FAMILY LAW ACT 1975

IN THE APPELLATE JURISDICTION OF THE FAMILY COURT OF AUSTRALIA AT SYDNEY

Appeal No. EA 30 of 2017

IN THE MATTER OF

FATHER
Applicant

AND

A GENDER AGENDA INC
First Intervenor

AUSTRALIAN HUMAN RIGHTS COMMISSION
Second Intervenor

SECRETARY FOR THE DEPARTMENT OF FAMILY AND COMMUNITY SERVICES
Third Intervenor

INDEPENDENT CHILDREN'S LAWYER

Supplementary Submissions of the Australian Human Rights Commission

1. These submissions are made in accordance with paragraph 2 of the orders made by Watts J on 25 August 2017 (as amended by orders made on 29 August 2017), and pursuant to s 94(2) of the *Family Law Act 1975* (Cth). They supplement the Commission's Summary of Argument filed 8 August 2017 by identifying the inferences of fact and law drawn by the Commission from the documents referred to in paragraph 52 of the Amended Case Stated.

2. In a case stated, there must be sufficient factual material before the Court to determine the questions of law. For this purpose, the Court may draw from the facts and the documents before it any inference, whether of fact or law, which

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could have been drawn from the same material by the trial judge: s 94(2).[1] Those inferences must necessarily follow from the facts stated or documents annexed.[2] Subsection 94A(2) allows the Court to ascertain from the contents of the case stated both the evidentiary facts as well as the ultimate facts from which the legal consequences ensue that govern the determination of the rights of parties.[3]

3. In this stated case, there is sufficient uncontroverted material from which appropriate inferences can be drawn to address the questions of law involved, namely: (a) whether Stage 2 treatment requires the Court's authorisation; and (b) whether it is appropriate for the Court to determine *Gillick* competency in all cases.

4. The Commission has arranged these inferences by reference to the matters set out in paragraphs 51, 60 and 61 of its Summary of Argument filed on 8 August 2017. In those paragraphs, the Commission submitted that the Court should depart from the view in *Re Jamie* that Stage 2 treatment requires court authorisation, and that it is necessary in all cases for the Court to assess *Gillick* competency, if it is satisfied of a number of matters. These supplementary submissions are provided to assist the Court in identifying the available factual material that goes to each of those matters.

5. The Commission submits that there is sufficient factual material in the Amended Case Stated to conclude that there are standard protocols for the treatment of gender dysphoria and that, based on the current state of knowledge about that condition, there is a sufficiently low risk of making the wrong decision about Stage 2 treatment, either as to the child's present or future capacity to consent or about what are the best interest of a child who cannot consent. The Commission takes the reference to making the 'wrong' decision to implicate both the standard of treatment of the patient, as well as the state of knowledge about the relevant condition.

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1 *In the Marriage of Smith and Saywell* (1980) 6 Fam LR 245 at 267 (Watson SJ); at 251 and 254 (Marshall SJ). See also *In the Marriage of ID and LC McKay* (1984) 59 ALR 117 at 129 (Nygh J).

2 See eg *Fowles v The Eastern and Australian Steamship Company Limited* (2913) 17 CLR 149 at 196 (Gavan Duffy and Rich JJ); *Re Alcoota Land Claim No 146* (1998) 82 FCR 391 at 395.

3 *In the Marriage of ID and LC McKay* (1984) 59 ALR 117 (FC) at 129 (Nygh J) (see also Fogarty J at 118-119), where it was explained that s 94A(2) was enacted to overcome the limitation referred to by the High Court in *R v Rigby* (1956) 100 CLR 146 at 150-151.

Availability of standard protocols for the treatment of gender dysphoria

6. Paragraphs 3 and 4 of the Amended Case Stated provide:

> Treatment guidelines for the care of trans and gender diverse children and adolescents are in place, with the World Professional Association for Transgender Health Standards of Care version 7 (2011) and the Endocrine Society Treatment Guidelines (2009) being the basis of treatment protocols internationally, including throughout Australia.
>
> Australia's specific guidelines for the standards of care and treatment for transgender and gender diverse children and adolescents are expected to be available in September 2017 (in the form annexed to the affidavit of Associate Professor Telfer sworn 7 August 2017 [**Telfer affidavit**]).

