FAMILY COURT OF AUSTRALIA

RE: LINCOLN (NO. 2) ***[2016] FamCA 1071***

FAMILY LAW – CHILDREN – MEDICAL PROCEDURES – Where the applicants are parents of a child with gender dysphoria – Where the applicants seek an order that the child is competent to consent to his own stage 3 treatment – Where the proposed treatment is male chest reconstruction surgery – Where the Secretary of the Department does not oppose the treatment but submits that the treatment requires Court authorisation and application of the best interests principle – Where the child is 15 years of age – Consideration of whether the child is *Gillick* competent – Where the child's treating medical experts and parents support the child commencing stage 3 treatment – Where each of the child's treating practitioners have expressed the opinion that the child is competent to the *Gillick* standard – Where the child is *Gillick* competent and can consent to the proposed treatment – Where the Court is of the view that the proposed treatment does not require Court authorisation if it is found that the child is *Gillick* competent – Order made that the child is competent to consent to the proposed treatment.

Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112
Re Jamie (2013) FLC 93-547
Re Leo [2015] FamCA 50
Re Quinn [2016] FamCA 617
Re Tony [2016] FamCA 936
Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218

Family Law Act 1975 (Cth) s 67ZC

APPLICANTS:	The Father and the Mother
RESPONDENT:	The Department
INDEPENDENT CHILDREN'S LAWYER:	Independent Children's Lawyer

FILE NUMBER: By Court Order File Number is suppressed

ORDERS MADE:	6 December 2016
DATE DELIVERED:	13 December 2016
JUDGMENT OF:	Johnston J

HEARING DATE: 6 December 2016

REPRESENTATION

By Court Order the names of solicitors have been suppressed

ORDERS MADE 6 DECEMBER 2016

1. Orders are made in accordance with the first occurring paragraphs 1, 2, 3 and 4 of the Annexure A to the Initiating Application filed on 15 November 2016, as set out hereunder:

    1. That the court finds that Lincoln (born [female name] B on … 2001) is competent to consent to male chest reconstruction surgery for the purposes of the treatment of Gender Dysphoria in Adolescents and Adults as identified in the Diagnostic and Statistical Manual of Mental Disorders (2013) DSM-5 on and from a date to be determined by the treating medical team of Lincoln.

    2. That the full name of Lincoln, his family members, his hospital, the Independent Children's Lawyer, his medical practitioners, his school, this court's file number, any Family Consultant, the State of Australia in which the proceedings were initiated, the name of Lincoln's parents' lawyers, and any other fact or matter that may identify Lincoln 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, and one cover-sheet of Reasons for Judgment that includes the file numbers and lawyers' names.

    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.

2. Reasons for judgment be reserved.

Note: The form of the order is subject to the entry of the order in the Court's records.

IT IS NOTED that publication of this judgment by this Court under the pseudonym *Re Lincoln (No. 2)* has been approved by the Chief Justice pursuant to s 121(9)(g) of the *Family Law Act 1975* (Cth).

Note: This copy of the Court's Reasons for Judgment may be subject to review to remedy minor typographical or grammatical errors (r 17.02A(b) of the Family Law Rules 2004 (Cth)), or to record a variation to the order pursuant to r 17.02 Family Law Rules 2004 (Cth).

FAMILY COURT OF AUSTRALIA

FILE NUMBER: By Court Order File Number is suppressed

The Father and the Mother
Applicants

And

The Department
Respondent

REASONS FOR JUDGMENT

INTRODUCTION

1. Lincoln was born on in 2001 and named B. Although born female Lincoln identifies as male. He has the condition of gender dysphoria. Lincoln has a very strong desire to have a bilateral mastectomy or what is referred to within the transgender community as "top surgery".

2. Lincoln's parents have filed an application seeking orders that the Court find that Lincoln is competent to consent to male chest reconstruction surgery for the purpose of treating his gender dysphoria. In the event that the Court found Lincoln not to be competent to consent to the surgery proposed, his parents seek an order that they be permitted to authorise the surgery proposed pursuant to s 67ZC of the *Family Law Act 1975* (Cth) ("the Act").

