At the time of the present judgment, the Australian Standards claimed to reflect the current authority of *Re Kelvin [2017]* FamCAFC 258.

Under the common law, once a child is found to be *Gillick* competent, the scope for parental consent diminishes as the child matures and their own capacity to give informed consent increases.[2] However, if the treatment in question is 'non-therapeutic', court approval is required notwithstanding the consent of a child or the child's parents (or those with parental responsibility). The Court has jurisdiction to resolve a dispute about a proposed treatment by making a declaration of *Gillick* competence or making an order under the Act.[3]

In *Re Kelvin*, the Court determined that Stage 2 treatment for children diagnosed with gender dysphoria is 'therapeutic' and that consent for such treatment lies within the bounds of parental authority.[4] This means that

[1] *Family Law Act 1975* (Cth) s 67C (*'FLA Act'*).
[2] *Secretary, Department of Health and Community Services v JWB and SMB* [1992] HCA 15; (1992) 175 CLR 218 (*'Marion's Case'*).
[3] *FLA Act* (n 1) ss 67ZC, 65D(1), 64B(2)(i), 34(1); *Re Kelvin* [2017] FamCAFC 258.
[4] *Re Kelvin* [2017] FamCAFC 258.

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Author: Batool Moussa, BA LLB (Hons), M SocPol

where the *Gillick* competence of a child is disputed by a medical practitioner, the parents can consent to Stage 2 treatment without the approval of the court.

Questions of law

Where an application to the court is mandatory

Having regard to the above legal principles, Watts J found that an application to the Court is mandatory (that is, court authorisation is required) if a parent or medical practitioner disputes:

- the child's capacity to consent (*Gillick* competence);
- a diagnosis of gender dysphoria; or
- the treatment proposed for gender dysphoria.

If the dispute is **solely** about child's capacity to consent, the Court must resolve that dispute by making a declaration as to whether the child is *Gillick* competent pursuant to s 34(1) of the Act.[5] If such a declaration is made, court authorisation is not required as the child can make an informed decision about commencing the treatment. *Gillick* competence is determined with reference to factual findings, without regard to parental responsibility or the 'best interests of the child' principle under the Act.[6]

If there is a dispute about the **diagnosis or proposed treatment**, the Court should determine the diagnosis, whether treatment is appropriate and, having regard to the 'best interests of the child' as a paramount consideration, make an order authorising or not authorising the treatment. In considering a child's 'best interests', the Court must give weight to the views of the child, 'in accordance with [their] maturity and level of understanding'.[7]

Why is an application to the court mandatory?

In concluding why an application to the court is mandatory in circumstances where a dispute cannot otherwise be resolved, Watts J clarified the approach taken in *Re Kelvin* and took stock of Bryant CJ's non-binding observations (*obiter dicta*) in *Re Jamie* [2013] *FamCAFC 110*. Watts J also followed the intervening submission of the Attorney-General of the Commonwealth.

The Court clarified that an order made authorising the administration of any treatment constitutes a 'departure from the exercise of a right and responsibility ordinarily vested in parents'.[8] In circumstances where consent or treatment are disputed, a medical practitioner who administers treatment without parental consent or approval of the Court runs the risk of preferencing the views of one parent over another, and exposing themselves to criminal or civil liability claims, particularly where one parent disputes the proposed treatment, and/or where one parent consents to the treatment and the other does not.[9]

Where diagnosis or treatment are disputed, why is Gillick competence alone not determinative?

Watts J confirmed existing law and the ruling authority of *Re Kelvin*. Absent any dispute by the parents or medical practitioner with regard to the diagnosis, proposed treatment, and *Gillick* competence of a child desiring gender affirming therapy, the child can consent to Stage 2 treatment without court authorisation. Where this is the case, 'it is a matter of the medical professional bodies to regulate what standards should apply to the medical treatment'.[10]

Where a dispute is present, medical practitioners must first ascertain 'whether or not a child's parents or legal guardians consent to the proposed treatment'.[11] If only *Gillick* competence is disputed, a declaration as to the child's capacity to make an informed decision must be determined by the Court. If a child is found to be *Gillick* competent, court authorisation is not required.