7. Each of these guidelines is identified in paragraph 52 of the Amended Case Stated:

   a. The World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexuals, Transgender and Gender Nonconforming People*, version 7 (2011) (**WPATH Standards of Care**) is identified at paragraph 52.4.

   b. The Endocrine Society Treatment Guidelines (2009) (**ES Guidelines**) is identified at paragraph 52.6.

   c. The proposed Australian Standards of Care and treatment guidelines for trans and gender diverse children and adolescents (2017) (**Australian Standards of Care**), which is annexed to the Telfer affidavit, is identified at paragraph 52.5.

8. The WPATH Standards of Care describe three stages of treatment for adolescents with gender dysphoria.[4] The same three stages are described in the ES Guidelines[5] and the Australian Standards of Care.[6]

9. The ES Guidelines note that the first edition of the WPATH Standards of Care was published in 1979 by the Harry Benjamin International Gender Dysphoria

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4 WPATH Standards of Care, Amended Case Stated (**ACS**) at [52.4], pp 18-21.
5 ES Guidelines, ACS at [52.6], p 3133.
6 Australian Standards of Care annexed to the Telfer affidavit, ACS at [52.5], pp 15-25.

Association and that successive editions have 'provided mental health and medical professionals with general guidelines for the evaluation and treatment of transsexual persons'.[7]

10. Version 7 of the WPATH Standards of Care was developed according to the process described in Appendix E of those standards, including through inviting papers from international experts which were then published in a peer reviewed journal, and incorporating this material into revisions of the Standards by a 34 member international Revision Committee with input from an International Advisory Group of eight transsexual, transgender, and gender non-conforming individuals.[8]

11. The ES Guidelines were developed by a taskforce appointed by The Endocrine Society to formulate evidence-based recommendations focused on hormone therapy, as one aspect of multidisciplinary treatment for gender dysphoria.[9]

12. The Australian Standards of Care was developed by The Royal Children's Hospital (**RCH**) Gender Service, a specialised unit within the Department of Adolescent Medicine,[10] and is expected to be accepted into practice by the Australian and New Zealand Professional Association for Transgender Health at the National Conference (which the Commission understands is scheduled for 30 September and 1 October 2017) and to be published in the subsequent months.[11]

Purpose for which treatment is provided

13. Paragraph 2 of the Amended Case Stated provides:

> The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) ... defines Gender Dysphoria as 'the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical intervention by means of hormones and/or surgery are not available'.

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7 ES Guidelines, ACS at [52.6], p 3134.
8 WPATH Standards of Care, ACS at [52.4], pp 109-112.
9 ES Guidelines, ACS at [52.6], pp 3135-3136.
10 Telfer affidavit, ACS at [52.5], para 7.
11 Telfer affidavit, ACS at [52.5], paras 13, 52.

14. The section of DSM-5 dealing with Gender Dysphoria is identified at paragraph 52.2 of the Amended Case Stated.

Change in terminology

15. The young person in *Re Jamie* was diagnosed with 'gender identity disorder' pursuant to DSM-IV.[12]

16. DSM-5 was published in May 2013, after the hearing in *Re Jamie* but prior to judgment being delivered.[13]

17. The young person in *Re Kelvin* was diagnosed with 'gender dysphoria' pursuant to DSM-5.[14]

18. DSM-5 says that: 'The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se'.[15]

19. The WPATH Standards of Care warn against 'pathologising' gender non-conformity. WPATH released a statement in May 2010 saying that: 'the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative'.[16]

20. The WPATH Standards of Care refer to the diagnostic criteria in the DSM as 'attempting to classify clusters of symptoms and conditions, not the individuals themselves' noting that 'transsexual, transgender, and gender non-conforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available'.[17]

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[12] *Re Jamie (special medical procedure)* [2011] FamCA 248 at [47].
[13] *Re Jamie* [2013] FamCAFC 110 at [69].
[14] ACS at [31].
[15] DSM-5, ACS at [52.2], p 451.
[16] WPATH Standards of Care, ACS at [52.4], p 4.
[17] WPATH Standards of Care, ACS at [52.4], pp 5-6.