3. The Secretary of the relevant State Government Department has been served with the application and has entered an appearance and made submissions. The Secretary takes a particular view of the relevant law applicable in these cases to which I shall come in due course. The Secretary does not oppose the surgery desired by Lincoln and his parents on the basis that the Secretary considers this to be in the best interests of the child.

4. At the hearing on 6 December 2016 it was submitted that if the Court was satisfied that Lincoln was competent to consent to the proposed treatment it would be in Lincoln's best interests to avail himself of an appointment which was available on 9 December 2016 for the proposed surgery. I accepted this submission and made orders on 6 December 2016, without giving reasons, that Lincoln was competent to consent to the treatment. These are my reasons for making the orders.

BACKGROUND

5. The parents met in 1998 and commenced a relationship thereafter.

6. Lincoln was born in 2001. Lincoln is the only child of each of the parents.

7. In 2007 Lincoln's parents separated. Initially Lincoln lived between the parents' homes in an equal time arrangement. By 2009 Lincoln commenced to live with his mother during the week and his father on most weekends. The parents maintain a cooperative relationship with regard to decisions about Lincoln's welfare.

8. In September 2014 Lincoln informed his mother that he felt he was "born into the wrong body". Lincoln had undertaken research on the internet and told his mother that he thought that he had gender dysphoria. He told his mother that he felt that he was a boy, not a girl. He said that he wanted help with his anxiety and depression.

9. Lincoln's mother said that in the year prior, Lincoln started to refuse to wear more feminine clothing. He would insist on getting shorter hair styles. Lincoln also started to self-harm. Lincoln's mother said that he became withdrawn and moody at school, and was getting bullied. His bedroom became masculine-looking and he started to imitate a lower sounding voice. By this stage Lincoln was experiencing depression, anxiety and suicidal thoughts.

10. In November 2014 Lincoln's mother told his father that Lincoln had said to her that he had gender dysphoria. Lincoln had asked his mother to discuss it with his father as he felt it was a subject too difficult to broach with his father. A few days later Lincoln's father spoke to Lincoln about what his mother had discussed with him. Lincoln's father said that he got the impression that Lincoln was extremely knowledgeable on the subject.

11. In approximately November 2014, Lincoln's parents made enquiries to consult with child, adolescent and adult psychiatrist, Dr K at Headspace in Suburb Q. However they were unable to obtain an appointment for Lincoln until March 2015.

12. Over the 2014/2015 Christmas period Lincoln experienced a period of severe depression.

13. In January 2015 Lincoln started wearing a chest binder in an endeavour to minimise the appearance of his breasts and by August 2015 he was wearing a chest binder every day.

14. On 26 March 2015 Lincoln attended his first appointment with Dr K. From this time, Lincoln saw Dr K approximately once every two weeks until October 2015.

15. From April 2015, Dr K prescribed Lincoln anti-depressants to assist with sleep.

16. In May 2015 Lincoln started attending endocrinologist, Dr M and thereafter commenced what is known as stage 1 treatment for gender dysphoria in the form of puberty blockers. I shall refer to this again below.

17. In October 2015 Lincoln enrolled in Y School. From this time, Lincoln's psychiatric care was transferred from Dr K to Dr J and a team of psychiatric nurses employed by Y School. Also in October 2015, Lincoln commenced seeing Dr H, consultant physician in endocrinology and metabolism.

18. On 28 January 2016 Lincoln's parents filed an Initiating Application in this Court seeking orders to declare Lincoln competent to consent to the administration of stage 2 treatment for gender dysphoria. I shall also refer to this treatment below.

19. In March 2016 Lincoln enrolled at A High School. He currently attends school full time.

20. On 22 April 2016 Justice Stevenson found that Lincoln was competent to consent to stage 2 treatment.

21. On 26 April 2016 Lincoln commenced stage 2 treatment. Shortly after the orders of 22 April 2016, Lincoln's birth certificate was amended.

