FAMILY COURT OF AUSTRALIA

RE: O (SPECIAL MEDICAL PROCEDURE) ***[2010] FamCA 1153***

FAMILY LAW - CHILDREN – Special medical procedures – Gender Identity Disorder

APPLICANT:	The Mother and the Father and the Hospital
RESPONDENT:	Office of the Public Advocate

FILE NUMBER: By Court Order File Number is suppressed

DATE DELIVERED:	2 December 2010
JUDGMENT OF:	DESSAU J
HEARING DATE:	23 November 2010

REPRESENTATION

By Court Order the names of counsel and solicitors have been suppressed.

ORDERS

IT IS ORDERED

1. That the applicant parents shall be authorised to consent to the following special medical procedures at the Hospital on behalf of O:

   (a) A procedure or procedures for extraction and storage of O's sperm, being either electro-ejaculation or needle extraction from the testes under the guidance of O's treating medical practitioners;

   (b) The administration of Zoladex (a GnRH agonist) in such dose, in such manner and with such frequency as necessary as determined in consultation with the treating medical practitioners to achieve suppression of gonadotrophins and testosterone to pre-pubertal levels;

   (c) At a time determined in consultation with the treating medical practitioners, the administration of oestrogen, using Progynova or such other hormonal treatment as considered most appropriate, in such dose, and with such frequency, as determined in consultation with the treating medical practitioners;

   (d) Any other hormonal and/or psychiatric or psychological treatment as determined in consultation with the treating medical practitioners and psychologist;

   for the purpose of treating O's diagnosed Gender Identity Disorder.

2. That the name of O, his family members, the hospital, the Respondent, his medical practitioners, his psychologist, his school, this Court's file number, the Family Consultant, the State of Australia in which the proceedings were initiated, the name of the lawyers, and any other fact or matter that may identify him shall not be published in any way, and only anonymised Reasons for Judgment and Orders (with cover-sheets excluding the registry, file number, and lawyers' names and details, as well as the parties' real names) shall be released by the Court to non-parties without further contrary order of a judge, it being noted that each party shall be handed one full copy of these orders with the relevant details included, to enable their execution.

3. That no person shall be permitted to search the Court file in this matter without first obtaining the leave of a judge.

4. That otherwise all existing applications shall be dismissed, the case removed from the list of cases awaiting finalisation, and the appointment of the Independent Children's Lawyer shall be discharged.

IT IS NOTED that publication of this judgment under the pseudonym *Re: O (Special Medical Procedure)* is approved pursuant to s 121(9)(g) of the *Family Law Act 1975* (Cth).

FAMILY COURT OF AUSTRALIA AT

FILE NUMBER: By Court Order the File Number is suppressed

The Mother and the Father and the Hospital
Applicant

And

Office of the Public Advocate
Respondent

REASONS FOR JUDGMENT

INTRODUCTION

1. O is a 16-year-old boy from a close-knit and loving family. He has been diagnosed with Gender Identity Disorder. His profound need to become a female is supported by his parents, paediatrician, psychiatrists, endocrinologist, psychologist, the Family Report writer, and the Independent Children's Lawyer.

2. The application before me, seeking orders to undertake the relevant medical procedures, has been brought by O's parents and the Hospital, a leading and respected institution in this State.

3. I recently made orders inviting both the Office of the Public Advocate and the Department of Human Services to intervene. The Office of the Public Advocate became a respondent to the proceedings. Their role, in questioning some of the expert evidence, was helpful. Ultimately, they did not oppose the orders sought. Department of Human Services did not seek to participate.

4. The application seeks that O's parents, (I shall refer to them as Mr and Mrs H), be authorised to consent effectively to four things which will be explained in further detail later in these Reasons:

   (a) For O to undergo a procedure known as "electro-ejaculation", for the purpose of collecting his semen for storage;

   (b) For O to be administered implants of a drug to effectively suppress continuing male pubescent development;

   (c) Subsequent oral application of oestrogen, to develop secondary female characteristics; and

   (d) Any other hormonal and/or psychiatric or psychological treatment recommended by O's treating endocrinologist and psychiatrist.

5. No orders are sought in respect of surgical intervention at this stage. What is sought is the first step in a process which, if pursued, would enable O to pursue life as a female.

6. O also has an earlier diagnosis of mild Asperger's Syndrome, which weighs on all aspects of his life, albeit to differing degrees. Its impact on the issues relevant to the proposed medical procedures shall be analysed in detail below.

