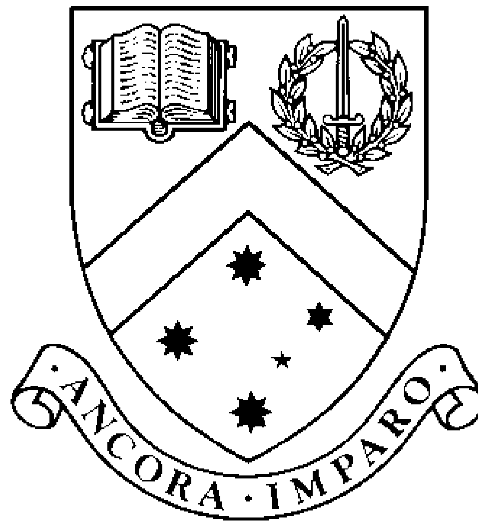
Treatment for Gender Identity Dysphoria

Children's Rights and Best Interests



Thesis

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ABSTRACT

In Australia, a child with Gender Identity Dysphoria – a condition where mental gender identity does not match biological sex – cannot obtain physical treatment for the condition without court authorisation. In deciding whether to grant such authorisation, a court must determine if the treatment would be in the child's best interests. I argue that, if international children's rights law directly applied in Australia, a child with Gender Identity Dysphoria would have the right to seek treatment without court authorisation. The best available data show that not treating the condition can carry significant risk, whereas treating the condition carries virtually no risk. I argue that, if these data are verified and a risk assessment is carried out in a particular case, it is *always* in the best interests of a child with Gender Identity Dysphoria to receive treatment.

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I Introduction

'Litigation in [the area of treatment for Gender Identity Dysphoria in children] is characterised by "conflict of rights" arguments: the right to bodily integrity and self determination versus [the] parents' right to ensure that children are protected from harm and from making impetuous decisions inimical to their best interests.'

– The Honourable Diana Bryant QC, Chief Justice, Family Court of Australia.[1]

In Australia, when a court decides whether or not to authorise certain medical treatments for children – including treatments for Gender Identity Dysphoria – the best interests of those children are paramount.

Determination of best interests can be a complex affair, as courts are required to consider and balance many factors. It is further complicated when related to a controversial medical condition.

Furthermore, it is important for courts to consider children's rights. These can be found embedded within Australian legislation and also in international law.

This thesis looks at children's rights and best interests in relation to treatment for Gender Identity Dysphoria. It explores the current legal landscape and examines the potential of international law, which does not directly apply in Australia, in influencing this landscape. Moreover, it considers the effect of the best and latest medical and legal data on best-interests considerations.

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[1] The Hon Diana Bryant, 'It's My Body, Isn't It? Children, Medical Treatment and Human Rights' (2009) 35(2) *Monash University Law Review* 193-211, 195.

Chapter II provides an overview of the applicable law, including international law.

Chapter III looks at Gender Identity Dysphoria (which is called 'Gender Identity Disorder' and 'Transsexualism' in the medical literature) including how it is defined in medicine and the law, how it is treated, and why it is controversial.

Children's rights under both Australian and international law as they apply to children seeking treatment for Gender Identity Dysphoria are examined in Chapter IV.

Crucial factors influencing best-interests determinations in relation to children with Gender Identity Dysphoria are discussed in Chapter V.

Finally, Chapter VI is the conclusion.

II THE LAW

A *Family Law Act and Family Law Courts*

1 *Overview*

The *Family Law Act 1975*[2] ('FLA') is Australia's primary legislative instrument governing the operation of family law. It is mostly concerned with children and parenting (Part VII), family dispute resolution (Part II), divorce (Part VI), and division of property after relationship breakdown (Part VIII).

Part IV of the FLA established the Family Court of Australia, a superior court of record, with both original and appellate jurisdiction. It sits in Australia's federal judicial hierarchy on the same level as the Federal Court of Australia. Decisions of the Full Court of the Family Court are appealable to the High Court of Australia.[3]

The Federal Magistrates Court, established in 1999,[4] also has jurisdiction under the FLA.[5] Decisions of the Federal Magistrates Court made under the jurisdiction conferred upon it by the FLA are appealable to the Family Court of Australia.[6]

These courts must exercise their jurisdiction having regard to, among other principles, 'the need to protect the rights of children and to promote their welfare'.[7]

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[2] *Family Law Act 1975* (Cth).

[3] Western Australia has its own Family Court of Western Australia.

[4] *Federal Magistrates Act 1999* (Cth) s 8.

[5] *Family Law Act 1975* (Cth) ss 33B(8A), 33C(3A), 39(5AA)-(5A), 39B(1)(b), 69H(4). State and territory courts of summary jurisdiction also have limited jurisdiction under the FLA.

[6] *Family Law Act 1975* (Cth) s 99AAA(1); *Federal Magistrates Act 1999* (Cth) s 20: Federal Magistrates Court decisions cannot be appealed directly to the High Court.

Hereinafter, the term 'family law courts' will be used to refer collectively to the Family Court of Australia and the Federal Magistrates Court.

2 *Children*

In its original form, due to the limited powers afforded to the Commonwealth Government under the Australian Constitution, the FLA applied to children of marriage only.[8] Following referrals of power by the States (except Western Australia), the FLA now applies to all children unless they attain 18 years of age, marry or enter a de facto relationship, or, in some cases, if they are under the care of a child-welfare agency.[9]

3 *Parental Responsibility*

(a) Overview

In the absence of a parenting order[10] to the contrary, each of a child's parents has parental responsibility for the child, irrespective of how the child was conceived and the marital status of the parents. Parental responsibility generally applies until a child attains 18 years of age.[11]

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[7] *Family Law Act 1975* (Cth) s 43(c).

[8] Under *Australian Constitution* s 51 (federal heads of power). In particular, ss 51 (xxi): 'Marriage', 51(xxii): 'Divorce and matrimonial Powers; and in relation thereto, parental rights, and the custody and guardianship of infants'.

[9] *Family Law Act 1975* (Cth) ss 65H, 69ZK; *Commonwealth Powers (Family Law – Children) Act 1986* (NSW); *Commonwealth Powers (Family Law – Children) Act 1986* (Qld); *Commonwealth Powers (Family Law – Children) Act 1986* (SA); *Commonwealth Powers (Family Law) Act 1987* (Tas); *Commonwealth Powers (Family Law – Children) Act 1986* (Vic). States may refer powers to the Commonwealth under *Australian Constitution* s 51(xxxvii).

[10] Parenting orders are the subject of Section 4 below.

[11] *Family Law Act 1975* (Cth) s 61C.

Parental responsibility encompasses 'the duties, powers, responsibilities and authority which, by law, parents have in relation to children'.[12]

Parental responsibility includes making decisions about authorisation of ordinary medical procedures, or in the case of special medical procedures, applying to the Family Court for authorisation.[13]

(b) Dwindling Parental Responsibility

It is not the case that parents are fully responsible for a child until the child turns 18, and then, on the day of the child's 18th birthday, parental responsibility disappears.

Instead, as a child under 18 develops maturity and capacity to make decisions for themself, parental responsibility dwindles.

Lord Denning MR of the UK Court of Appeal said of custody in *Hewer v Bryant*[14] that 'it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, and the more so the older he is. It starts with a right of control and ends with little more than advice'.[15]

This concept of dwindling parental rights[16] was upheld and broadened by the House of Lords in the *Gillick*[17] case.

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[12] *Family Law Act 1975* (Cth) s 61B.

[13] *Re: Brodie (Special Medical Procedures: Jurisdiction)* [2007] FamCA 776 [44]-[47]. Special medical procedures are discussed in Section 6 below.

[14] *Hewer v Bryant* [1970] 1 QB 357.

[15] Ibid 369.

[16] In the contemporary Australian context, focus has moved from parental rights to parental responsibility.

[17] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

In this case, a government health department had circulated advice to doctors, regarding prescription of contraceptives to girls under the age of 16 years. The advice stated that, although it would normally be preferable for doctors to seek parental consent before prescribing contraceptives to girls under 16, in special circumstances doctors could provide advice and prescriptions to a girl under 16 without parental consent.

Victoria Gillick, who had five daughters under 16, sought assurance from the authority that her daughters would not receive contraceptive advice or treatment without parental consent. After such assurance was refused, Mrs Gillick sought a court declaration that the department's advice was unlawful, arguing that it was inconsistent with her parental rights.

The majority of the House of Lords held that 'capacity to consent is a question of fact in every case'.[18] Lord Scarman said:[19]

> Parental rights … do not wholly disappear until the age of majority. … But the common law has never treated such rights as sovereign or beyond review and control. Nor has our law ever treated the child as other than a person with capacities and rights recognized by law. The principle of the law … is that parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child.

[18] Ibid 153.

[19] Ibid 183-4. Quotation as set out by Mason CJ, Dawson, Toohey and Gaudron JJ, in *Department of Health & Community Services v JWB & SMB ("Marion's Case")* (1992) 175 CLR 218, 237.

His Lordship went on to summarise the position of the House of Lords:

> It is that parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.[20]

This principle, now commonly referred to as *Gillick competence*, was unanimously adopted in Australia by the High Court in *Marion's Case*.[21] Mason CJ, Dawson, Toohey and Gaudron JJ said '[t]his approach, though lacking the certainty of a fixed age rule, accords with experience and with psychology. It should be followed in this country as part of the common law.'[22]

Furthermore, a majority in *Marion's Case* held that an intellectually disabled child may be Gillick competent, stating that

> it is important to stress that it cannot be presumed that an intellectually disabled child is, by virtue of his or her disability, incapable of giving consent to treatment. The capacity of a child to give informed consent to medical treatment depends on the rate of development of each individual. And if *Gillick* is taken to reflect the common law in Australia, as we think it now does, these propositions are true as a matter of law.[23]

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[20] Ibid 186.