22. Since commencing stage 2 treatment Lincoln has adapted well to the changes. His voice has deepened and he has started to grow body hair. He has experienced some improvement with his energy levels and mood to the point where he has ceased using anti-depressant medications.

23. On 24 August 2016 Dr K consulted with Lincoln's parents to determine parental support for Lincoln's proposed chest masculinisation surgery.

24. On 5 September 2016 Lincoln and his parents consulted with plastic surgeon, Dr V in Sydney.

25. On 5 October 2016 Dr K interviewed Lincoln to determine his *Gillick* competence with respect to chest masculinisation surgery.

26. In 2017 Lincoln will commence attending year 11 at F High School.

DIAGNOSIS

27. Dr K has expressed the opinion that Lincoln fulfils the DSM-5 criteria for gender dysphoria in adolescents and adults. Dr K also said that Lincoln has a history of major depression, deliberate self-harm, oppositional defiant disorder and school refusal. He said that Lincoln has successfully resolved all of these difficulties over the period of treatment, and has been managing very well without anti-depressant medications over the last three months, that three months being from September 2016.

THE WPATH GUIDELINES

28. Guidelines have been published by the World Professional Association for Transgender Health, Standards of Care ("the WPATH Guidelines"). These set out the generally accepted interventions which fall into three stages as follows:

    1. *Fully Reversible Interventions:* These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (mostly commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH Analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

    2. *Partially Reversible Interventions:* These include hormone therapy to masculinise or feminise the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g. deepening of the voice caused by testosterone).

    3. *Irreversible Interventions:* These are surgical procedures.

       A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

       …

       Genital surgery should not be carried out until (i) patients reach the legal age of majority to give consent for medical procedures in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

       Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable depending on an adolescent's specific clinical situation and goals for gender identity expression.

       Risks of Withholding Medical Treatment for Adolescents

> Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatisation. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescents (*Nuttbrock* et al, (2010), withholding puberty suppression and subsequent feminising or masculinising hormone therapy is not a neutral option for adolescents.

29. Lincoln's treating doctors recommend that top surgery take place as soon as possible.

30. The surgery is not opposed by the Secretary of the Department.

31. An Independent Children's Lawyer ("ICL") has been appointed for Lincoln. The ICL supports the child's competence to make the decision himself and supports the surgery.

THE APPLICABLE LAW

32. In *Re Jamie* (2013) FLC 93-547 the Full Court dealt comprehensively with the circumstances in which court authorisation is necessary for stage 1 and stage 2 treatment of gender identity disorders. At page 87,326 Bryant CJ concluded in summary as follows:

> …
>
> a) Stage one of the treatment of the medical condition known as childhood gender identity disorder is not a medical procedure or a treatment which falls within the class of cases described in *Marion's case* (*Secretary Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218) which attract the jurisdiction of the Family Court of Australia under s 67ZC of the (*Family Law Act* 1975 (Cth)) Act and require court authorisation.
>
> b) If there is a dispute about whether treatment should be provided (in respect of either stage one or stage two), and what form treatment should take, it is appropriate for this to be determined by the court under s 67ZC.
>
> c) In relation to stage two treatment, as it is presently described, court authorisation for parental consent will remain appropriate unless the child concerned is *Gillick* competent.
>
> d) If the child is *Gillick* competent, then the child can consent to the treatment and no court authorisation is required, absent any controversy.

e) The question of whether a child is *Gillick* competent, even where the treating doctors and the parents agree, is a matter to be determined by the court.

f) If there is a dispute between the parents, child and treating medical practitioners, or any of them, regarding the treatment and/or whether or not the child is *Gillick* competent, the court should make an assessment about whether to authorise stage two having regard to the best interests of the child as the paramount consideration. In making this assessment, the court should give significant weight to the views of the child in accordance with his or her age or maturity.

33. At page 87,332 paragraph 188 Finn J said as follows:

> 188. If the court was completely satisfied of the child's capacity to consent to stage two treatment, it would be unnecessary for it to have to authorise the treatment. That could be left to the child. But if the court had any doubt about that capacity, then it would have to determine for itself the question of whether the stage two treatment should be authorised.