7. I took the unusual course in this case of advising the parties of my decision – to allow the application – at the end of the hearing, without providing reasons or formally pronouncing orders. I did so in light of the urgency, expressed by the experts, for O to know the outcome. It also struck me as compassionate for his parents, who have keenly felt every step of his journey with him, to know sooner than later that they will be permitted to consent to the procedures that they so genuinely believe will promote O's best interests.

8. These then are my reasons for that decision.

BACKGROUND

9. O is the eldest child of Mr and Mrs H. His younger sister, J, is presently 14 years' old.

10. As a young child O displayed no apparent health issues. He was always regarded as extremely bright. His parents said that from the earliest time he could read (before he started 4-year-old kindergarten), he preferred non-fiction texts, and rarely engaged in imaginative play. His mother recounted occasions when O enjoyed dressing up as a girl, but said that they did not identify any particular development issues until O reached mid-primary school.

11. At that time, his parents began to have concerns in respect of his capacity to manage his temper, and adapt to change. He also began to express feelings of depression and suicidal ideation.

12. In about June 2006, when O was aged 12, his parents arranged for a psychological assessment of him by a clinical psychologist, Dr E. Dr E made the diagnosis of Autism Spectrum Disorder (Asperger's type). Dr E specialises in autism spectrum disorders and has continued to see O in a therapeutic relationship.

13. O experienced significant difficulties and anxiety when he commenced high school, in the Acceleration Program of a select entry government school. He was prescribed anti-anxiety medication, Lovan, by his paediatrician Dr M.

14. In around mid-2008, when the father and J were on holidays, the mother saw O go into his sister's room during the night to dress in her clothing. She also discovered that O had been accessing websites seeking information on "cross-dressing boys".

15. When the mother spoke to the father about what she had discovered, he told her that he himself had enjoyed dressing as a girl when he was a teenager, but that he later "grew out" of it. They decided not to confront O about it, leaving it for him to approach them if and when he chose.

16. By early 2009, O's anxiety had become unmanageable for him. He was keeping himself awake at night, and avoiding school. In around mid-March 2009, O first disclosed to his mother his interest in dressing in female clothing.

17. On 26 March 2009, following a consultation with Dr E, O advised his parents of an "epiphany", and that he "wanted to become a female". Thereafter O began his own independent research, and sought advice from his paediatrician in relation to suspending puberty before his body matured into that of an adult man.

18. The paediatrician referred O and his parents to Associate Professor P, a Consultant Child and Adolescent Psychiatrist at the Hospital. By this time, O was just short of 15 years' old. The onset of his puberty was already significant.

19. Mrs H described O becoming increasingly uncomfortable with the way his body was developing. In the week before his first appointment with Professor P, (in about July 2009), O was extremely anxious at the prospect that Professor P might not support his transition from male to female. He became so anxious that he was unable to sleep and was articulating suicidal thoughts. O's school informed the parents that O had ingested lead solder, with the expressed intention of harming himself.

20. In that same week, Mrs H overheard a telephone call O made to Lifeline, a suicide prevention hotline, in which he disclosed that he had contemplated throwing himself off the school roof, his main concern being that he would not be able to access the treatment that he wanted to suspend his puberty.

21. In early 2010, O changed schools to a small independent school well attuned to his needs. The parents and O perceive this school as having an open and accepting culture. Mrs H swore that with the change of school, and O's on-going consultation with Professor P, he had become more settled, and his school attendance improved. Although they have not yet specifically discussed with the school these proposed medical procedures, the family is confident that the school will be accepting and prepared to help O to manage the process. O and his family are also entirely open to continuing psychiatric and psychological help for him.

THE LEGAL PRINCIPLES

22. Section 60B(1) of the *Family Law Act* 1975 sets out the objects of Part VII of the Act. One of the objects is to ensure that parents fulfil their duties and meet their responsibilities concerning the care, welfare and development of their children.

23. In deciding a particular parenting order, the best interests of the child are the paramount consideration (s 60CA). The primary and additional considerations

for the Court in determining what is in the child's best interests are set out in s 60CC(2) and (3).

24. It is generally within the bounds of a parent's responsibility to be able to consent to medical treatment for and on behalf of their child. There are however certain procedures, referred to in the authorities as "special medical procedures", that fall beyond that responsibility and require determination by the Court, as part of the Court's parens patriae or welfare jurisdiction (see *Secretary, Department of Health and Community Services the JWB and SMB* (1992) FLC 92-293 (*Marion's case*)). It is conceded by the applicants in this case that whether or not the extraction of sperm procedure falls within that definition, the proposed hormone treatment certainly does.

25. In 1995, s 67ZC of the Act was inserted, specifically providing that the Court has jurisdiction to make orders relating to the welfare of children. The child's best interests remain the paramount consideration.