[21] *Department of Health & Community Services v JWB & SMB ("Marion's Case")* (1992) 175 CLR 218. The facts of this case are discussed in Section 6 below.

[22] Ibid 237-8.

[23] Ibid 239.

4 *Parenting Orders*

A family law court has power to make parenting orders as it thinks proper.[24]

An application for a parenting order in relation to a child may be made by either or both of the child's parents, the child, a grandparent, or any other person concerned with the care, welfare or development of the child.[25]

A parenting order may deal with one or more of:[26]

- the person or persons with whom a child lives;
- the time a child spends with other persons;
- allocation of parental responsibility;
- communication a child has with other persons;
- child maintenance;
- steps to be taken before the order may be varied by the court;
- the process to use for resolving disputes about the order;
- any aspect of care, welfare or development of the child; and
- any other aspect of parental responsibility for the child.

5 *Best Interests*

A family law court making a decision about a parenting order must regard the best interests of a child as paramount.[27]

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[24] *Family Law Act 1975* (Cth) s 65D.

[25] *Family Law Act 1975* (Cth) s 65C.

[26] *Family Law Act 1975* (Cth) s 64B(2).

[27] *Family Law Act 1975* (Cth) s 60CA.

FLA s 60CC sets out how a court must determine a child's best interests including 'primary considerations' and 'additional considerations'.

The primary considerations are:

- 'the benefit to the child of having a meaningful relationship with both of the child's parents'; and
- 'the need to protect the child from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or family violence.'

The additional considerations are:

- 'any views expressed by the child' and 'the weight [a court] should give to [those] views';[28]
- the nature of the child's relationships with parents and other significant people;
- 'the willingness and ability of each of the child's parents to facilitate, and encourage, a close and continuing relationship between the child and the other parent';
- 'the likely effect of any changes in the child's circumstances' including separation from significant people;
- 'the practical difficulty and expense of a child spending time with and communication with a parent' and whether these affect the child's right to maintain relationships;

[28] Views of the child are discussed in detail in the context of rights in Section IV.B.2 below, and in the context of best interests in Part V.C below.

- the capacity of parents and other significant persons to provide for the needs of the child;
- characteristics of the child and either parent, including maturity, sex, lifestyle and background;
- an indigenous child's right to enjoy indigenous culture;
- each parent's attitude to the child and to parental responsibility;
- 'any family violence involving the child or a member of the child's family', including applicable family violence orders;
- 'whether it would be preferable to make the order that would be least likely to lead to the institution of further proceedings in relation to the child'; and
- anything else the court considers relevant.

The application of these considerations is discussed in Chapter V below.

6 *The Welfare Jurisdiction and Special Medical Procedures*

A family law court 'has jurisdiction to make orders relating to the welfare of children', subject to best-interests considerations, under FLA s 67ZC.

(a) Special Medical Procedures

A parent (or other person with parental responsibility) may normally give authorisation for a child to undergo a medical procedure.[29] Some *special medical procedures*, however, require court authorisation.

In *Marion's Case*, already mentioned in the context of dwindling parental responsibility,[30] the parents of a 14-year-old girl with 'mental retardation' applied to

[29] *Family Law Act 1975* (Cth) s 1(4): 'major long-term issues … includes … the child's health'.

the Family Court for authorisation for performance of sterilisation procedures (hysterectomy and ovariectomy) upon the girl.

In the first instance, the Family Court was asked to determine whether or not the parents could lawfully authorise such procedures without an order of the Court, and, if not, whether the Family Court had jurisdiction to provide such authorisation.

In 1992, the case came before the High Court on appeal. A key consideration was whether the sterilisation was a therapeutic or non-therapeutic treatment. Therapeutic treatment was considered to be 'for the traditional medical purpose of preserving life or directly treating or preventing physical illness', whereas non-therapeutic treatment was 'for other purposes' such as 'the enhancement or preservation of quality of life'.[31]

A majority of the High Court held that a person with parental responsibility could not lawfully authorise the sterilisation of a child for non-therapeutic purposes. Court authorisation was required

> 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.[32]

The High Court held that the Family Court had power to authorise such a procedure under the welfare jurisdiction.

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[30] See Section 3 above.

[31] *Department of Health & Community Services v JWB & SMB ("Marion's Case")* (1992) 175 CLR 218, 269, 296.

[32] Ibid 250.

(i) Gender Transition

Mushin J of the Family Court applied *Marion's Case* to find that court authorisation was required for sex re-assignment surgery on a child with an intersex condition.[33]

In 2004, Nicholson CJ of the Family Court held in *Re: Alex (No 1)*[34] that staged treatment for Gender Identity Dysphoria, including reversible and irreversible hormonal treatments, should be regarded as a single treatment plan. His Honour held that such a treatment plan requires court authorisation.[35]

Gender Identity Dysphoria, its treatments, and the *Re: Alex* cases, are discussed in detail in Chapter III below.

(b) Scope of the Welfare Jurisdiction

The scope of the welfare jurisdiction is limited. The High Court considered the scope of FLA s 67ZC in *MIMIA v B*,[36] a case about children being held in immigration detention. In their joint judgment, Gleeson CJ and McHugh J said that '[s]ection 67ZC … does not itself expressly give jurisdiction in respect of a "matter"' under sections 75 and 76 of the *Constitution*.[37] After further discussion, their Honours came to the conclusion that:

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[33] *In Re A* (1993) 16 Fam LR 715, 720.

[34] *Re Alex (hormonal treatment for gender dysphoria)* (2004) Fam LR 503. This case is discussed in detail in Section III.B.2 below.

[35] Ibid 536-8.

[36] *Minister for Immigration and Multicultural and Indigenous Affairs v B and Anor* (2004) 206 ALR 130.

[37] Ibid 135. *Australian Constitution* s 75 sets out certain matters over which the High Court has original jurisdiction, and s 76 sets out matters over which the Parliament may confer original jurisdiction upon the High Court.

> The valid application of s 67ZC, therefore, is dependent upon some other provision in Pt VII of the [FLA] creating a "matter" within the meaning of ss 75 or 76 of the Constitution to which the jurisdiction conferred by s 67ZC can attach. Consequently, it is necessary to turn to other provisions in the Act – particularly Pt VII – to determine the jurisdiction, if any, that s 67ZC validly confers. … The provisions of [ss 60B, 61B and 61C] provide ample support for an application by a parent for an order under s 67ZC. [38]

Carter J of the Family Court determined that authorisation of a special medical procedure comes under the section 61B definition of *parental responsibility*, and 'is directly related to the care, welfare or development of [the] child'. Her Honour held that the Family Court's power under section 65D to make parenting orders, coupled with the section 65C provisions as to who may apply for a parenting order, is sufficient for attachment of section 67ZC, giving the Family Court 'both jurisdiction and power to deal with' an application by a child's parent for authorisation for the child to undergo a special medical procedure, whether that child is nuptial or ex-nuptial.[39]

Bryant CJ subsequently held in *Re: Alex (No 2)*[40] that where legislation 'effectively places the Secretary [of a government department] "in the shoes" of the natural parent of a child for whom the Secretary is a guardian', the Secretary is the child's 'legal "parent"'. As a result, her Honour held that the Family Court had jurisdiction

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[38] Ibid 140.

[39] *Re: Brodie (Special Medical Procedures: Jurisdiction)* [2007] FamCA 776 [44] – [47].

[40] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009).

to hear an application for authorisation of a special medical procedure brought by the Secretary.[41]

B *Convention on the Rights of the Child*

The United Nations *Convention on the Rights of the Child*[42] ('CROC') is a human rights instrument that has gained virtually universal acceptance. 193 countries, including all members of the United Nations except Somalia and the United States of America, have ratified it.[43]

CROC contains provisions covering a wide range of themes. Several of these are relevant to the current discussion, and are considered in Part IV.C below.

1 *Application in Australia*

Notwithstanding that they have been ratified by Australia, provisions of international treaties do not form part of Australian law unless they have been incorporated by statute. No legislation has, to date, been passed to give domestic effect to the rights embodied in CROC.[44]

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[41] Ibid [122] – [131].

[42] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1588 UNTS 530 (entered into force 2 September 1990; entered into force for Australia 16 January 1991).

[43] United Nations, *United Nations Treaty Collection* <http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en> at 31 August 2010.

[44] Bryant, above n 1, 196.

However, the High Court of Australia has held that, where statutes and regulations are ambiguous, they should be construed in accordance with Australia's international obligations.[45]

The Full Court of the Family Court has held that CROC is especially significant, due to its almost universal international acceptance and its use as a source for amendments to the FLA. The FLA is not a code. It should be read in the context of CROC.[46]

In obiter, in *MIMIA v B*, Callinan J of the High Court stated that '[CROC] cannot expand the intended and clearly identified scope of Pt VII of the [FLA]'.[47] The other four justices in this case did not discuss CROC in their judgments.

As such, the application of CROC in Australia remains untested in the High Court, and the position of the Full Court of the Family Court is good law.

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[45] *Minister of State for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 287, 315.

[46] *B and B: Family Law Reform Act 1995* (1997) 21 Fam LR 676, 742-6. CROC art 3 is embodied in FLA s 60CA.

[47] *Minister for Immigration and Multicultural and Indigenous Affairs v B and Anor* (2004) 206 ALR 130, 186.

III GENDER IDENTITY DYSPHORIA

A *Diagnostic Definitions: Gender Identity Disorder and Transsexualism*

The American Psychiatric Association's *Diagnostic and statistical manual of mental disorders*[48] ('DSM') and the World Health Organization's *ICD-10: international statistical classification of diseases and related health problems*[49] ('ICD') are the two internationally recognised diagnostic manuals for mental disorders.[50]

Both manuals provide diagnostic criteria and codes for Gender Identity Dysphoria[51] ('GID') based on whether or not the patient is pre-pubescent.