34. At page 87,333 paragraphs [195]-[196] Strickland J said as follows:

> 195. In relation to stage two treatment, I agree that the therapeutic benefits of the treatment need to be weighed against the risks involved and the consequences which arise out of the treatment being irreversible, but that given the nature of the changes that would result for the child that treatment should require court authorisation. This would not be the case though where the child is able to give consent to the proposed treatment.
>
> 196. Whether the child is able to fully understand and give informed consent to stage two treatment, and thus court authorisation is not required, is a threshold issue that the court must decide. This is because of the requirement by the High Court majority in *Marion's* case that it is for the court to authorise medical treatment that is irreversible where there is a significant risk of the wrong decision being made as to the child's capacity to consent to the treatment, and where the consequences of such a wrong decision are particularly grave.

35. Accordingly, the Full Court determined that in cases where the proposed treatment is irreversible or partially reversible, the issue to determine is whether the child is competent within the meaning of the House of Lords decision in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 ("*Gillick*") to consent to the treatment. In the event that the Court

found that the child was competent in this respect, it would not be necessary for the Court to authorise the treatment.

36. It is submitted by the Secretary that the medical treatment proposed in this case is what is generally known as stage 3 treatment within the WPATH, standards of care. Under these standards of care, irreversible interventions are defined as surgical procedures. It is submitted by the Secretary that on the basis that what is proposed is irreversible and requires a surgical procedure, it therefore falls within the category of treatment discussed in *Marion's case* which attracts jurisdiction under s 67ZC of the Act and requires Court authorisation and application of the best interests principle.

37. I must say I am unpersuaded that as a matter of law the Court would need to rely on its jurisdiction under s 67ZC of the Act and act to authorise the proposed treatment. It is true that surgery is different from the medical treatment generally provided pursuant to stage 2. In fact a double mastectomy operation would fall within stage 3 treatment. And it is true that the guidance given by the Full Court in *Re Jamie* was in the context of what would be required in respect of stages 1 and 2 of the treatment. But I would not read down what the Full Court said in *Re Jamie* about *Gillick* competence in the manner submitted by counsel for the Secretary.

38. In my view, it is useful to return to the words of Lord Scarman when his Lordship was considering in *Gillick* (above) what is meant by a child's competence to give a consent valid in law. The relevant passage is at 188-189 and is as follows:

> … I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances. Emergency, parental neglect, abandonment of the child or inability to find the parent are examples of exceptional situations justifying the doctor proceeding to treat the child without parental knowledge and consent but there will arise, no doubt, other exceptional situations in which it will be reasonable for the doctor to proceed without the parent's consent.

I must say I am at a loss to understand how this principle would apply to stage 2 treatment but not to stage 3 treatment.

39. I agree with the approach taken by Rees J in *Re Leo* [2015] FamCA 50 where her Honour said at paragraph [11] as follows:

> The decision of the Full Court does not refer to a Stage 3 procedure, however, it is clear from the judgment of the Full Court that, in referring to Stage 2 intervention, the Court is dealing with treatment, the consequences of which are irreversible and that the stages referred to as Stage 2 and Stage 3 in the "Standards of Care" document equate to Stage 2 in the judgment of the Full Court.

40. I respectfully propose to take the same approach as that taken by Rees J in *Re Leo* and in *Re Quinn* [2016] FamCA 617. That is to adopt the guidance of the Full Court in *Re Jamie* and determine whether or not Lincoln is *Gillick* competent to consent to the proposed treatment. A similar approach was taken by Gill J in *Re Tony* [2011] FamCA 936.

EVIDENCE

41. The child, the child's parents and the child's treating medical professionals all agree to the proposed procedure.

42. As I have said, the question ultimately becomes whether Lincoln has sufficient intelligence and understanding to enable him to understand fully what is involved in the proposed surgical procedure to give a consent valid in law.