[5] Ibid 258, [66].
[6] *Re Imogen* (No. 6) [2020] FamCA 761, [43] ('*Re Imogen*').
[7] *Re Jamie* [2013] *FamCAFC 110*, [140] (Bryant CJ); *Re Imogen* (n 6), [59].
[8] *Re Imogen* (n 6), [59].
[9] Ibid.
[10] Ibid [63].
[11] Ibid.

Conclusions in relation to diagnosis, treatment and consent

The Court acknowledged that the case was heard in the context of an emerging debate about the treatment and diagnosis of trans and gender diverse children.

His Honour considered evidence adduced by expert witnesses about Imogen's particular circumstances and current research into trans health and gender affirming healthcare more broadly. Experts gave different views about the consensus medical approach in Australia and internationally.

Diagnosis

Watts J accepted Imogen's diagnosis of gender dysphoria and that the diagnosis is associated with 'clinically significant distress and impairment in social and other important areas of functioning'.[12] Evidence from Imogen's treating psychiatrist was accepted because they had assessed Imogen's stated 'self-experience over a longer period of time, including her awareness of the sources of her distress'.[13]

The mother's expert psychiatrist opined that Imogen's distress is primarily caused by a 'post-traumatic mental health condition, rather than her sense of gender incongruence'.[14] The Court rejected this claim as it did not adequately explain why Imogen's 'distress, anxiety and reluctance' was not associated with the discomfort she expressed about her own body.[15]

Gillick competence

Watts J determined that Imogen is *Gillick* competent to provide consent to Stage 2 treatment.[16] Imogen's treating psychiatrist opined that she demonstrated an informed knowledge of the effects of gender affirming treatment, and that she is 'able to weigh the risks and benefits in the balance' in a manner that is consistent with the maturity level of other *Gillick* competent adolescents who presented for the same treatment.[17] The mother's expert psychiatrist was of the view that Imogen did not understand the full ramifications or effects of the treatment in the long run.[18]

His Honour was satisfied that Imogen demonstrated intelligence, maturity and an ability to understand and weigh in balance the advantages and disadvantages of the proposed Stage 2 treatment, including 'possible consequences that cannot be entirely foreseen'.[19] The Court accepted that Imogen had reached an informed decision in her hope that the treatment will reduce the distress associated with her feelings of gender incongruence.[20]

Treatment

Watts J accepted evidence that the gender affirming model of healthcare is the consensus medical approach taken in treating gender dysphoria.[21] Watts J placed less weight on evidence that questioned the efficacy of Stage 2 therapy for gender dysphoria and rejected evidence that advocated for psychotherapy, both in this case and more broadly, as the preferred and exclusive model of care for Imogen.[22]

The Court determined that the exclusive use of a psychotherapeutic approach is a 'risky and unproven strategy' for treating gender dysphoria as it would delay gender affirmation for up to 12 months.[23] A gender affirming approach to treatment was found to be in Imogen's 'best interests'. The Court accepted expert

[12] Op cit 8 [182].
[13] Ibid.
[14] Ibid [174].
[15] Ibid [176].
[16] Ibid [199].
[17] Ibid [186].
[18] Ibid [189].
[19] Ibid [198].
[20] Ibid.
[21] Ibid [224].
[22] Ibid [239].
[23] Ibid [226].

recommendations that the mental health and well-being benefits facilitated through such treatment 'is very likely to significantly outweigh any current or future risks to [Imogen's] health and well-being'.[24]

In coming to those conclusions, the Court considered evidence about the complexities of research into gender affirming health care, including claims by the mother's expert that gender-affirming treatment did not reduce suicidality,[25] and that participants in studies of people who have transitioned and were lost to follow-up affirms their subsequent regret or an experience of an adverse outcome.[26] The Court rejected the evidence given by the mother's expert.

With regard to both Imogen's particular circumstances and 'best interests' as a paramount consideration, the Court made an order authorising the administration of Stage 2 therapy for Imogen.[27]

[24] Op cit 8 [212], [217], [231].
[25] Ibid [155].
[26] Ibid [157], [159], [165].
[27] Ibid [231].