26. The procedure to be followed in applications for Medical Procedures is contained in Chapter IV, Division 4.2.3 of the *Family Law Rules* 2004.

27. Rule 4.09(1) provides that evidence must be given "to satisfy the court that the proposed medical procedure is in the best interests of the child".

28. Largely following a list of matters expressed by Nicholson CJ in *Re Marion (No.2)* (1994) FLC92-448, Rule 4.09(2) provides that evidence must be included from "a medical, psychological or other relevant expert" to establish:

    (a) the exact nature and purpose of the proposed medical procedure;

    (b) the particular condition of the child for which the procedure is required;

    (c) the likely long-term physical, social and psychological effects on the child:

        (i) if the procedure is carried out; and

        (ii) if the procedure is not carried out;

    (d) the nature and degree of any risk to the child from the procedure;

    (e) if alternative and less invasive treatment is available — the reason the procedure is recommended instead of the alternative treatments;

    (f) that the procedure is necessary for the welfare of the child;

    (g) if the child is capable of making an informed decision about the procedure — whether the child agrees to the procedure;

    (h) if the child is incapable of making an informed decision about the procedure — that the child:

        (i) is currently incapable of making an informed decision; and

(ii) is unlikely to develop sufficiently to be able to make an informed decision within the time in which the procedure should be carried out, or within the foreseeable future;

(i) whether the child's parents or carer agree to the procedure.

29. Although each case mostly turns on its own facts, Gender Identity Disorder has been considered in several of the reported decisions including *Re Alex: Hormonal Treatment for Gender Identity Dysphoria*(2004) FLC 93-175, *Re Alex*(2009) 42 Fam LR 645, and *Re Brodie (Special Medical Procedures)* [2008] FamCA 334, and in each the procedures were permitted.

MATERIAL RELIED UPON

30. The applicant parents relied upon their Initiating Application filed 26 August 2010, the affidavit of Mrs H filed 26 August 2010 and the affidavit of Mr H filed 26 August 2010.

31. The applicant parents, and the Hospital, and the Independent Children's Lawyer otherwise all relied upon:

- The affidavit of psychologist Dr E sworn 3 November 2010 filed 5 November 2010
- The affidavit of Dr E sworn 9 August 2010 filed 26 August 2010
- The affidavit of psychiatrist Assoc. Professor P sworn 7 September 2010 filed 9 September 2010
- The affidavit of Assoc. Professor P (Exhibit ICL 1)
- The affidavit of Psychiatrist Professor N sworn 19 October 2010 filed 29 October 2010
- The affidavit of Professor N sworn 4 August 2010 filed 26 August 2010
- The affidavit of paediatrician Dr M sworn 18 October 2010 filed 21 October 2010
- The affidavit of Dr M sworn 19 August 2010 filed 26 August 2010
- The affidavit of endocrinologist Professor W sworn 6 October 2010 filed 14 October 2010
- The affidavit of Professor W sworn 18 August 2010 filed 26 August 2010
- The Family Report prepared by the Family Consultant dated 20 October 2010

32. Only Professor W, Professor P, and Dr E were called. There was only brief cross-examination of them. That was because meticulous preparation by all the parties had already ensured there was detailed material, covering each aspect that the Court must consider under the Family Law Rules, to determine O's best interests.

33. In particular, the Independent Children's Lawyer performed at the high level required in a case with such issues of moment for the young person at the centre of the proceedings.

34. The experts were of the highest calibre, and co-operative and thorough in preparing substantial reports (in most instances, more than one each).

35. The Office of the Public Advocate was helpful in forwarding specific written questions to some of the experts, and in turn the experts provided their written answers in advance of the hearing.

36. Finally, the Family Report writer was an experienced Family Consultant who offered a most thorough assessment of the family from the broader perspective required in considering O's circumstances, beyond just questions associated with the actual medical procedures.

37. I note here the importance of protecting O's identity. On 9 September 2010, when there was a mention before me, I made orders that the proceedings in this matter be referred to in the published list of daily cases as "O and the Hospital". I also made orders that an account of the proceedings, including the names of counsel, whether in anonymised form or otherwise, not be published unless in a form authorised by me.

38. Some aspects of anonymisation were put off until the final part of the hearing. In the event, the issue was not raised again. That does not detract from the strength and reasonableness of the parents' view that O's identity should be protected in every possible way. I agree. There is no doubt on the evidence that he is struggling and suffering enough with the momentous issues he has had to face. Any public identification could only compound his difficulties and could put him at risk.