DSM provides:

- 302.6: Gender Identity Disorder in Children; and
- 302.85: Gender Identity Disorder in Adolescents or Adults.

ICD provides:

- F64.2: Gender Identity Disorder of Childhood; and
- F64.0: Transsexualism.

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[48] American Psychiatric Association Task Force on DSM-IV, *Diagnostic and statistical manual of mental disorders : DSM-IV-TR* (4th ed, American Psychiatric Association, Washington, DC, 2000). Extract reproduced in Appendix A. DSM is generally used in Australia and USA.

[49] World Health Organization, *ICD-10: international statistical classification of diseases and related health problems* (10th revision, 2nd ed, World Health Organization, Geneva, 2004), 343. Extract of World Health Organization, *The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research* (World Health Organization, Geneva, 1993) reproduced in Appendix B. ICD is generally used in Europe, including UK.

[50] Peter Riedesser, Michael Schulte-Markwort and Kathrin Marutt, *Cross-walks ICD-10 – DSM IV-TR: a synopsis of classifications of mental disorders* (Hogrefe & Huber, Göttingen, Germany, 2003), 1.

[51] Under the names 'Gender Identity Disorder' and 'Transsexualism'.

These DSM and ICD diagnoses (respective to age) are considered to be completely corresponding.[52] The World Professional Association for Transgender Health[53] ('WPATH') expects that the differences between the DSM and ICD diagnoses will be eliminated in the future.[54]

1 *DSM*

DSM has four diagnostic criteria for Gender Identity Disorder:[55]

- '[a] strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)';
- '[p]ersistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex';
- no concurrent physical intersex condition; and
- 'clinically significant distress or impairment in social, occupational, or other important areas of functioning'.

While the DSM criteria are the same for both age-based classifications, manifestations of the first two criteria in children are differentiated from those in adolescents and adults.

The Family Court of Australia has accepted the DSM definition, preferring the term 'Gender Identity Dysphoria' over 'Gender Identity Disorder'.[56]

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[52] Ibid 25.

[53] Known until 2006 as The Harry Benjamin International Gender Dysphoria Association.

[54] The Harry Benjamin International Gender Dysphoria Association, *Standards of Care for Gender Identity Disorders* (6 ed, The Harry Benjamin International Gender Dysphoria Association, Minneapolis, 2001), 6.

[55] American Psychiatric Association Task Force on DSM-IV, above n 48, 581-2.

2 *ICD*

ICD has three criteria for Transsexualism:[57]

- the desire to 'live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormonal treatment';
- persistence over at least two years; and
- '[t]he disorder is not a symptom of another mental disorder'.

The ICD criteria for Gender Identity Disorder of Childhood are different for girls and boys, but can be summarised as:[58]

- persistent and intense distress about being of the current sex, a stated desire to be the other sex (not merely a desire for perceived cultural advantages of the other sex), or insistence that that the child is the other sex;
- either of:
    - aversion to, or rejection of, normative clothing and activities of the current sex and desire for those of the other sex; or
    - persistent repudiation of the child's current sexual anatomical structures;
- the child has not reached puberty; and
- persistence over at least six months.

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[56] *Re Alex (hormonal treatment for gender dysphoria)* (2004) Fam LR 503 [101].

[57] World Health Organization, *The ICD-10 diagnostic criteria for research*, above n 49, 133-4.

[58] Ibid 134-5.

B *Australian Case Law: Transsexualism and Gender Identity Dysphoria*

The two leading series of Australian cases that involved definition of transsexualism are the *Re: Kevin* cases[59] and the *Re: Alex* cases.[60] These series of cases, although both decided by the Family Court of Australia in relatively close succession, heard very different expert evidence and reached different, though not entirely inconsistent, conclusions on how transsexualism or GID should be classified.

1 *Re: Kevin*

In *Re: Kevin*, Kevin and his wife sought a declaration under FLA s 113 that their marriage was valid.

The key question was whether or not Kevin, who was born biologically female but had had his sex re-assigned by the time of his marriage to a woman, was a man for the purposes of marriage legislation.

The *Marriage Act 1961* (Cth) defines marriage as 'the union of *a man and a woman* to the exclusion of all others, voluntarily entered into for life'[61] (emphasis added). The FLA reiterates this definition, requiring family law courts to have regard to 'the need to preserve and protect the institution of marriage' as defined in the *Marriage Act*.[62]

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[59] *Re Kevin: Validity of Marriage of Transsexual* (2001) 28 Fam LR 158; *Attorney-General for the Commonwealth v Kevin and Others* (2003) 30 Fam LR 1.

[60] *Re Alex (hormonal treatment for gender dysphoria)* (2004) Fam LR 503; *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009).

[61] *Marriage Act 1961* (Cth) s 5.

[62] *Family Law Act 1975* (Cth) s 43(1)(a).

In the first instance, it was argued that the 'traditional understanding' that individuals with transsexualism merely have one biological sex and another psychological sex (as accepted in the DSM and ICD diagnoses) was incorrect. It was argued that gender identity stems from brain development, and that transsexualism is therefore an intersex condition. This was supported by expert evidence.[63]

However, it was also noted that such brain development could not be identified precisely. Other expert evidence referred to Kevin's 'psychological sex' and 'brain sex or mental sex'.[64]

Chisholm J noted that the experts did not claim that the *brain sex theory* was certain, but that, as a judge, his Honour's task was to determine on the balance of probabilities if the theory was likely to be true. His Honour accepted that 'brain development is (at least) an important determinant of a person's sense of being a man or a woman.'[65]

On appeal, the Full Court of the Family Court upheld Chisholm J's conclusion that 'brain sex and/or psyche were at least of equal importance as the sex of a person at birth'.[66] While the Full Court was open to the *brain sex theory*, this judgment neither conclusively confirmed nor rejected it. The case also did not specifically confirm or reject the definition of transsexualism as a mental disorder.

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[63] *Re Kevin: Validity of Marriage of Transsexual* (2001) 28 Fam LR 158, 212.

[64] Ibid 170, 212.

[65] Ibid 214.

[66] *Attorney-General for the Commonwealth v Kevin and Others* (2003) 30 Fam LR 1, 4-5.

2 *Re: Alex*

Both *Re: Alex* cases were about authorisation of special medical procedures on a child. Alex was born biologically female, but had identified as male from a very young age. In *Re: Alex (No 1),*[67] when Alex was 13 years old, court authorisation was sought to commence a physical transition from female to male through commencement of hormone treatment. In *Re: Alex (No 2),*[68] the then 17-year-old Alex sought and was granted authorisation to undergo bilateral mastectomies.

In the *Re: Alex* cases, the Family Court did not consider the *brain sex theory*.

The Court used the term 'Gender Identity Dysphoria' to describe Alex's transsexualism. It did not use the term 'Gender Identity Disorder', due to Nicholson CJ finding it 'questionable whether this condition is properly described as a disorder'.[69] Nonetheless, the court did accept, and rely on, the DSM definition of Gender Identity Disorder.[70]

Other aspects of the *Re: Alex* cases are discussed in subsequent sections and chapters.

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[67] *Re Alex (hormonal treatment for gender dysphoria)* (2004) Fam LR 503.

[68] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009).

[69] *Re Alex (hormonal treatment for gender dysphoria)* (2004) Fam LR 503 [2].

[70] Ibid [101].

C *Treatments*

WPATH's *Standards of Care*[71] ('WPATH-SOC') provides the most widely accepted and professionally followed guidelines for treatments for GID.[72]

The British Royal College of Psychiatrists has issued specific guidelines for treatment for GID in children.[73] These guidelines are substantially similar to the WPATH-SOC guidelines for children.

A progressive course of treatment, consistent with the WPATH-SOC guidelines, was followed in the *Re: Alex* cases.

1 *WPATH Standards of Care*

WPATH-SOC sets out treatment guidelines for GID in children.[74] It describes *Psychological and Social Interventions*, and *Physical Interventions*, the latter being divided into *fully reversible*, *partially reversible* and *irreversible* interventions.[75]

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[71] The Harry Benjamin International Gender Dysphoria Association, above n 54. Reproduced in Appendix C.

[72] P. T. Cohen-Kettenis, H. A. Delemarre-van de Waal and L. J. G. Gooren, 'The Treatment of Adolescent Transsexuals: Changing Insights' (2008) 5(8) *Journal of Sexual Medicine* 1892-7, 1893; R. Nick Gorton, Jamie Buth and Dean Spade, *Medical Therapy and Health Maintenance for Transgender Men: A Guide For Health Care Providers* (1 ed, Lyon-Martin Women's Health Services, San Francisco, 2005), 13.

[73] Domenico Di Ceglie, Claire Sturge and Adrian Sutton, *Gender identity disorders in children and adolescents: Guidelines for management*, Royal College of Psychiatrists (1998) <http://www.rcpsych.ac.uk/files/pdfversion/cr63.pdf > at 29 August 2010.

[74] WPATH-SOC uses the phrase 'children and adolescents'. Whilst the medical literature uses the word 'child' as distinct from 'adolescent', this thesis uses 'child' in the Australian and International legal sense – as distinct only from 'adult', adulthood being attained at the age of 18 years (see *Family Law Act 1975* (Cth) s 61C; *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1588 UNTS 530, art 1 (entered into force 2 September 1990; entered into force for Australia 16 January 1991)).

[75] The Harry Benjamin International Gender Dysphoria Association, above n 54, 9-10.