Persistence: differences between children and adolescents

21. The material before the Court suggests a high level of persistence of gender dysphoria from adolescence into adulthood. The WPATH Standards of Care refer to a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all of whom continued with sex reassignment, beginning with hormone therapy.[18]

22. The Australian Standards of Care require a diagnosis of Gender Dysphoria in Adolescence prior to commencement of Stage 1 puberty suppression.[19]

23. According to DSM-5 and the WPATH Standards of Care, rates of persistence of gender dysphoria from childhood into adolescence vary.[20] Some of these studies examining persistence in children 'were conducted across several decades during which the opportunity and social acceptance for gender reassignment has increased dramatically'.[21]

24. Associate Professor Telfer reports that data from The Royal Children's Hospital in Melbourne from 2003 to 2017 showed that 96% of all patients who were assessed and received a diagnosis of gender dysphoria continued to identify as transgender or gender diverse into late adolescence. Out of a total of 342 patients, 14 transitioned back to their birth sex. None of these 14 had commenced Stage 2 treatment and all of them were significantly younger than the group seeking Stage 2 treatment.[22]

25. According to Steensma et al, intensity of early gender dysphoria appears to be an important predictor of persistence of gender dysphoria.[23]

Lack of alternative treatments

26. There is no evidence of any alternatives treatments for gender dysphoria.

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[18] WPATH Standards of Care, ACS at [52.4], p 11.
[19] Australian Standards of Care annexed to the Telfer affidavit, ACS at [52.5], p 23.
[20] DSM-5, ACS at [52.2], p 455; WPATH Standards of Care, ACS at [52.4], p 11. See also ES Guidelines, ACS at [52.6], p 3138.
[21] Steensma et al 'Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study' (2013) 52(6) *Journal of the American Academy of Child and Adolescent Psychiatry* 582, ACS at [52.10], p 582.
[22] Telfer affidavit, ACS at [52.5], at [58]-[59].
[23] Steensma et al 'Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study' (2013) 52(6) *Journal of the American Academy of Child and Adolescent Psychiatry* 582, ACS at [52.10], pp 582, 587-589.

27. Both the WPATH Standards of Care and the Australian Standards of Care refer to research indicating that treatment aimed at trying to change a person's gender identity to become more congruent with their sex assigned at birth has been attempted in the past without success and is no longer considered ethical.[24]

Risks if treatment is withheld or delayed

28. Paragraphs 12 to 18 of the Amended Case Stated describe risks of not providing treatment.

29. The ES Guidelines note that early medical intervention may prevent psychological harm.[25] In describing the evidence supporting its recommendation for Stage 1 treatment to suppress pubertal development, the ES Guidelines say:

> The experience of full biological puberty, an undesirable condition, may seriously interfere with healthy psychological functioning and well-being. Suffering from gender dysphoria without being able to present socially in the desired social role or to stop the development of secondary sex characteristics may result in an arrest in emotional, social or intellectual development.[26]

30. The Australian Guidelines provide that '[p]uberty suppression typically relieves distress for trans adolescents by halting progression of physical changes such as breast growth in trans males and voice deepening in trans females'.[27] Those guidelines describe a number of matters relevant to the timing of the administration of Stage 2 cross sex hormones.[28]

31. In particular, the Australian Guidelines note that the biological implications of delaying hormones include prolonged administration of puberty suppression, where used, with increasing duration of suppression associated with osteopenia.[29]

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[24] WPATH Standards of Care, ACS at [52.4], pp 16 and 32; Australian Standards of Care annexed to the Telfer affidavit, ACS at [52.5], p 5.
[25] ES Guidelines, ACS at [52.6], p 3139.
[26] ES Guidelines, ACS at [52.6], p 3140.
[27] Australian Standards of Care annexed to the Telfer affidavit, ACS at [52.5], p 15.
[28] Australian Standards of Care annexed to the Telfer affidavit, ACS at [52.5], p 17.
[29] Australian Standards of Care annexed to the Telfer affidavit, ACS at [52.5], p 17.