39. Accordingly, in this judgment, he is referred to as O, his parents' and sibling's identities are not disclosed, the Hospital's name is not disclosed, the experts' names are not disclosed, and I shall make orders to ensure that no details that could identify him are published, or disclosed to any non-party without court order. Such orders shall also apply to the file number, the lawyers' names, and the State of Australia in which the case was initiated. Only the parties shall receive a copy of these Reasons with some identifying details on the coversheet, and one full set of orders including names, to facilitate the proper execution of orders.

40. I turn to the evidence. The most convenient way for me to consider the evidence is under the umbrella of the matters set out above in Rule 4.09(2), albeit in a slightly different sequence.

(b) The particular condition of the child for which the procedure is required

41. In mid-2009, Professor P diagnosed O as meeting the criteria for Gender Identity Disorder in Adolescence, Transsexual Type, male to female (DSM IV 302.85). He has continued to see O over many sessions.

42. Professor P is a consultant child and adolescent psychiatrist who has worked at the Hospital for 30 years. He has considerable experience working with children and adolescents with a range of gender identity development disorders. He is part of an interdepartmental psychiatric and endocrinology group that meets regularly to discuss matters of childhood gender identity, and he has regular liaison with the NHS Gender Identity Development Disorder National Clinic in the United Kingdom.

43. Professor P described O as:

> …an intelligent and expressive 16-year-old boy with mild Asperger's syndrome who has experienced a consistent wish over many years to be female and revulsion of his own male body.

44. Specifically in arriving at his diagnosis, Professor P noted of O:

> A. A strong and persistent cross-gender identification
>
> a. Repeatedly stated desire to be of female sex.
>
> b. Has a persistent desire to where [sic] female clothing.
>
> c. Has a strong and consistent preference for cross-sex role in play and fantasies
>
> d. Has a strong preference for female friends
>
> and
>
> B. Experiences persistent discomfort with his sex and offence at inappropriateness in the gender role of the male sex. He feels disgust with the presence of his penis and testes and wishes that he did not have them. He has an aversion to male-type style rough-and-tumble play and rejects male stereotype games and activities. He has had a persistent desire to be female and has requested hormone treatment to alter his sexual characteristics. In fantasy on-line computer games he has enacted his wish to be a female, but he finds the prospect of living in the real world as a female with his friends and family as very confronting and difficult.
>
> C. [O] does not have a concurrent disorder of physical sexual development.

D. [O's] gender identity disorder causes clinically significant distress and impairment in his social, emotional and other areas of functioning. He experiences a significant depressive mood disorder with at times suicidal ideation as a consequence of the dilemma in which he finds himself. He is very socially isolated although he has significant personal and social strengths.

45. In May 2010, Professor P referred O to Professor N, for a second opinion. Professor N is the director of Developmental Psychology at a well-respected Centre within a large university. She is a specialist child and adolescent psychiatrist. Professor N confirmed Professor P's diagnosis.

(a) The Exact Nature and Purpose of the Proposed Medical Procedure

46. Professor W is the Senior Endocrinologist at the Hospital. Throughout his career, he has taken a particular research and clinical interest in disorders of sex development. He is widely published in the area, presents at international meetings, and has been involved in the management of a number of young people experiencing transsexualism.

47. In his second report, Professor W set out the treatment proposed for O. It is proposed in two stages.

48. The first stage involves a subcutaneous implant of a gonadotrophin releasing hormone analogue called Zoladex, also known as a GnRH analogue, to suppress male puberty, or more specifically to suppress pituitary gonadotrophin secretion.

49. Initially the implants will be administered every 12 weeks, but Professor W said this regime is sometimes insufficient, so that a patient may then require a more frequent administration, every 8 to 10 weeks.

50. Professor W noted that the Hospital has extensive experience with Zoladex as it is "used routinely in the in the treatment of children with precocious puberty".

51. The second stage of treatment, referred to by Professor W as "cross-sex hormone therapy", is the oral administration of the female hormone, Oestrogen. Professor W envisaged that the specific female hormone given to O will be Progynova, and that the daily dosage would be increased over a six to twelve month period, from 1mg to 2mg daily.

52. The Zoladex implants are continued after stage two commences, either until O's Oestrogen levels are sufficient to suppress his pituitary gonadotrophin secretion, or until his testes are removed, whichever is earlier. Professor W noted that it is hard to anticipate the timing of when the Zoladex would be discontinued. It would depend on how O's body reacts to the treatment.

53. In evidence Professor W said that he would probably start the second stage treatment within a few months of the male hormones being suppressed. He said he could not be clear on the timing at this stage. He referred to the US

Guidelines on Endocrine Treatment of Trans-sexual Persons, but emphasised that much depends on the age of the person at the hormone blocking stage. He said that if one adhered to the US Guidelines, there could be a long period between the two stages of treatment. However, O is commencing the first stage of treatment at an older age than many patients.