(a) Psychological and Social Interventions

WPATH-SOC guidelines for psychological and social interventions:

- recognition and acceptance of the 'gender identity problem';
- complete psychodiagnostic and psychiatric assessment, including a family evaluation; and
- 'focus on ameliorating any comorbid problems' and reduction of stress related to the child's GID, including support in making decisions regarding the extent of the child's assumption of gender roles, the extent to which others might be informed of the condition, and management of uncertainty and anxiety.

(b) Physical Interventions

WPATH-SOC recommends a staged process where the child, and the child's family, have 'adequate time … to assimilate fully the effects of earlier interventions', with three stages of physical intervention:

> 1. Fully reversible interventions. These involve the use of LHRH [luteinizing hormone-releasing hormone] agonists or medroxyprogesterone to suppress estrogen or testosterone production, and consequently to delay the physical changes of puberty.
>
> 2. Partially reversible interventions. These include hormonal interventions that masculinize or feminize the body, such as administration of testosterone to biologic females and estrogen to biologic males. Reversal may involve surgical intervention.
>
> 3. Irreversible interventions. These are surgical procedures.

Children are only eligible for physical interventions once pubertal changes have begun.

2 *Re: Alex*

The application in *Re: Alex (No 1)* sought court authorisation for hormonal interventions only. The course of treatment recommended by the medical experts in this case, and subsequently authorised by the Court, was consistent with the WPATH-SOC guidelines.

Initially, only fully reversible interventions were to be administered. Essentially, Alex was to take the contraceptive pill without the monthly sugar-pill cycle, to continually prevent menstruation. From the age of 16, irreversible hormonal interventions[76] to masculinise Alex's body were to be administered, expectedly resulting in voice change and growth of muscles, facial and body hair, as well as growth of the clitoris. Alex continued to receive ongoing psychiatric and psychological support while receiving physical treatment.[77]

These hormonal interventions were followed in *Re: Alex (No 2)* according to expert recommendation and subsequent court authorisation that Alex receive, at the age of 17 years, bilateral mastectomies.[78] This progression from hormonal interventions to surgical intervention was consistent with the WPATH-SOC guidelines.

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[76] These interventions, labelled 'irreversible' by the experts in the case, fall within the scope of those described as 'partially reversible' in WPATH-SOC.

[77] *Re Alex (hormonal treatment for gender dysphoria)* (2004) Fam LR 503 [109] – [123].

[78] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009) [35] – [49].

D *Associated Problems*

DSM notes several problems associated with GID.[79] These include:

- social isolation and ostracism, which may lead to low self-esteem, and school aversion/dropping out of school;
- impaired relationships with parents;
- co-existence of other disorders, namely
  - Separation Anxiety Disorder;
  - Generalised Anxiety Disorder;
  - Depression;
- substance-abuse; and
- suicide attempts.

Adolescents with GID, in particular, are 'at risk for depression and suicidal ideation and suicide attempts.'[80]

E *Persistence*

I have searched many research databases for information on persistence of GID in children. These databases covered many journals in the fields of medicine, psychiatry and psychology, including journals specialising in areas such sexual medicine, sexual behaviour, and adolescent psychiatry.

There appears to be only one source of useful persistence data, namely the Amsterdam VU University Medical Centre. Statistics from this centre have been

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[79] American Psychiatric Association Task Force on DSM-IV, above n 48, 578-9.

[80] Ibid 578.

published in papers by various sets of authors, with Professor Cohen-Kettenis being the one author common to all of them. Professor Cohen-Kettenis was also consulted in relation to *Re: Alex (No 2)*.[81]

As can be seen in the following sections, the sample sizes used in the Amsterdam statistics are either quite small or unknown. This makes reliance on these data risky. Nonetheless, statistics from the Amsterdam VU University Medical Centre are considered to be the 'best data on long-term outcome of adolescents with GID'.[82]

The only other studies I could find are from the 1970s and 1980s – a time when the GID diagnoses did not exist – such as one that looked at sexual-orientation outcomes of 'behaviourally feminine boys'.[83]

1 *Pre-pubescent Children*

A recently published study by Wallien and Cohen-Kettenis[84] found that only 27% of patients that had gender dysphoria as young children[85] were still gender dysphoric later in life.[86]

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[81] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009) [48]. The judgment refers only to a 'Dutch professor of gender development and psychopathology [with] considerable experience in assisting young people presenting with [GID]', but this professor was identified as Cohen-Kettenis in an email from Family Law Courts National Communication to Johannes Schmidt, 10 August 2010. This email correspondence is included in Appendix D.

[82] Kenneth J. Zucker, 'Gender identity development and issues' (2004) 13(3) *Child and Adolescent Psychiatric Clinics of North America* 551-568, 557.

[83] R Green, 'Gender identity in childhood and later sexual orientation: follow-up' (1985) 142(3) *American Journal of Psychiatry* 339-341.

[84] Madeleine S. C. Wallien and Peggy T. Cohen-Kettenis, 'Psychosexual Outcome of Gender-Dysphoric Children' (2008) 47(12) *Journal of the American Academy of Child & Adolescent Psychiatry* 1413-23.

[85] 59 boys, 18 girls; mean age 8.4 years, age range 5-12 years.

[86] Mean age 18.9 years, age range 16-28 years.

However, as young children, not all of the patients met the diagnostic criteria for Gender Identity Disorder in Children. Of those children diagnosed with Gender Identity Disorder in Children (DSM 302.6), 50% of the boys and 75% of the girls remained gender dysphoric.[87]

2 *Pubescent Children (Adolescents)*

Professor Cohen-Kettenis is quoted in *Re: Alex (No2)* as saying that young people presenting with gender dysphoria when puberty is underway 'literally never change their mind'.[88] Indeed, a co-authored paper confirms that

> at the Amsterdam gender identity clinic for adolescents, none of the patients who were diagnosed with [Gender Identity Disorder] and considered eligible for [sex re-assignment] dropped out of the diagnostic or treatment procedures or regretted [sex re-assignment].[89]

F *Controversy*

1 *Mental v Physical Condition*

The DSM and ICD diagnoses are based on the idea that inconsistency between gender identity and anatomic sex constitutes a mental disorder – DSM is a manual for mental disorders, and the ICD diagnoses appear in the 'Mental and Behavioural Disorders' section.

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[87] Wallien and Cohen-Kettenis, above n 84, 1415.

[88] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009) [48].

[89] Cohen-Kettenis, Delemarre-van de Waal and Gooren, above n 72, 1895. The number of patients referred to is not provided.

This approach has been criticised in the literature with arguments that transsexualism is 'an intersex condition – where the sex indicated by the phenotype and genotype is opposite the morphological sex of the brain'.[90] Wallbank argues that '[c]larity requires that an adequate distinction be made between transsexualism and … mental disorders properly described as *Gender Dysphoria/Gender Identity Disorder*' (emphasis in original).[91]

Wallbank, acting for the Applicant, put this argument in *Re: Kevin*.

WPATH notes that both the DSM and ICD diagnoses are 'based more on clinical reasoning than on scientific investigation.'[92]

2 *Social Construct*

> *'Governments that consist of very few women have hurried to recognize as women men who believe that they are women and had themselves castrated to prove it, because they see women not as another sex but as a non-sex. No so-called sex-change has ever begged for a uterus-and-ovaries transplant; if uterus-and-ovaries transplants were made mandatory for wannabe women they would disappear overnight. The insistence that manmade women be accepted as women is the institutional expression of the mistaken conviction that women are defective males.'*
>
> – Germaine Greer.[93]

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[90] Karen Gurney, 'Bad Policy, Bad Law: The Derogation of Human Rights for People with Transsexualism Since the 'Justice' Statement' (2006) 31(1) *Alternative Law Journal* 36-38, 36. Gurney is a lawyer, chemist, biologist and self-described 'advocate for people with transsexualism'.

[91] Rachael Wallbank, '*Re Kevin* In perspective' (2004) 9(2) *Deakin Law Review* 461-502, 470. Wallbank is a lawyer.

[92] The Harry Benjamin International Gender Dysphoria Association, above n 54, 6.

[93] Germaine Greer, *The Whole Woman* (1st ed, Doubleday, London, 1999), 80-1.

There are arguments in the literature that gender identity, and gender itself, are merely social constructs and that consequently GID cannot actually exist. Such arguments are predominantly made from the perspective of Queer Theory and Feminist Theory.[94]

Sociological arguments are beyond the scope of this thesis and will therefore not be discussed further.

3 *Review of DSM Diagnoses*

DSM is currently under review. Experts are currently debating how, if at all, Gender Identity Disorder should be included in DSM-V. Options under consideration include:

- making the diagnostic criteria more stringent;
- dropping the criterion of impairment or stress, since in cultures where there is no stigma associated with the condition, the level of associated impairment or stress is low, resulting in people being unable to be diagnosed or receive treatment under the current criteria;
- using more appropriate nomenclature, such as 'gender dysphoria'; and
- providing diagnoses for varying degrees of the condition.[95]

[94] See, eg, Nan Seuffert, 'Reflections on Transgender Immigration' (2009) 18(2) *Griffith Law Review* 428-52; Sheila Jeffreys, 'Judicial child abuse: The family court of Australia, gender identity disorder, and the 'Alex' case' (2006) 29(1) *Women's Studies International Forum* 1-12.

[95] For detailed discussion of the potential changes under consideration, see Peggy Cohen-Kettenis and Friedemann Pfäfflin, 'The DSM Diagnostic Criteria for Gender Identity Disorder in Adolescents and Adults' (2010) 39(2) *Archives of Sexual Behavior* 499-513.

I do not possess expertise in medicine, psychiatry or psychology. However, having read the arguments of experts, both in the literature and as relayed in judgments, the suggested changes seem sensible.