32. In 2016, Costa and Colizzi conducted a review of 17 studies dealing with the effect of cross sex hormonal treatment on adults with gender dysphoria. They found that, 'when treated with hormone therapy, gender dysphoria individuals reported less anxiety, dissociation, perceived stress, social distress, and higher mental health-related quality of life and self esteem'. They considered that the reduction in metal distress was most likely the result of the desired body changes obtained as a result of the hormone therapy (rather than, for example, a direct biological effect of the hormones). They concluded that 'timely hormonal treatment intervention represents a crucial issue in gender dysphoria individuals' mental health-related outcomes'.[30]

33. Associate Professor Telfer indicates that delay in treatment increases mental health co-morbidities such as anxiety and depression, as well as increasing risk for self-harm and suicide.[31]

34. Associate Professor Telfer offers her experience over the course of 17 years as a specialist Paediatrician in Adolescent and Transgender Medicine as the basis for her observations on the adverse effects of delay on adolescents seeking treatment.[32]

35. The Commission draws the inference from those observations that failure to provide timely medical treatment may be harmful to those seeking treatment. In addition to the considerations identified at paragraph 51 of the Commission's primary submissions, that inference should inform the Court's assessment as to whether it is necessary in all cases to determine *Gillick* competency (see paragraphs 60-61 of the Commission's primary submissions).

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[30] Costa and Colizzi, 'The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systemic review' (2016) 12 *Neuropsychiatric Disease and Treatment* 1953, ACS at [52.12], p 1964-1965.

[31] Telfer affidavit, ACS at [52.5], at [37]. The Telfer affidavit also attests more broadly to the impact of delay and financial pressures on patients and families, at paragraphs 32-37, 42-47. It is understood that the Secretary, Department of Family and Community Services objects to these paragraphs.

[32] Telfer affidavit, ACS at [52.5], paras 38-41, 48-50. The Commission understands that these paragraphs of the Telfer affidavit are not objected to by any party.

Potential future health impacts if treatment is provided

36. The WPATH Standards of Care describe the expected physical effects of hormone therapy.[33]

37. Appendix B of the WPATH Standards of Care describes the medical risks of hormone therapy.[34]

38. Associate Professor Telfer reports that at The Royal Children's Hospital, the process of obtaining informed consent to treatment includes time allocated in clinical consultations to discuss with the adolescent and their parent/guardians the hospital's patient information documents and consent forms which outline both the reversible and irreversible effects of the treatment, the impact of treatment on fertility, the risk of treatment regret and the impacts of treatment that are not currently known.[35]

Evidence of patients' satisfaction with the treatment

39. The WPATH Standards of Care report that most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery.[36]

40. The WPATH Standards of Care refer to a prospective study in the Netherlands that evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment. Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. The WPATH Standards of Care say that 'this is the largest prospective study to affirm the results from retrospective studies that a combination of hormone

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[33] WPATH Standards of Care, ACS at [52.4], pp 36-38. See also Australian Standards of Care annexed to the Telfer affidavit, ACS at [52.5], p 16. Both of these are adapted from the ES Guidelines, ACS at [52.6], p 3145.

[34] WPATH Standards of Care, ACS at [52.4], Appendix B 'Overview of Medical Risks of Hormone Therapy' pp 97-104, see also pp 39-40.

[35] Telfer affidavit, ACS at [52.5], at [21].