54. It is important to note that although the medical practitioners referred to the two-stage process, they were clear that it is part of one package of treatment. Professor W had referred to the fact that the staged process would give O and his family time to consider whether to embark on the second stage, (the first stage being fully reversible upon cessation of treatment), but the evidence did not suggest that a change of heart was likely. Nor did it suggest that there should be any undue delay between stages, nor that O and the family should need to return to this Court for the transsexual process to be approved in two separate stages. The experts, including Professor W, were clear that, although there could be a pause between stages if considered appropriate at the time, the treatment should be seen as one process.

(e) If alternative and less invasive treatment is available – the reason the procedure is recommended instead of the alternative treatments

55. The evidence does not suggest that there is any less invasive treatment appropriate to treat O's gender identity disorder. Professor W, the expert endocrinologist, was clear that any other drugs would be less effective and would have more adverse side-effects.

56. I note again that at least the first stage, the suppression of male pubescence, is reversible, if the treatment is stopped. As to the second stage, once O develops female breasts, the only way of reversal – if sought in the future – would be by way of mastectomy. The development of female breasts though is integral to the treatment of the disorder.

57. When it comes to the electro-ejaculation procedure, there is definitely a less invasive method for sperm collection. It simply involves masturbation. The evidence was that at this stage O has shown a significant degree of distress at the prospect of that form of ejaculation, but has also indicated that he has not experienced sexual feelings or fantasies that would promote it. He has indicated to Professor W that he would "give it a try", before resorting to electro-ejaculation.

58. The two alternative procedures then for the collection of sperm are electro-ejaculation – as proposed in this case – or via a needle into the testes. Professor W said that the preference is for the electro-ejaculation procedure because it reaps more sperm. In either instance, given O's psychological anxieties surrounding the procedure, it would be performed only under general anaesthetic. Professor W did not suggest any risk from the procedure, save there

is always a risk associated with general anaesthetic. He emphasised though but that nowadays that risk is very small.

(c) the likely long-term physical, social and psychological effects on the child:

(i) if the procedure is carried out; and

(ii) if the procedure is not carried out;

(d) the nature and degree of any risk to the child from the procedure;

59. These considerations are at the heart of this case. There is no question, on the evidence of the parents, and all the expert evidence, that O's mental health is being placed at serious risk without the two-stage treatment proposed by the experts.

60. The past two years for O have been dogged by periods of significant depression and suicidal thoughts associated with his gender identity.

61. O has reported to his treating psychiatrist, Professor P, disgust about his body. He is revolted by the presence of his penis. He generally tries to hide his penis and testes and the profile of his genitalia. He has shaved off his bodily hair. He wears his hair in a long style. He wants to have breasts. He practises speaking in a high pitched female voice and is very concerned about his deepening voice. Recently he took three days off school after catching a glimpse of his reflection in a mirror. He was overwhelmed by distress. According to Professor P, he feels "visceral disgust" when he looks at his body.

62. Professor P reported that O's affect significantly deteriorated in the 12 to 18 months preceding the report. O has told him that "at times he feels his life is not worth living because of the feeling of being trapped in the wrong body".

63. Professor P confirmed that O sought help from a suicide help-line to prevent self-harming. He also confirmed that O's literal approach to matters prevents him dressing as a female outside of the confines of his own bedroom. He cannot comprehend presenting himself as a female while he is still so evidently male. This is the bind that causes him palpable distress. He quotes O has saying "I desperately want to be a girl. I can't cope, I just can't stand it."

64. Professor P notes that O's views of his gender and physical appearance have not changed in the past two years.

65. Professor P considered the physical, social and psychological effects on O of both receiving the treatment, and not receiving the treatment. He concluded that, should O be permitted the treatment, his mental state will be much improved. If he is able to look at living as a female, it will reduce the risk to his mental health and general welfare. If the treatment is not permitted, he expects O's extreme distress, intense anxiety and depressive mood disorder to continue. Moreover, if the treatment is not permitted, the risk of O's "on-going suicidal preoccupation and intent is high".

66. In Professor P's opinion, there is a "real urgency" about the treatment being commenced, particularly in light of O's increased distress at his changing body and the likely permanence of some of those changes. He believes that the delivery of the female sex hormone will permit O the opportunity to present himself as a female, something he has been yearning to do for a considerable time, but has been prevented, due to his male appearance.

67. O's treating paediatrician, Dr M, said that O is likely to suffer "significant psycho social harm" if he does not receive the treatment sought. In her opinion, any delay in commencing the treatment would be akin to no treatment, considering the considerable progress of O's current pubertal development. She did not envisage an adverse effect on O's mental, emotional and or physical health should the treatment proceed.