The Family Court already prefers the word 'dysphoria' to 'disorder'. The word 'disorder' is negative – definitions include 'lack of order or regular arrangement' and 'an irregularity'. 'Dysphoria', on the other hand, means 'a state of dissatisfaction, anxiety, restlessness or fidgeting'.[96] The latter seems a more accurate description of the condition.

Having separate diagnoses for different levels of gender dysphoria also seems sensible. Currently, it is all or nothing – either a person has GID, with the appropriate treatment potentially including irreversible physical interventions, or the person has not, meaning no treatment is available. Providing a spectrum of diagnoses would allow for treatment options that are more appropriate for individual circumstances.

G *Proceeding with GID*

The *Re: Alex* cases are currently good law in Australia despite the criticisms noted above and despite direct criticisms of the Family Court's acceptance of the Gender Identity Disorder diagnosis.[97]

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[96] *Macquarie Dictionary Online* (Macquarie Dictionary Publishers, Sydney, 2010) <http://www.macquariedictionary.com.au/> at 19 September 2010.

[97] See, eg, Lachlan Harrison-Smith, 'Changing Sex on the Birth Register: Leave Room for 'I'! Regulation and Repression of Transsexual Identities in Theory and Law' (2007) 10(2) *Flinders Journal of Law Reform* 211-39, 217; Wallbank, above n 91, 488; and, generally, Rachael Wallbank, 'Re Alex "Through a Looking Glass"' (2004) (37) *Australian Children's Rights News* 28-37; Jeffreys, above n 94.

I cannot predict what conclusions medical experts will reach in relation to the new version of DSM. Therefore, I must rely on the current DSM diagnoses.

Moreover, it seems highly likely that, were it generally accepted that the condition be physiological, the recommended treatments would remain the same.

This thesis follows the Family Court in using the term Gender Identity Dysphoria, and focuses its discussion of rights and best interests with reference the current DSM definitions.

IV CHILDREN'S RIGHTS

'I think it fair to say that however well-intentioned we may be, our legal system in Australia does not protect the rights of children adequately.'

– The Honourable Alastair Nicholson AO RFD QC, Chief Justice (Retired), Family Court of Australia.[98]

'There is a view that young people can't possess legal rights unless they are also fully responsible. If they are "not responsible" – because of their age, dependency or lack of proof of maturity – then they can't have rights, either. It is illogical: adults possess rights even when they are thoroughly irresponsible, just because of their age and status.'

– Moira Rayner, Special Counsel, Council for Equal Opportunity in Employment Ltd.[99]

A *Overview*

This chapter is concerned with children's rights to treatment for GID. Much of the focus of both the FLA and CROC[100] is on the best interests of children.

In practice, under the FLA, best interests generally trump rights – the rights are normally only applied to inform best-interests considerations. However, this thesis

[98] Alastair Nicholson, 'Children and Young People: The Law and Human Rights' (2002) 24(9) *Bulletin (Law Society of S.A.)* 11-4, 18-9, 11.

[99] Moira Rayner, 'Young People and the Law' (2005) 17(2) *Legaldate* 5-7, 5.

[100] The ACT and Victorian human rights instruments do not provide any additional relevant rights. *Human Rights Act 2004* (ACT) s 16 and *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 15 provide the right of freedom of expression including freedom to seek information. As discussed below, these rights are provided by CROC, and partially implemented in FLA.

aims not just to survey the current state of the law, but also to explore how the law might be influenced by children's rights considerations.

As will be discussed in Part B of this chapter, the FLA contains some express rights as well as implied rights within best-interests provisions.

Part C of this chapter considers how certain CROC provisions might apply to GID treatments. This Part aims to find constructions of these provisions that favour a child's right to treatment for GID.

Where potential conflicts arise between rights and best interests, the discussion in this chapter favours children's rights.

B *Family Law Act*

1 *Rights within Best Interests*

The provisions of Part VII of the FLA (the Part concerning children) are set out with a focus on children's best interests.[101] Couched within these provisions are some implied and express rights.

The objects of FLA Part VII are to ensure children's best interests by various means, including 'protecting children from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or family violence' and 'ensuring that parents fulfil their duties, and meet their responsibilities, concerning the care, welfare and development of their children'.[102]

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[101] See overview of best interests in Section II.A.5 above, and discussion of applicable best interests in Chapter V below.

[102] *Family Law Act 1975* (Cth) ss 60B(1)(b), 60B(1)(d).

The first of these is a partial implementation of CROC Article 19. Section C.5 below, discusses the possible impact of this subsection of the FLA and the corresponding CROC article on children's rights to treatment for GID.

The second is about parental responsibility.[103] This sub-section of the FLA implies that children have a right to have their parents (or other persons with parental responsibility) meet their parental responsibilities. As was noted in Section II.A.6 above, this responsibility includes making decisions about authorisation of ordinary medical procedures, or in the case of special medical procedures, applying to the Family Court for authorisation.[104]

Children with GID, therefore, clearly have a right under the FLA to have decisions about authorisation of treatment made in their best interests.

In enumerating the principles that underlie Part VII, the FLA expressly refers to children's rights (insofar as these do not conflict with a child's best interests) including the rights to know and be cared for by both parents; to spend time with both parents, and other people of significance; and to enjoy their culture.[105]

These express rights are of little relevance to the current discussion, beyond the right to 'be cared for' by parents reinforcing the implied right to have parents exercise their parental responsibility, as discussed earlier in this section.

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[103] Parental responsibility was discussed in Section II.A.3 above.

[104] *Re: Brodie (Special Medical Procedures: Jurisdiction)* [2007] FamCA 776 [44] – [47].

[105] *Family Law Act 1975* (Cth) s 60B(2)-(3).

2 *A Right to be Heard*

In determining a child's best interests, a family law court is required to consider any views expressed by the child. These views are normally expressed through family reports or independent children's lawyers.[106]

Fitzgerald argues that this does not amount to a right for the child to be heard, nor to express their views freely. This argument is based on statistics from Family Court Annual Reports that show that the proportion of Family Court cases that proceed to hearings is quite low.[107]

However, as all physical interventions to treat GID fall within the category of special medical procedures,[108] all parenting orders made under the welfare jurisdiction to authorise such interventions will, by necessity, involve hearings. In such cases, 'if the child is capable of making an informed decision about the [special medical] procedure', the Family Court must be given evidence as to whether or not the child agrees to the procedure.[109]

The ways in which children's views may be heard and the weight that should be applied to them, are discussed in the context of best interests in Part V.C below.

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[106] *Family Law Act 1975* (Cth) ss 60CC(3)(a), 60CD, 62G(2), 68L. In a matter before the Family Court, a party may seek leave for a child to give evidence directly, by way of affidavit or through electronic communication, such as video conference: *Family Law Rules 2004* (Cth) r 15.02.

[107] Robyn Fitzgerald, 'How Are Children Heard in Family Law Proceedings in Australia?' (2002) (6) *Southern Cross University Law Review* 177-203, 183. The Annual Reports relied on by Fitzgerald are now quite old. However, more recent Annual Reports show that the proportion of cases proceeding to hearings is still low.

[108] See discussion in Subsection II.A.6(a)(i) above.

[109] *Family Law Rules 2004* (Cth) r 4.09.

C *CROC*

As previously discussed,[110] CROC does not directly form part of Australian law. However, Australian law should, where possible, be construed so as to give effect to CROC.

Each of the following seven sections examines an article of CROC that enumerates rights that may be compromised if children with GID are denied treatment.

1 *Article 6(2) – Survival and Development of the Child*

> States Parties shall ensure to the maximum extent possible the survival and development of the child.[111]

(a) Survival

As noted in Part III.D above, children with GID are at increased risk of anxiety, depression, substance abuse and suicide.[112] These, quite obviously, threaten survival.

(b) Development

Low self-esteem, stemming from social isolation and ostracism, can lead to children with GID avoiding or dropping out of school.[113] Children with GID, therefore, have a reduced chance of completing their education, impeding their development.

Mr C, a surgeon to a Gender Dysphoria Clinic at a major hospital, gave evidence in *Re: Alex (No 2)* that 'refusal [to allow Alex's bilateral mastectomies] can only have a

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[110] See Section II.B.1 above.

[111] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1588 UNTS 530, art 6(2) (entered into force 2 September 1990; entered into force for Australia 16 January 1991).

[112] American Psychiatric Association Task Force on DSM-IV, above n 48.

[113] Ibid 578.

negative outcome on his personal development, social interactions and relationships.'[114]

(c) Application

Whereas the survival and development of a child will not necessarily be affected by untreated GID, they are threatened by it. Article 6(2) requires that they are 'ensure[d] to the maximum extent possible'. It follows that these risks to survival and development should be mitigated, wherever possible.

Such risks must, of course, be weighed against the risks of treating GID. Ignoring those risks inherent to any medical procedure, the primary risk to consider is the application of an irreversible treatment followed by a change of mind.

As previously discussed,[115] the best available data suggest that there is no risk of such a change of mind.[116] It follows that in order to maximally ensure the survival and development of a child with GID, the child must be allowed, subject to assessment of the risks from non-treatment a particular case, to undergo age-appropriate treatment.[117]

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[114] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009) [36].

[115] See Part III.E above.

[116] The balance of risks is further discussed in Part V.B below.

[117] In accordance with WPATH-SOC.

2 *Article 8(1) – Preservation of Identity*

> States Parties undertake to respect the right of the child to preserve his or her identity…[118]

Nicholson CJ in *Re: Alex (No 1)* accepted a submission that gender identity is, arguably, within the scope of article 8(1).[119]

In *Re: Alex (No 2)*, Associate Professor P, a Consultant Psychiatrist at a children's hospital mental health service, gave evidence that Alex's surgery 'would allow him to confidently develop his identity as a male'.[120]

If it is accepted that article 8(1) applies to gender identity, then there is a strong argument that children have a right to have congruency between their biological sex and their gender identity, if this is achievable. A child with GID therefore has a right to treatment to bring about such congruency.