[36] WPATH Standards of Care, ACS at [52.4], Appendix D 'Evidence for Clinical Outcomes of Therapeutic Approaches' p 108.

therapy and surgery improves gender dysphoria and other areas of psychosocial functioning'.[37]

Longitudinal study

41. The article, 'Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment', published in the journal *Pediatrics* in 2014 by de Vries, McGuire, Steensma, Wagenaar, Doreleijers and Cohen-Kettenis, and identified at paragraph 52.8 of the Amended Case Stated, describes what it calls 'the first longer-term longitudinal evaluation of the effectiveness' of puberty suppression in treatment for gender dysphoria after cross-sex hormone treatment and gender reassignment surgery.

42. The study involved 55 young transgender adults (22 transwomen and 33 transmen) who had received puberty suppression during adolescence, had received cross-sex hormones (**CSH**), and had undergone gender reassignment surgery (**GRS**). The participants were all part of the first cohort of 70 adolescents with gender dysphoria who were prescribed puberty suppression at the Centre of Expertise on Gender Dysphoria of the VU University Medical Centre in the Netherlands and who continued with gender reassignment surgery between 2004 and 2011. The article describes why the remaining 15 young people in this group were not included in the study.[38]

43. The study showed that gender dysphoria and body image difficulties persisted through puberty suppression and remitted after the administration of cross-sex hormones and gender reassignment surgery.[39]

44. The study found that: 'psychological functioning improved steadily over time, resulting in rates of clinical problems that are indistinguishable from general population samples ... and quality of life, satisfaction with life, and subjective happiness comparable to same-age peers'.[40]

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[37] WPATH Standards of Care, ACS at [52.4], Appendix D 'Evidence for Clinical Outcomes of Therapeutic Approaches' p 108, referring to Smith, Van Goozen, Kuiper and Cohen-Kettenis 'Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals' (2005) 35(1) *Psychological Medicine* 89-99.

[38] de Vries et al, ACS at [52.8], p 697.

[39] de Vries et al, ACS at [52.8], p 699.

[40] de Vries et al, ACS at [52.8], p 702.

45. In terms of subjective well being, the study found that: '[n]one of the participants reported regret during puberty suppression, CSH treatment, or after GRS. Satisfaction with appearance in the new gender was high, and at T2 [one year after gender reassignment surgery] no one reported being treated by others as someone of their assigned gender. All young adults reported they were very or fairly satisfied with their surgeries.'[41]

Other issues – co-existing health concerns

46. The WPATH Standards of Care note that there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric children and adolescents than in the general population.[42]

47. Under the WPATH Standards of Care, one of the criteria that must be met in order for adolescents to be prescribed puberty suppressing hormones is that '[a]ny co-existing psychological, medical, or social problems that could interfere with treatment ... have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment'.[43]

48. The WPATH Standards of Care provide that '[t]he presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria'.[44]

49. The draft Australian Standards of Care note that clinical guidelines for the management of co-existing autistic spectrum disorder and gender dysphoria have recently been developed.[45]

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41 de Vries et al, ACS at [52.8], pp 700-701.
42 WPATH Standards of Care, ACS at [52.4], pp 12-13. See also DSM-5, ACS at [52.2], p 459.
43 WPATH Standards of Care, ACS at [52.4], p19. See also draft Australian Standards of Care annexed to the Telfer affidavit, ACS at [52.5], p 18.
44 WPATH Standards of Care, ACS at [52.4], p25.
45 Draft Australian Standards of Care annexed to the Telfer affidavit, ACS at [52.5], pp 9 and 12, referring to Strang, Meagher, Kenworthy et al 'Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents' (2016) *Journal of Clinical Child and Adolescent Psychology*.

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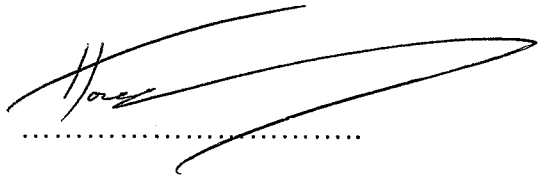

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