68. Dr E, O's treating psychologist since 2006, also expressed concern for O's mental health, without the treatment. As he put it, he has known O for a long time: he has dealt with him "on his journey". In his opinion, if this application is refused, O would "absolutely be at risk of self-harm". That view was also endorsed by Professor W, and by the Family Report writer. It remains a significant concern of his parents.

69. I am satisfied that the risks facing O, in the event that the treatment does not proceed, have been properly weighed by the experts against any risks arising from treatment.

70. First, as noted, Professor W advised the Court of a low-level of risk associated with a general anaesthesia accompanying the electro-ejaculation procedure.

71. Professor P said that although he is a psychiatrist and not an endocrinologist, as a medical professional he understands that the hormone inhibiter may slightly affect O's bone mineral density, but the female hormone, when introduced, will counteract that. He noted too the possible effect of prolonged use of the female hormone on O's spermatogenesis. That concern was to some extent ameliorated, given the proposed procedure to collect sperm, for storage should O at a later stage wish to have children.

72. Professor P also noted a hypothetical connection between the administration of an external hormone and slight brain development but did not express any significant concern in that regard.

73. Professor W noted a chance that in the first few weeks, Zoladex could stimulate O's pituitary gonadotrophin secretion, which may in turn result in him experiencing increased erections, but it would be temporary. Medium term side effects of the hormone could cause "tiredness, reduced muscle strength and hot flushes". He deposed that there were no known adverse long-term effects of Zoladex. While it does inhibit fertility, that is "fully reversible".

74. In the short term, Progynova, used in the second stage, may cause temporary nausea and a suppressed appetite. Medium term, considered to be 2 to 3 years, O would develop female breasts. Theoretically, in the long term, Progynova may increase O's risk of developing breast cancer, but Professor W was not aware of it having occurred in any person who has transitioned. He cautions that O's risk of venous thrombosis and cardiovascular disease could also increase, but that is most marked in women over 40 years old who smoke.

75. Professor W advised that if O were to stop the Progynova, most effects would be reversible, save for any breast development. The only risk arising in that regard would be if O determined in the future that he did not want to live as a female, the breasts could only be removed by mastectomy. When asked if that would be "major surgery", Professor W said that it would depend on the size of the breast at the time. As noted above, the breast development proceeds over several years.

76. Otherwise, the professionals agreed that even if the treatment proceeds, O will still require on-going psychological and counselling assistance, to help with the various issues that will inevitably arise for him.

(g) If the child is capable of making an informed decision about the procedure – whether the child agrees to the procedure

77. Despite the combined complexities of O's youth, the depression and anxiety that he has suffered, and the symptoms of Asperger's syndrome, the consensus amongst all the professionals was that he is capable of making and has made an informed decision about the procedures. That accords with his parents' assessment.

78. His psychologist Dr E has continued to see O to address his anxiety and depression, social difficulties, and attendance at school. In light of O's father's experience of gender identity confusion as an adolescent, which later resolved on its own, Dr E attempted to discuss with O the possibility of postponing treatment. Dr E said he has been unsuccessful in engaging O in such discussions, as O is unable to imagine such a path for himself.

79. Dr E described O as "very bright" but with a "marked spread of strengths and weaknesses across his cognitive profile". When pressed in evidence to expand upon the weaknesses, Dr E referred to the process of writing, social understanding, a typically obsessive approach in his pursuit of interests, a "concrete" approach to issues, and being on the "social outer", that is not in the "main pack" of his peers.

80. Expanding on O's strengths, Dr E described him as "incredibly bright", not impulsive, capable of extensive research, and that in some areas he shows more maturity than his peers, and can "think things through".

81. In noting the enormous amount of research O has done in respect of what options are available to him, Dr E described it as "impressive". He referred to

the fact that O has, via online chat-rooms, sought out others in similar predicaments as a way to "normalise his experience".

82. Dr E did not see O's Asperger's playing any role in his capacity to adequately think through the gender identity issues or to give informed consent, nor for that matter as a factor in any possible change of heart in the future.

83. In the treating psychiatrist Professor P's professional opinion, O understands both the nature and purpose of the proposed treatment, and his Asperger's syndrome has not diminished his capacity in that respect.

84. Professor P was satisfied that O has the capacity to make an informed decision about the proposed treatment, that he has sought appropriate information, and that he understands explanations given to him by the professionals.

85. Professor P was satisfied that O has insight into how difficult it will be for him to live as a female, despite his desperate desire to do so. Professor P described O's parents as supportive of his wish to have the proposed treatment.