Indeed, Bryant CJ has stated that:

> If a young person's gender expression is accorded status as an enforceable human right, that begs the question whether the Family Court's permission would even be required to perform medical procedures on a young person who strongly wishes to give physical effect to their expressed gender. [121]

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[118] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1588 UNTS 530, art 8(1) (entered into force 2 September 1990; entered into force for Australia 16 January 1991).

[119] *Re Alex (hormonal treatment for gender dysphoria)* (2004) Fam LR 503 [220], [223].

[120] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009) [38].

[121] Bryant, above n 1, 210.

3 *Article 12 – Expression of Views*

> 1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
>
> 2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.[122]

Article 12 has been given effect by the FLA. The right to be heard is discussed in Section B.2 above.

4 *Article 13(1) – Freedom to Seek Information*

> 1. The child shall have the right to … freedom to seek, receive and impart information and ideas of all kinds … through any … media of the child's choice.[123]

It could be reasonably argued that medical advice and diagnosis are information. It could be similarly argued that a health care professional, such as a medical doctor or a psychologist, is a source (or in the language of the article, a 'medium') from whom a child could seek information.

Whilst medical advice and diagnosis do not strictly amount to treatment in the sense of a special medical procedure, they are essential preconditions to such treatment.

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[122] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1588 UNTS 530, art 12 (entered into force 2 September 1990; entered into force for Australia 16 January 1991).

[123] Ibid art 13(1).

A child therefore has the right to seek advice and diagnosis from a health care professional.

Furthermore, some or all of the WPATH-SOC social and psychological interventions could arguably fall within the scope of receiving information under article 13(1). Consequently, a child diagnosed with GID arguably has a right to these interventions.

5 *Article 19 – Protection from Violence, Injury, Negligent Treatment*

> 1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
>
> 2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.[124]

It is clear from its context that the intent of article 19(1) is to prevent family violence and other child abuse.

However, for the sake of argument, this Section examines how the article could apply to a child with GID.

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[124] Ibid art 19.

As discussed in relation to article 6(2),[125] children with GID are at increased risk of various mental illnesses and suicide. It seems reasonable to equate mental *illness* with mental *injury*. Suicide obviously results in death, which is surely the ultimate physical injury. It is reasonable to assume that in some cases attempted suicide will result in physical and/or mental injury.

Ignoring the last clause of article 19(1), this leads to a construction of the article whereby 'States Parties shall take all appropriate … measures to protect the child from' mental illness, suicide and attempted suicide. In other words, following the arguments of Section 1 above, appropriate action must be taken to protect the child from the risks of untreated GID.

Whilst one could argue that a child will always be 'in the care of [a person] who has care of the child', it would be naïve to assume that this clause, although tautological, could be ignored. It makes it clear that article 19(1) intends to prevent injury and abuse *perpetrated by* the person who has care of the child.

Consequently, having GID does not of itself bring a child under protection from article 19.

6 *Article 23 – Disabled Children*

> 1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

[125] See Section 1 above.

> 2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension … of assistance … which is appropriate to the child's condition …
>
> 3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall … be designed to ensure that the disabled child has effective access to and receives … health care services … in a manner conducive to the child's achieving the fullest possible social integration and individual development …[126]

(a) GID as a Disability

Under Commonwealth legislation, the definition of 'disability' includes 'total or partial loss of the person's … mental functions' and 'a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour'.[127]

It may be controversial to assert that a person with GID is suffering the loss of their mental functions, but it is certainly reasonable to say that such a person has a disorder that results in disturbed behaviour. The diagnostic criteria for GID require the observation of disturbed behaviour.[128]

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[126] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1588 UNTS 530, art 23(1) – (3) (entered into force 2 September 1990; entered into force for Australia 16 January 1991).

[127] *Disability Discrimination Act 1992* (Cth) s 4. cf *Disability Act 2006* (Vic) s 3 which requires sensory, physical or neurological impairment, acquired brain injury, intellectual disability or developmental delay; and *Disability Services Act 1991* (ACT) s 2, *Disability Services Act 1993* (NSW) s 5, *Disability Services Act* (NT) s 2, *Disability Services Act 2006* (Qld) s 11, *Disability Services Act 1993* (SA) s 3, *Disability Services Act 1992* (Tas) s 3, and *Disability Services Act 1993* (WA) s 3, all of which require that the impairment results in substantially reduced capacity for communication, learning or mobility (Qld, SA and WA also accept substantially reduced capacity for social interaction).

[128] American Psychiatric Association Task Force on DSM-IV, above n 48, 581.

Therefore, GID is a disability under Commonwealth law, and CROC art 23 applies to a child with GID.

(b) Participation in the Community

Article 23(1) requires that a disabled child be able to enjoy a 'full and decent life, in conditions [that] ensure dignity … and facilitate … active participation in the community'.

As has already been discussed, GID in children often leads to social isolation and ostracism. Denying a child treatment for GID may deny that child the opportunity to participate in the community.

(c) Special Care, Assistance, and Health Care Services

Article 23(2)-(3) gives a disabled child the right to care, assistance and health care services such that the child can achieve 'the fullest possible social integration and individual development'.

Again, GID can prevent integration and development. Treating a child's GID can help the child towards developing, and towards achieving social integration.

Article 23 therefore gives a child with GID who is also afflicted with an associated problem the right to treatment.

7 *Article 24 – Enjoyment of the Highest Standard of Health and Treatment*

> 1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

> 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: …
>
> (f) To develop preventive health care…[129]

(a) Highest Attainable Standard

Despite problems in the hospital systems of some Australian states, it would be difficult to argue that Australia, on the whole, lacks world-class health facilities and health care.

Indeed, the *Re: Kevin* and *Re: Alex* cases demonstrate that the 'highest attainable standard' in Australia's health system can provide the full gamut of GID treatments, from counselling through to hormone treatments and sex re-assignment surgeries.

Article 24 suggests a prima facie right to medical treatment in accordance with current best practice.[130] Recognised best practice in relation to GID treatments is as set out in WPATH-SOC.

(b) Preventative Health Care

Early intervention for children with GID may prevent the need for more invasive intervention later. This proposition factored into Bryant CJ's decision to authorise bilateral mastectomies in *Re: Alex (No 2)*. Her Honour noted in the judgment that:

> If the surgery is not performed, the evidence is that there is a risk of further breast growth, meaning that a larger excision would be required if surgery were to be

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[129] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1588 UNTS 530, art 24(1) – (2) (entered into force 2 September 1990; entered into force for Australia 16 January 1991).

[130] Subject, presumably, to funding availability.

> performed when Alex was 18 years or older with the concomitant risk of a longer recovery period and more extensive scarring.[131]

This early intervention argument must be considered on the facts of individual cases. Article 24(2)(f) does not provide a child with a general right to treatment for GID.

8 *Conclusion*

Whilst article 19 is not applicable, the rights provided by the other articles discussed above apply to children with GID. If CROC directly applied in Australia, a child with GID would have the right to receive age-appropriate treatment.

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[131] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009) [172].

V CHILDREN'S BEST INTERESTS

'It is a mistake to think that there is always only one right answer to the question of what the best interests of a child require. ... Best interests are values, not facts. They involve a discretionary judgment in respect of which judges can come to opposite but reasonable conclusions.'

– High Court of Australia, per McHugh, Gummow and Callinan JJ.[132]

'Before the best interests of the child can be determined, some principle, rule or standard must be applied to the facts and circumstances of the case'

– High Court of Australia, per McHugh J.[133]

A *Overview*

Children's best interests must be the paramount consideration when a family law court makes a parenting order.[134] Most of the considerations that must inform a court in determining the best interests of a child relate to the child's living arrangements, and with whom the child is to spend time and have contact.

This chapter focuses on the two directly relevant considerations that can affect the best interests of a child seeking access to treatment for GID.

Part B looks at protecting the child from harm whilst Part C looks in detail at the views of the child.

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[132] *CDJ v VAJ* (1998) 197 CLR 172, 219.

[133] *Department of Health & Community Services v JWB & SMB ("Marion's Case")* (1992) 175 CLR 218, 320.

[134] Section II.A.5 above provides an overview of best-interests requirements under the FLA.

B *Protecting from Harm*

1 *The Primary Consideration*

One of the primary considerations that must inform a family law court's determination of a child's best interests is 'the need to protect the child from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or family violence.'[135]

Whilst the wording is different, this section of the FLA is essentially equivalent to CROC art 19.[136] The arguments on how the CROC article can be applied to children seeking treatment for GID also hold true for the FLA provision.

Applying those arguments, 'the need to protect the child from physical or psychological harm' could be construed as 'the need to protect the child from mental illness, suicide and attempted suicide'.

Conversely, the argument that the CROC article does not apply, due to the requirement of the harm being perpetrated by a caregiver, also holds true here. FLA s 60CC(2)(b) requires that the harm come from subjection or exposure to abuse, neglect or family violence. The Family Court has held that 'consideration relating to the need to protect a child from physical or psychological harm [under s 60CC(2)] will require findings on a historical basis of any family violence and consideration of family violence orders'.[137]

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[135] *Family Law Act 1975* (Cth) s 60CC(2)(b).

[136] See Section IV.C.5 above.

[137] *Nawaqaliva and Marshall* (2006) FLC ¶93-296 [36].