43. The father said in his affidavit that on 5 September 2006 he and the mother took Lincoln for an initial consultation with plastic surgeon Dr V. He said that at this consultation Dr V examined Lincoln and discussed the subcutaneous double mastectomy procedure. He said that Lincoln has been very clear that the top surgery is an absolute necessity for him. He said that Lincoln has an excellent understanding of the surgical process and the likely scarring it will leave. He said that in all conversations he has had with the child Lincoln has shown a strong desire to have surgery and accepts any of the possible physical discomfort and scarring it may bring. He said that Lincoln has a positive view of the surgery. He said that Lincoln talks positively of his desire to lead a more active life, such as going to the beach, playing sports and feeling free to join in with his friends. The father said that Lincoln has discussed the greater confidence and ease top surgery will bring him.

44. The mother said that Lincoln is a deep thinker and is not swayed by other people's opinions. She said that he never makes sudden, dramatic decisions, decides over time after discussion, after considering the advantages and disadvantages of an issue.

45. Dr V, cosmetic plastic surgeon, said that he saw Lincoln with his parents on 5 September 2016. He said that he had a lengthy discussion with Lincoln and his parents about gender affirming chest masculinisation surgery. He said that at the consultation, various surgical options were discussed at length. He said that the surgical procedure he proposed for Lincoln was a full scar mastectomy with nipple areolar reconstruction and repositioning using inferior vascularised

pedicles. He said that detailed explanation was supported by the use of clinical photos of other patients who had undergone such procedures to show Lincoln and his parents the likely physical outcome from the surgeries. He said that both ideal and less ideal results were shown and that particular emphasis was placed on the potential for poor scars, poor chest contour and an unsatisfactory aesthetic outcome. He said that at the conclusion of the consultation he provided Lincoln and his parents with written information about the surgery and asked them to arrange a second consultation prior to surgery so that he could ensure that Lincoln and his parents had a full understanding of the proposed surgery to enable him to make an informed decision about proceeding with such. Dr V said that at the conclusion of the consultation he considered that Lincoln and his parents had a good understanding of the proposed surgery, the likely outcome, recovery process, potential complication and relevant aesthetic issues. He said that Lincoln had a clear understanding of the purpose of the surgery which was to give him a more masculine chest configuration. He said that he was confident that Lincoln can maturely describe the surgery and both the advantages and disadvantages of it, and make a rational decision about proceeding with the surgery. Dr V said that he also believed that Lincoln appreciates the permanence of the decision to undergo mastectomy surgery.

46. Dr V also said that he saw Lincoln and his parents for the second consultation on 28 November 2016. He said that he went through the surgery again including all the relevant risk and complications and discussion about the expected outcome. He said that he believes Lincoln and his parents have a good understanding of the surgery.

47. Dr H, consultant physician, endocrinology and metabolism, has seen Lincoln on four occasions since October 2015. Dr H is the endocrinologist who has been treating Lincoln with the stage 2 treatment since April 2016. This has involved injections of primoteston, a depot intramuscular testosterone preparation initially every three weeks but since 26 July 2016 each two weeks. He described Lincoln's response to treatment as excellent and says there have been significant improvements in Lincoln's gender dysphoria. He said that there have been significant physical changes analogous to normal male puberty in response to the treatment which Lincoln has found gratifying. He said that there have been no adverse effects from treatment. He said that he believes that Lincoln is able to comprehend the nature of the treatment such that he is able to provide informed consent. He said that Lincoln is aware of the potential benefits and negative effects of treatment. He said that Lincoln is aware that the effects of surgery are irreversible and therefore permanent. He said that Lincoln's expectations of surgery are realistic such that he does not expect treatment to address all future psychological and social difficulties that he may encounter.

48. As indicated above, Dr K, child, adolescent and adult psychiatrist has been assisting Lincoln since 26 March 2015. Dr K interviewed Lincoln on 5 October 2016 in respect of *Gillick* competence concerning chest masculinisation surgery. Dr K said that Lincoln has been a committed and cooperative participant throughout his therapeutic relationship with him, even when Dr K needed to express views that Lincoln was not completely comfortable with. Dr K said that Lincoln has not ceased or altered his medications without prior consultation with him. He said that the child has similarly engaged with his endocrinologist and that he has expressed confidence and trust in Dr V. Dr K said that he did not foresee any realistic chance of non-adherence to Dr V's treatment and management.