86. The psychiatrist who gave the second opinion, Professor N, considered O's "limited experience" of living as a female and noted that "this, along with his social isolation and depression needs to be a focus of intervention".

87. In her second report, Professor N highlighted that a complicating factor for O is the degree of his "disorder and depressive feelings". She noted that his Asperger's syndrome makes it difficult for him to predict and prepare for the undoubtedly challenging social implications of gender transition and that he will require ongoing professional assistance to manage this. I am confident that he and his family are committed to and comforted by such assistance.

88. Having noted all those issues for O, Professor N still concluded that O has a good knowledge and understanding of the proposed treatment.

89. O's treating paediatrician, Dr M, was satisfied that O has the cognisance and maturity to understand the options available to him and "make appropriate decisions for himself".

90. Dr M did not consider that O's Asperger's syndrome detracts from his capacity to properly contemplate his gender identity and make decisions. Further, in her opinion, O's developmental age and stage make it unlikely that he will change his views about gender transition in the future.

91. The endocrinologist, Professor W, was also satisfied of O's capacity to understand. He based that on his own assessments, but most particularly on the assessments of the psychiatrists. He found it harder to engage O, which may have been because of his role in discussing processes rather than exploring O's feelings in the more general sense undertaken by other experts, or because he has been involved over a shorter period than others.

92. When this matter first came before me on 9 September 2010, I made an Order for a Family Report to be prepared by a Family Consultant. In addition to hearing O's wishes, it was important for me to understand his place in the family unit, the impact of the proposed medical procedure on him and his close family members, and the family's capacity to support him.

93. In reporting on her interviews with the family, the Family Consultant framed nine key issues as follows:

- The nature of O's wishes.
- The strength of those wishes.
- O's capacity to make an informed decision regarding the proposed treatment considering his age, intelligence, maturity and the impact of Asperger's syndrome on this.
- His capacity in the short and long term to make the changes necessary in his lifestyle associated with the process of considering whether to live as a female during the proposed treatment phase.
- His parents' attitude to his proposals and their capacity to support him.
- The impact on the family unit and J in particular, of his proposals.
- The impact of the Court refusing O's request.
- The effect of the Court delaying the process.
- The benefits, if any, of delaying the process.

94. In line with the evidence of the other professionals, the Family Consultant reported that O's wish to have the treatment to suppress his pubertal development, and to develop secondary female characterises, remained "firm and unwavering". In her opinion, O has an excellent understanding of the proposed treatment. She described his understanding as being "in a manner far beyond what his chronological age of 16 might suggest, and despite his Asperger's condition".

95. Regarding his capacity to make the changes necessary to live as a female, the Family Consultant said that until O's physical appearance is changed, he will find it difficult to even contemplate living as a female, let alone take steps to effect it. The Family Consultant noted however that during the time in which she was in contact with O, he did "unexpectedly" and "seriously" dress as a female in front of his family, which was positively received by them.

96. The Family Consultant was satisfied that O has received ongoing unconditional support from his parents in respect of his gender identity disorder and the course of treatment he seeks. She noted that, despite the immense financial burden occasioned by O's parent's having to bring this matter to Court, they are "fully

focused" on O's best interests, and it is their intention to continue to support O in all respects of his life into the future.

97. Understandably, O's issues have had an immeasurable effect on his family. O and his parents have sought to protect J as far as possible, and until recently she has had limited involvement. The Family Consultant described J as "a highly intelligent, poised young woman whose appearance belies her years". With insight, J is able to recognise that she may experience some issues should O undergo the treatment, but she is keen to support her brother nonetheless. The Family Consultant found J to be "resilient", and noted that she is well supported by her family to manage any impact on her of O transitioning to female.

98. The Family Consultant's opinion was that there is unlikely to be any benefit to O of refusing and or delaying the treatment, given the stage of his physical development, and his strong and steadfast desire to have the treatment. She too was significantly concerned about O's mental health and welfare should the treatment not progress with some urgency.

99. While acknowledging that no-one can be expected to fully understand the obstacles ahead of them, the Family Consultant considered that O and those supporting him have made every effort to do so. In recommending that both the puberty blocking and subsequent hormone treatment occur "as a matter of urgency", the Family Consultant had concluded:

> …What is clear is that if [O] is forced to continue his physical developmental [sic] as a male he will find it increasingly intolerable and this may pose a risk not only to his emotional wellbeing but also pose a risk of self harm or suicide. Whilst there may be some minimal risks in taking the first two steps of medical treatment which [O] is requesting, they would appear to be far less than the risks of not doing so for [O].