In *Re: Alex (No 2)*, Bryant CJ rejected the submission of the independent children's lawyer that section 60CC(2)(b) was relevant to the application to allow Alex's bilateral mastectomies. Her Honour did so on the basis of the same reasoning as has been applied above.[138]

2 *An Additional Consideration*

However, unlike CROC, the FLA provides a catch-all best-interests consideration in section 60CC(3)(m). Bryant CJ 'consider[ed] matters pertaining to psychological harm under the "additional considerations".'[139]

This means that when making a best-interests determination, a court may consider the need to protect a child from harm, irrespective of whether or not that harm comes from family violence. Indeed, in the context of a special medical procedure, such as treatment of a child's GID, court authorisation is required precisely 'because of the significant risk of making the wrong decision' and 'because the consequences of a wrong decision are particularly grave.'[140] These 'consequences' – potential consequences of both *authorising* the medical procedure and *not authorising* the procedure – must certainly include possible physical and psychological harm.

Therefore, an informed determination of the best interests of a child seeking treatment for GID requires an assessment of the risks of harm from treatment as against the risks from a lack of treatment.

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[138] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009) [162].

[139] Ibid.

[140] *Department of Health & Community Services v JWB & SMB ("Marion's Case")* (1992) 175 CLR 218, 250. See full discussion of special medical procedures in Section II.A.6 above.

3 *Balancing Risks*

(a) Risks of Non-treatment

As had already been discussed in this Part and elsewhere in this thesis,[141] a child with GID is at increased risk of various mental illnesses, suicide and attempted suicide. Consequently, denying such a child treatment for GID is a failure to mitigate these risks.

Cohen-Kettenis et al argue that:

> Nonintervention is not a neutral option, but has clear negative life-long consequences for the quality of life of those individuals who had to wait for treatment until after puberty. It may lead to irresponsible and risky, unhealthy actions of the patient in order to get access to the desired medication, distrust against professionals, with negative consequences for other aspects of their health care. It may lead to developmental arrest, and a psychological functioning forever hampered by shame about one's appearance. This implies that "in dubio abstine" may actually be harmful. [142]

(b) Risks of Treatment

In the 10 months that I have spent researching this topic, even after reading what I consider compelling evidence to support a child's *right* to treatment for GID, I have always come back to asking myself these questions: What if the child changes their mind? Is a child really capable of making such a big decision – of even grasping the consequences?

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[141] See Part III.D and Section IV.C.5 above.

[142] Cohen-Kettenis, Delemarre-van de Waal and Gooren, above n 72, 1896.

The risks of irreversible treatment for GID are fairly self-evident. Aside from the risks inherent to any medical treatment, there is the risk that a person's body is being irreversibly altered based on a psychiatric condition that may in time desist. More poignant is the fact that it is a child's body that is to be altered, based on the wishes of a child.

Sex re-assignment surgery involves permanent sterilisation – a male-to-female re-assignment involves castration, and a female-to-male re-assignment involves hysterectomy and ovariectomy.

Even masculinising or feminising hormonal treatments, considered in WPATH-SOC to be partially reversible,[143] may require surgical intervention to reversed.[144]

(c) The Balance

Part of the risk of not treating a child's GID is the increased chance (compared to children without GID) of that child having associated problems such as a related mental illness. The weight of such risk is difficult to quantify in general terms. Fortunately, the Family Court, in making a decision about best interests, is bound to consider the particular child and facts that are subject to the application. In a special medical procedure case, the Court will have expert medical evidence about the child's mental health, and will therefore know if there are associated problems to consider. A child in such a case is also likely to be represented by an independent children's lawyer, who would be able to raise further relevant facts.

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[143] See Section III.C.1 above.

[144] The Harry Benjamin International Gender Dysphoria Association, above n 54, 10.

The long-term risks of non-treatment, as outlined by Cohen-Kettenis et al, would need to be considered in any case. Without further information, the level of these risks is difficult to quantify.

In fact, the only risk considered in this Part that can be quantified at all is the risk of desistence of a child's GID. The question of persistence/desistence of GID is key. If there is sufficient certainty that a child's GID will persist, then risks associated with desistance (irreversibility of treatments) will be correspondingly negated.

As stated earlier, the available data[145] suggest that children who are diagnosed with GID after puberty has commenced 'literally never change their minds'.

Persistence in pre-pubescent children diagnosed with GID in Children is lower (50% for biological boys; 75% for biological girls). However, the WPATH-SOC allow only children whose 'pubertal changes have begun' to undergo any physical interventions, whether reversible or irreversible.[146]

Whilst it is problematic that these persistence data are based on a very limited sample from a single clinic, they are the best information that is currently available.

Based on these statistics, the risk posed by treatment is negligible. The only conclusion that can consequently be reached is that the risks posed by non-treatment outweigh the risks of treatment.

On the basis of protecting a child with GID from harm, once again treatment is in the child's best interests.

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[145] See Part III.E above.

[146] The Harry Benjamin International Gender Dysphoria Association, above n 54, 10.

C *Views of the Child*

In determining a child's best interests, a court must consider 'any views expressed by the child and any factors (such as the child's maturity or level of understanding) that the court thinks are relevant to the weight it should give to the child's views'.[147]

As discussed earlier, children have a right to express their views in special medical procedure cases.[148] This Part examines how those views may be communicated and how much weight they should carry when a court considers a child's best interests.

1 *Direct Communication of the Child's Views*

(a) Overview

Ordinarily, children's views are expressed through family reports or independent children's lawyers.[149] In a matter before the Family Court, a party may seek leave for a child to give evidence directly.[150]

A recent University of Sydney study canvassed the views of children, parents and judges, about children talking directly with judges in parenting disputes.[151] Whilst not all aspects of the findings are relevant to children seeking treatment for GID, many can be applied to this issue.

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[147] *Family Law Act 1975* (Cth) s 60CC(3)(a).

[148] See Sections IV.B.2 and IV.C.3 above.

[149] *Family Law Act 1975* (Cth) ss 60CC(3)(a), 60CD, 62G(2), 68L.

[150] *Family Law Rules 2004* (Cth) r 15.02.

[151] Patrick Parkinson, Judy Cashmore and Judi Single, 'Parents' and Children's Views on Talking to Judges in Parenting Disputes in Australia' (2007) 21(1) *International Journal of Law, Policy and the Family* 84-107; Patrick Parkinson and Judy Cashmore, 'Judicial Conversations With Children in Parenting Disputes: The Views Of Australian Judges' (2007) 21(2) *International Journal of Law, Policy and the Family* 160-89.

The study showed that many children that had been involved in contested cases, in one or both of the family law courts, wanted the option of speaking directly to the decision-makers in their cases. 85% of children (in contested an uncontested cases)[152] responded that the option of talking to the judge in chambers should be open to them. The primary relevant reasons given by the children were a desire to be acknowledged and to have a say; and a desire for judges to receive the children's views without misinterpretation.[153]

In the same study, 75% of judges[154] said that they either would never talk to children for forensic purposes, or were 'extremely reluctant' to do so. Their primary concerns were risks to quality of decision-making, from a lack of skills and qualifications of judges (as opposed to counsellors or psychologists) in interviewing children; risks to quality of decision-making, because the judge would become part of the evidence-gathering process, and would, therefore, no longer be a neutral decision-maker; and risks to children, due to the potentially frightening environment of chambers and courtrooms, 'gruff and … forbidding' judges and, as noted above, a lack of judges' skills in interviewing children.[155]

However, those judges who had talked with children noted two key benefits of doing so. These were hearing children's views first-hand, giving judges a better sense of children's views than an expert report alone could; and canvassing options, giving

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[152] 85% of the 35 children who participated in both rounds of interviews conducted in the study. A further 12 children participated in only one interview, and their responses are not reflected in this figure.

[153] A third reason, specific to residence/contact cases, was a desire to provide information to judges, without the children's parents knowing about it.

[154] 15 of 20; 6 of 6 Federal Magistrates, and 9 of 14 Family Court judges.

[155] Parkinson and Cashmore, above n 151, 162, 164, 167-170, 175-176.

children an opportunity to comment on a range of possible outcomes from their cases.

None of the judges entertained the idea of a direct interview displacing expert assessments such as family reports.

It is reasonable to extrapolate that both the concerns and benefits can be applied to cases about special medical procedures, and in particular GID cases. In such cases, it would be useful for the decision-maker to meet the child face-to-face or to have the child's views conveyed through an independent children's lawyer.

(b) Judges' Lack of Skills and Qualifications in Interviewing Children

The first of the judges' concerns – the lack of skills and qualifications in interviewing children – is particularly relevant to GID cases, where medical and psychiatric assessments are necessary, and where there are increased risks of other mental illnesses. However, since the judges would only speak with children in addition to receiving expert evidence, this risk does not seem significant.

Bryant CJ's approach in *Re: Alex (No 2)* struck a good balance of this concern and the benefit of hearing directly from the child. The trial 'proceed[ed] in the form of a round table discussion' with 'medical witnesses [asked] to give their evidence concurrently', and the child sitting at the table and being 'told … at the commencement of the proceedings that he had liberty to speak directly to [her Honour] if he wished'.[156]

[156] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009) [33]–[34], [40].

This gave the child the opportunity to express his views, but in the presence of experts who could assist both the child and the judge to ensure the views were properly communicated. In fact, '[i]n general … Alex chose to communicate his views through the [independent children's lawyer].'[157]

(c) Risk to Neutrality

The concern over judges becoming part of the evidence-gathering process and therefore compromising their neutrality in decision-making has two parts: that 'talking with a child in chambers would damage at least the perception of fairness and due process' and that a judge's conversation may become an issue, with a party potentially wishing to cross-examine the judge.[158]

The approach taken in *Re: Alex (No 2)* may allay these concerns, as in this round-table format all parties are present while the child's views are directly expressed. Furthermore, the approach is not adversarial. The usual approach to evidence – evidence in chief followed by cross-examination – does not apply.