49. In respect of Lincoln's competence to consent to the *Gillick* standard Dr K said as follows.

> 18.1 [Lincoln] demonstrated the **ability to comprehend and retain both existing and new information regarding the proposed treatment** as we conducted the interview. He was not very knowledgeable about details concerning possible side effects and complications of the surgery, but this did not strike me as being out of keeping with his stage of development and with the amount of knowledge of older patients seeking similar surgery.
>
> 18.2 **Ability to provide a full explanation, in terms appropriate to the child's level of maturity and education, of the nature of the treatment**
>
> [Lincoln] referred to the procedure as "top surgery", which is a commonly used term in the transgender community. He said that the surgeon "will cut into the nipple and breast tissue in a U-shape, pull it down and take away the breast tissue. He will reshape the chest into a man's shape. ([Lincoln]) will be in hospital for one night and go home the next day. (He) will be given pain medication and will need to have drainage tubes and wear a post-surgical vest for at least four weeks. ([Lincoln]) won't be able to do much for three weeks and then will be able to walk around and go to school but not do any exercise for another four weeks. The scars will be mainly healed in two months, but not faded until a few years (have passed).
>
> 18.3 **Ability to describe the advantages of the treatment**
>
> [Lincoln] said, "I have a lot of body dysphoria concerning that part of my body. I won't have to wear a binder every day – I absolutely hate that. I can't breathe properly in it. I can't do sport. It soaks up all the sweat – it's really hot and unbearable in the summer. I want to be able to run around. My body shape isn't even very good in a binder – I have to wear layers of clothing. I want to be able to just

wear a t-shirt. I spent the whole of (last) summer in a jumper. My body will look the way I want it to.

It will absolutely help the way that other people see me. I will be a lot more comfortable coming out as people will look at me and wouldn't see a female body."

18.4 **Ability to describe the disadvantages of the treatment**

[Lincoln] answered, "Expense, that's a big thing. My Dad will be able to raise the money (by selling a valuable [item] that he owns). There's going to be pain and there's going to be scarring." When I asked about his inability to breast feed a baby in the future, [Lincoln] said, "I'd rather die than have a baby." When I asked what would happen if the results of the surgery were not satisfactory, he replied, "I can have follow-up surgery if necessary – (Dr [V]) does it for free." When I asked [Lincoln] if he thought that there was any chance of regret in the future for having had the surgery, he replied with an emphatic "No".

18.5 **Ability to weigh the advantages and disadvantages in the balance, and arrive at an informed decision about whether and when he should proceed with the treatment**

[Lincoln] was clearly aware of the main advantages and disadvantages of the procedure. He said that the advantages were "all the way" and had no doubt that he wants to have the surgery. This attitude was reiterated in a recent review interview on 23 November, in which he was eagerly anticipating the Court hearing and stated his clear hope to have the surgery during the forthcoming summer school holidays

18.6 [Lincoln] acknowledged that the **treatment will not necessarily address all of the psychological and social difficulties that he had before its commencement** (although there is still much subjective distress, there has been objective improvement already). He anticipates that he will still have a lesser but ongoing degree of gender dysphoria.

18.7 It is my clinical opinion that [Lincoln] is **free to the greatest extent possible from temporary factors such as pressure of pain that could impair his judgment in providing his consent to the treatment.**

(original emphasis)

CONCLUSION

50. In my view, on the basis of all the above evidence Lincoln is competent to consent to the proposed treatment.

51. If I am wrong in this conclusion, then I accept the submissions of all parties and the Secretary that the proposed treatment is in the best interests of Lincoln.

I certify that the preceding fifty one (51) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Johnston delivered on 13 December 2016.

Associate:

Date: 13 December 2016

Source: http://www.austlii.edu.au/au/cases/cth/family_ct/2016/1071.html