(h) If the child is incapable of making an informed decision about the procedure – that the child:

(i) is currently incapable of making an informed decision; and

(ii) is unlikely to develop sufficiently to be able to make an informed decision within the time in which the procedure should be carried out, or within the foreseeable future

100. Having found O is capable of making an informed decision, I do not need to consider this aspect further.

(i) Whether the child's parents or carers agree to the procedure

101. O is very fortunate to be close to his parents, and to have the capacity for open communication with them.

102. Mr and Mrs H have been profoundly troubled by O's distress, respectful of his reasoning, and steadfast in seeking the very finest medical experts to inform, advise, and support O and the family.

103. They have waited appropriately to explore whether O would "grow out" of his desire to live as a female. They have considered the effect of his Asperger's on his capacity to form a decision. They have considered the cocktail of issues that could lie ahead for O following his transition. They have not acted precipitously.

104. O is fortunate in having parents who adore and respect him, with the capacity to prudently consider every angle, in arriving at the decision to agree to the procedure.

(f) That the procedure is necessary for the welfare of the child

105. For the reasons already given, the expert evidence is clear that this package of treatment to enable O's transition from male to female is necessary for his welfare.

106. Professor P summed it up, expressing an opinion that the treatment "is necessary for the mental health and welfare of O". He stated that:

> [O's] preoccupation with the distress around his body and gender identity is persistent and pervasive and this has disrupted his psychological development as well as his social and cognitive development…Although [O] has a very high level of intelligence his emotional disruption has meant that he has been very limited in the development of his formal learning and academic school. If [O] is able to be comfortable with his identity and his body I believe he will be able to engage with his peers and in his social and academic activities.

CONCLUSION

107. As I have already emphasised, O's best interests are the paramount concern in this case. In determining a child's best interests, I must consider the factors set out in s 60CC of the Act. In this case I have not addressed individual factors in detail. Many are not apposite to the particular issue before me. O's wishes are important. The parents' capacities to meet O's needs and make decisions for him are also important. I am satisfied that I have covered those, and other relevant factors within the detailed reasons given above.

108. The responsibility of decision-making in parenting cases, requiring the Court to project a child's best interests into the future, always weighs heavily, but never more heavily than when considering a special medical procedure, part of which will ultimately be irreversible or at least, difficult to reverse.

109. In this case, the heavy onus is lightened in some respects. I have the uncontradicted evidence of a range of experts, recognised at the top of their

respective fields. There is a thorough assessment by an experienced Family Consultant who has been able to confirm that these exquisitely difficult decisions about O are being made by two loving parents in a close and caring family. Finally, all the evidence points to O himself being a bright and resourceful young person, considered and determined in articulating his steadfast desire to live a fulfilling life as a female, and suffering terribly and at serious risk unless that can be achieved.

110. I am satisfied that the orders sought by the applicants are the orders that will promote O's best interests.

ORDERS

111. The orders I propose are as follows:

1. That the applicant parents shall be authorised to consent to the following special medical procedures at the Hospital on behalf of O:

   (a) The procedure known as "electro-ejaculation" for the purpose of collecting O's semen for storage;

   (b) The administration of Zoladex (a GnRH agonist) in such dose, in such manner and with such frequency as determined in consultation with the treating medical practitioners to achieve suppression of gonadotrophins and testosterone to pre-pubertal levels;

   (c) At a time determined in consultation with the treating medical practitioners, the administration of oestrogen, using Progynova, in such dose and with such frequency as determined in consultation with the treating medical practitioners;

   (d) Any other hormonal and/or psychiatric or psychological treatment as determined in consultation with the treating medical practitioners and psychologist;

   for the purpose of treating O's diagnosed Gender Identity Disorder.

2. That the name of O, his family members, the hospital, his medical practitioners, his psychologist, his school, this Court's file number, the Family Consultant, the State of Australia in which the proceedings were initiated, the name of the lawyers, and any other fact or matter that may identify him shall not be published in any way, and only anonymised Reasons for Judgment and Orders (with cover-sheets excluding the registry, file number, and lawyers' names and details, as well as the parties' real names) shall be released by the Court to non-parties without further contrary order of a judge, it being noted that each party shall be handed one full copy of these orders with the relevant details included to enable their execution.

3. That no person shall be permitted to search the Court file in this matter without first obtaining the leave of a judge.

4. That otherwise all existing applications shall be dismissed, the case removed from the list of cases awaiting finalisation, and the appointment of the Independent Children's Lawyer shall be discharged.

I certify that the preceding one hundred and eleven (111) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Dessau delivered on 2 December 2010

Associate:

Date: 2 December 2010