It is important to note that this approach worked in *Re: Alex (No 2)* at least in part because no party to the proceeding opposed authorisation for the treatment. In a case where there is opposition to treatment, hearing concurrent evidence in the form of a discussion may lead to chaos. Furthermore, in such a case, the child in question may be reluctant to express her or his views in such an open and potentially hostile forum.

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[157] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009) [33].

[158] Parkinson and Cashmore, above n 151, 168-9.

(d) Risk to Children

The risk to children should be the gravest of the judges' concerns. The entire point of considering a child's views is to inform a decision about that child's best interests. It would be ludicrous to compromise the child's best interests in the process of determining them.

I assume that the risk of frightening a child seeking authorisation for treatment for GID is lower than the risk of frightening a child in a non-GID proceeding, such as one that determines with which parent a child is to live.

Court authorisation is required for hormonal and surgical interventions only[159] and best-practice in GID treatment is to allow only children who have reached puberty to undergo physical intervention.[160] It seems unlikely that anyone would apply to the Family Court for authorisation to undergo such a treatment without the backing of a medical expert.

The average age of such a child is, therefore, almost certainly higher than that of a child in another type of proceeding.

Furthermore, it clearly takes a lot of courage for a pubescent child to seek diagnosis and treatment for GID.

As long as the child is not compelled to speak directly to the judge, the risk of the child being frightened seems to be far outweighed by the potential benefits of the judge hearing directly from the child.

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[159] See Section II.A.6 above.

[160] See Section III.C.1 above.

2 *Weighting Children's Views*

The Full Court of the Family Court has held that '[w]hat is required is that [children's views] be given appropriate and careful consideration and not simply treated as a factor in the determination of the child's best interests without giving them further significance.'[161]

An application that seeks authorisation for treatment for a child's GID can only come about as a result of the expression of the child's views, since the child could not be diagnosed without expressing a strong cross-gender identification.[162]

As outlined in the immediately preceding section, I believe it is reasonable to assume that such a child is pubescent. Age is not the determining factor in judging 'maturity and understanding' but it does play its part.

Ultimately, the weight placed by the Court upon a child's views in a special medical procedure case will usually be determined on the basis of the same considerations as the child's Gillick competence – the child's intelligence and maturity to fully understand the proposed treatment.

Paradoxically, a Gillick competent child would not require court authorisation for treatment, and yet only a family law court could determine the child to be Gillick competent.

In *Re: Alex (No 2)*, Bryant CJ said that she was 'not satisfied that Alex [was] not Gillick competent and therefore unable to himself consent to the surgery.'[163] In that

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[161] *R and R: Children's Wishes* (2000) FLC ¶93-000 [44].

[162] See Section III.A.1 above.

case, none of the parties raised the issue of Gillick competence. Her Honour took 'the view that the issue of Gillick competence [was] academic unless [her Honour] intend[ed] to make orders not permitting the procedure.'[164]

It is difficult to find fault in the existing approach.

The only meritorious argument I have seen that questions the validity of requiring that a child be competent before the child is allowed to make decisions about special medical procedures is one of equity. It is that a child must be Gillick competent to make such a decision, whereas no such onus is placed on an adult making the same decision.[165]

This double standard does seem unfair. From a human rights (self determination) perspective, it may be a compelling argument in favour of allowing children to decide for themselves, even if they are not deemed competent. From a harm-minimisation perspective, the logical corollary is a requirement that adults be Gillick competent before they can consent to non-therapeutic medical procedures.

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[163] *Re: Alex* [2009] FamCA (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009) [147].

[164] Ibid.

[165] See Rayner quote at the start of Chapter IV above.

VI Conclusion

A *Controversy and Conflict*

Treatment for children with GID is controversial.

The diagnosis itself has been questioned from deeply opposed perspectives – those who believe gender dysphoria is caused by physiological rather than psychological factors; those who believe it simply does not exist; and those on the frontline who deal with it, looking to better define diagnoses that they admit are 'based more on clinical reasoning than on scientific investigation.'[166]

The fact that the patients in question are children adds further controversy. Children are presumed to be in need of protection from their own lack of maturity, intelligence and responsibility.

There are conflicts between children's rights and their best interests. The rights under the FLA are limited to ensuring that best interests are paramount. CROC rights have limited application in Australia and are, in any case, constrained by the principle of the paramountcy of a child's best interests.

B *Rights*

The Chief Justice of the Family Court has posited that if CROC article 8 (preservation of identity) had the force of law, a child with GID would not require court authorisation for treatment.

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[166] The Harry Benjamin International Gender Dysphoria Association, above n 54, 6.

In my reckoning, if CROC as a whole were adopted in domestic law, this proposition would be further supported by articles 6(2) (survival and development) and 23 (rights of disabled children) and, in particular, article 24(1) (highest attainable standard of health).

C *Best Interests*

The most important consideration in determining the best interests of a child with GID is the need to protect the child from harm. The available data show that, without a doubt, a pubescent child will be best protected from harm if permitted to undergo progressive treatment in accordance with WPATH-SOC.

Children should be invited to express their views directly in any unopposed proceeding for authorisation of treatment for GID.

D *On Balance*

Despite the controversy surrounding GID, I am convinced that the DSM diagnoses are basically appropriate, but can only be improved by the sensible changes suggested for DSM-V.

If the statistic of zero-desistance in pubescent children with GID is accurate – and that is a big 'if' – then it will almost always be in the best interests of a child with GID to be treated. It should be noted, however, that anecdotal evidence from one clinic is hardly representative. If a wider persistence study were undertaken (perhaps once the diagnoses are updated in DSM-V) and showed consistent results, then there would be a far stronger case for a child's absolute right to be treated for GID.

Until such time, I can only conclude that the status quo strikes a fair balance.

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United Nations, *United Nations Treaty Collection* <http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en> at 31 August 2010

Appendix A DSM EXTRACT

The following is an extract from:

> American Psychiatric Association Task Force on DSM-IV, *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th ed, American Psychiatric Association, Washington, DC, 2000).

Copyright 2000 American Psychiatric Association.

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Appendix B ICD EXTRACT

The following is an extract from:

> World Health Organization, The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research (World Health Organization, Geneva, 1993).

Copyright 1993 World Health Organization.

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The contents of this appendix have been removed in the online version of this document, for copyright reasons.

Appendix C WPATH Standards of Care

The following is the entire publication

> The Harry Benjamin International Gender Dysphoria Association, *Standards Of Care For Gender Identity Disorders* (6 ed, The Harry Benjamin International Gender Dysphoria Association, Minneapolis, 2001).

Copyright 2001 World Professional Association for Transgender Health.

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The contents of this appendix have been removed in the online version of this document, as permission for reproduction was sought for purposes of assessment only.

The WPATH Standards of care may be found at http://www.wpath.org/publications_standards.cfm

Appendix D EMAIL BETWEEN SCHMIDT AND FAMILY COURT

Following is the email exchange between Schmidt and Family Law Courts National Communication.

Subject: The Dutch Professor
From: Johannes Schmidt <jsch17@student.monash.edu>
Date: 9 August 2010 18:16:12 AEST
To: communication@familylawcourts.gov.au

To Whom It May Concern:

This message is intended for Chief Justice Bryant's research adviser, or Her Honour's associate, for neither of whom I could find published email addresses.

I am a Monash University law student, and I am currently conducting honours research, under the supervision of Dr. Renata Alexander, into Children's Rights and Best Interests in relation to treatment for Gender Identity Disorder (referred to as Gender Identity Dysphoria by Her Honour). As part of this research, I am looking into persistence rates for children and adolescents diagnosed with the condition.

In the judgment in Re: Alex (No. 2) (published online as RE: ALEX - BC200951248), Her Honour wrote, at paragraph 48:

Professor W told the Court that he has spoken to a Dutch professor of gender development and psychopathology who has considerable experience in assisting young people presenting with gender identity dysphoria. Professor W said he had been informed by the Dutch professor that if a young person presents with gender dysphoria after puberty is well under way, as Alex did, they "literally" never change their mind. Professor W explained that although vacillation may occur in younger children who have not reached puberty, that is not the case for those who present during or after puberty.

I wish to include this information, along with published studies I have found in the literature. I am concerned that, if one of the published studies is that of the "Dutch professor", I will add unjustified weight to that study (giving the impression that two separate studies showed similar results, when, in reality, only one study showed such results). This is especially so because one of the main studies referred to in the literature was undertaken by two Dutch professors.

I would like to know if I may be told the name of the Dutch professor referred to in the case. Alternatively, it would be sufficient to know if that professor was one of:

* Professor Cohen-Kettenis; or
* Professor van Goozen.

I cannot imagine that my knowledge of this information would compromise Alex's anonymity.

I thank you for your assistance in this matter.

Yours Faithfully,
Johannes Schmidt.

B. Soft Eng (Hons)
Final-year candidate, LLB (Hons)

Subject: Re: The Dutch Professor [SEC=UNCLASSIFIED]
From: communication@familylawcourts.gov.au
Date: 10 August 2010 10:03:35 AEST
To: Johannes Schmidt <jsch17@student.monash.edu>

Hello Joanne

I have forwarded your email to Chief Justice Bryant's chambers and have been advised that the name of the Dutch professor is Professor Cohen-Kettenis.

Kind regards

Family Law Courts National Communication

Family Court of Australia | Federal Magistrates Court of Australia

Please note this response provides information only and is not a substitute for independent legal advice.

Further queries can be directed to the Family Law Courts on 1300 352 000 for the cost of a local call.

[Schmidt's original email quoted.]

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It is noted that legal privilege is not waived because you have read this e-mail.
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